
HOUSE JOINT MEMORIAL 4014

State of Washington 60th Legislature 2007 Regular Session

By Representatives Morrell, Cody, Darneille, Hankins, Lovick, Linville, Kessler, Morris, Goodman, Clibborn, Williams, Green, Grant, Kagi, Moeller, Conway and Seaquist

Read first time . Referred to .

1 TO THE HONORABLE GEORGE W. BUSH, PRESIDENT OF THE UNITED STATES,
2 AND TO THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF
3 REPRESENTATIVES, AND TO THE SENATE AND HOUSE OF REPRESENTATIVES OF THE
4 UNITED STATES, IN CONGRESS ASSEMBLED:

5 We, your Memorialists, the Senate and House of Representatives of
6 the State of Washington, in legislative session assembled, respectfully
7 represent and petition as follows:

8 WHEREAS, The Washington State Legislature finds and declares that:

9 (1) The objective of our health care system is health, not just the
10 financing and delivery of health care services;

11 (2) The objective of "health" cannot be achieved unless all
12 individuals have timely access to a basic set of effective health
13 services;

14 (3) Public resources are finite, and therefore the public resources
15 available for health care are also finite;

16 (4) Finite resources require that explicit priorities be set
17 through an open process with public input to determine what will and
18 will not be financed with public resources; and

19 (5) Those with more disposable income will always be able to

1 purchase more health care than those who depend solely on public
2 resources; and

3 WHEREAS, The Washington State Legislature finds that:

4 (1) The current health care system is unsustainable due to outdated
5 federal policies reflecting the realities of the last century, rather
6 than the realities of today, and is based on a set of assumptions which
7 are no longer valid;

8 (2) The ability of states to maintain the public's health is
9 increasingly constrained by these federal policies which were built
10 around categories rather than a commitment to ensure all citizens have
11 timely access to effective health services;

12 (3) Federal programs, which were established through three specific
13 acts of Congress in the last century, were enacted separately at
14 different times for different reasons and reflect no sense of common
15 purpose;

16 (4) The economic and demographic environment in which these
17 programs were created has changed dramatically over the past 50 years
18 while the programs themselves continue to reflect a set of
19 circumstances that existed in the mid-20th century;

20 (5) Any reform effort that fails to address the contradictions and
21 inequities embodied in these federal programs and fails to bring them
22 into alignment with the realities of the 21st century will also fail to
23 achieve meaningful reform, perpetuating the status quo and the
24 contradictions, inequities, and consequences outlined in this Memorial;
25 and

26 (6) Any strategies for financing, mandating, or developing new
27 programs to expand access that fail to address what will be covered
28 with public resources and how those services will be delivered will do
29 little to stem escalating medical costs, make health care more
30 affordable, or create a sustainable system; and

31 WHEREAS, The Tax Reform Act of 1954 excluded the cost of employer-
32 sponsored health insurance from the definition of taxable income, thus
33 granting a public subsidy to employer-sponsored coverage and creating
34 the major private sector component of the current United States health
35 care system:

36 (1) Since it was created over 50 years ago, the public subsidy of
37 employer-sponsored coverage has grown nationally to over \$200 billion

1 a year and is financed by all taxpayers, including a growing number of
2 workers who do not benefit from employer-sponsored coverage and are
3 often uninsured;

4 (2) This subsidy is extremely regressive, meaning that it is more
5 valuable to employees in higher tax brackets than to those in lower tax
6 brackets;

7 (3) Since the inception of the public subsidy of employer-sponsored
8 coverage, a highly competitive global economy has developed which
9 increasingly puts United States businesses at a competitive
10 disadvantage with businesses in other countries not burdened by the
11 spiraling cost of providing health care to their employees;

12 (4) As the cost of health care continues to increase, the number of
13 private sector employers offering health insurance coverage to their
14 employees is steadily declining, currently at a rate of over four
15 percent per year;

16 (5) As the cost of health care continues to increase, employers
17 have shifted additional costs to employees through higher premium
18 contributions, higher deductibles, higher coinsurance, and higher
19 copayments or have decreased benefit levels to help keep costs down;
20 and

21 (6) Conflicts over the cost of health care are a key element in
22 virtually all labor disputes, often resulting in work stoppage and lost
23 productivity; and

24 WHEREAS, Medicaid was enacted in 1965 to improve financial access
25 to health care for certain categories of poor citizens, primarily:
26 Poor women and children; those who are blind; and those with
27 disabilities. Only those who fit into one of these categories are
28 eligible for the program. In addition, Medicaid pays for the premiums,
29 coinsurance, and deductibles for low-income seniors who are covered by
30 Medicare and pays for services like long-term care which are not
31 covered by Medicare, giving these individuals "dual eligibility":

32 (1) Because eligibility for Medicaid is based on "categories," not
33 strictly on financial need, current federal policy has created a
34 distinction between the "deserving poor," those who fit into a
35 category, and the "undeserving poor," those who do not. As a
36 consequence, many poor citizens are ineligible for Medicaid even though
37 they are deeply impoverished;

1 (2) There is a huge administrative cost involved with determining
2 who is eligible for the 28 different Medicaid categories which exist
3 today;

4 (3) Those who have dual eligibility in both Medicaid and Medicare
5 account for only 14 percent of Medicaid enrollment but over 40 percent
6 of program cost, making them the most expensive part of the Medicaid
7 population. As the population ages, the number of those with dual
8 eligibility will increase substantially, driving up the cost of the
9 program; and

10 (4) Medicaid has become a backstop for the decline in private
11 sector employer-sponsored coverage. Twenty years ago 75 percent of
12 those enrolled in Medicaid were receiving welfare, while today less
13 than one-fourth are receiving public cash assistance. Most of those on
14 Medicaid are workers and their families who simply have medical needs
15 which they cannot afford; and

16 WHEREAS, Medicare was enacted in 1965 in order to improve financial
17 access to health care for older citizens. It is an entitlement program
18 beginning at age 65 regardless of the income of the retiree and is
19 financed primarily by taxes paid by those who are currently working.
20 It covers acute care services but not long-term care services:

21 (1) Forty years ago those over the age of 65 constituted the single
22 poorest segment of the population, but Social Security and Medicare
23 have greatly improved the financial status of many seniors after
24 retirement. Yet all retirees are entitled to publicly financed health
25 care paid for primarily by current workers, many of whom cannot afford
26 health care for themselves and their families;

27 (2) Medicare does not cover long-term care, therefore those who
28 need long-term care services must spend themselves into poverty in
29 order to become eligible for Medicaid, dual eligibility, at which point
30 their needs compete directly with those of poor women and children; and

31 (3) Certainly there are many frail, elderly citizens who need and
32 deserve publicly subsidized health care, but there are many children
33 and working citizens who deserve exactly the same thing and are
34 eligible for nothing; and

35 WHEREAS, These outdated federal laws were enacted over the past 30
36 years and increasingly jeopardize the health of our population,
37 undermine the strength of our economy, and put the future of our
38 children at risk; and

1 WHEREAS, These federal programs have resulted in the following
2 consequences:

3 (1) Misaligned Incentives: The incentives in the current system
4 are aligned to finance health care services rather than to produce
5 health. These incentives reward the use of procedures and technology
6 to treat the medical consequences of disease and disability rather than
7 to prevent it in the first place. Misaligned incentives encourage the
8 overutilization of resources with little regard for the health benefit
9 produced, particularly from a population standpoint;

10 (2) Rising Health Care Costs: Misaligned incentives, an aging
11 population, a growing incidence of chronic disease, a financing
12 structure which shields the true cost of treatment decisions from both
13 providers and consumers, and advancing technology have all led to
14 dramatic medical cost inflation. The cost of health care is growing at
15 an average three times as fast as general inflation, dramatically
16 exceeding the growth in state revenues, workers' wages, and typical
17 business earnings. The United States spent \$1.9 trillion on health
18 care in 2004, \$6,280 per person which far exceeded the amount spent by
19 any other country in the world, many of which have far better
20 population health statistics than does the United States;

21 (3) Cost Shifting: As health care costs increase, both employers
22 and states are forced to drop people from insurance coverage, steadily
23 driving up the number of uninsured citizens who cannot afford the cost
24 of care. Many of these people delay seeking needed treatment until
25 they are very sick, resulting in higher needs when they turn to more
26 costly levels of care and hospital emergency rooms, where federal laws
27 require that they be seen and treated. The resulting uncompensated
28 cost is then shifted back to public and private third-party payers,
29 including government health care programs financed by taxpayers, and to
30 employers offering health care coverage to their workers, forcing them
31 to drop more people from coverage, repeating the cycle;

32 (4) Increasing Uninsured: Over 15 percent of Washingtonians,
33 approximately 700,000 people, do not have health insurance. These
34 individuals receive less effective care and receive it later than those
35 with coverage, often when they are very sick. On average they are less
36 healthy and less able to function effectively in their daily lives.
37 This pattern of delayed treatment shifts costs to those who do have

1 coverage, creating a cycle that increases costs and makes health care
2 unaffordable for even more Washingtonians;

3 (5) Impact on Individual Washingtonians: Rising health insurance
4 premiums are far outpacing inflation, which has caused wage growth to
5 lag, thereby reducing take-home pay. In addition, nearly two in five
6 adults now have difficulty paying medical bills, and nearly half of all
7 individuals who file for bankruptcy do so due to medical expenses.
8 Washington workers are losing jobs as businesses move the production of
9 goods and the provision of services abroad where health coverage is not
10 an expense and labor costs are lower. So, not only are wages lagging
11 and medical bills mounting, but jobs are disappearing as well;

12 (6) Impact on the Health of Washingtonians: Washington falls short
13 in optimizing the health of its citizens as federal programs have
14 created a system where resources are continually focused on acute care.
15 This neglects the significant contribution of prevention activities
16 that improve quality of life, reduce the burden of disease and chronic
17 illness, and reduce the costs of acute and chronic disease management;

18 (7) Impact on Washington's Businesses: Employers have been faced
19 with spiraling premiums or, in the case of large self-insured
20 employers, unrelenting increases in medical claims costs. These
21 increases have reduced the profitability and competitiveness of many
22 employers and the wages they may pay their employees. Their response
23 in many instances has been to reduce benefits or contribution levels,
24 to pass the additional costs on to their employees through cost
25 sharing, or to drop coverage for their employees or their employees'
26 dependents; and

27 (8) Impact on Washington's Budget: Rising health care costs have
28 had an increasing impact on the state's budget. While enrollment grew
29 in Washington's health programs during the 1990s, state revenues did
30 not keep pace with the costs of providing health care services to an
31 expanding population. During the recession and the subsequent budget
32 crisis in the early part of this decade, the state was forced to cut or
33 reduce essential health care coverage to thousands of Washington's most
34 vulnerable residents because it lacked adequate resources to pay for
35 that coverage, or competing priorities required the reallocation of
36 those public resources to other areas. Many Washingtonians who lost
37 coverage because of these actions ended up in the emergency room, often

1 when they were very sick and needed more costly care, and the
2 uncompensated cost was then shifted back to the state; and

3 WHEREAS, Unless these federal policies are fundamentally changed,
4 they will lead to the following consequences in the future:

5 (1) Medicare Insolvency: The pending insolvency of the Medicare
6 program is being driven by a huge demographic shift. Since 1900 the
7 United States population has tripled; the population of those over the
8 age of 65 has grown ten times; and the population over the age of 85
9 has grown 30 times. Today 13 percent of the population of the United
10 States is over the age of 65, by 2030 twenty percent will be over the
11 age of 65. The fastest growing segment of the United States population
12 is people over 100 while the second fastest growing segment is people
13 over the age of 85. We are experiencing profound social and economic
14 consequences due to very high proportions of elderly persons, very high
15 dependency ratios accompanied by continuing low fertility, and very low
16 mortality. In 1957 a woman had, on average, 3.8 children. Today she
17 has 2.0. During the last half century an extraordinarily large
18 generation has been followed by an extraordinarily small generation.
19 In March of 2005, the board of trustees for Social Security and
20 Medicare warned that the Medicare trust fund will become insolvent in
21 2018. Trustees also reported that Medicare's expenditures will surpass
22 Social Security's by 2024 and double them by 2079. Medicare's total
23 unfunded liability was shown at \$65.4 trillion, with the new
24 prescription drug benefit accounting for \$18.2 trillion. In 2004,
25 Medicare accounted for 8 percent of all federal income taxes. This is
26 estimated to rise to 19 percent in 2015, 32 percent in 2025, and more
27 than 90 percent by 2075;

28 (2) Currency Crisis and Loss of Self-Determination: The United
29 States national debt is now approaching \$9 trillion and is escalating
30 even as the population ages. While Congress is preoccupied with the
31 solvency of the Social Security system, the real challenge is Medicare.
32 The Social Security gap is around \$5 trillion but, by comparison, when
33 the baby boom generation reaches age 65 the unfunded entitlement in
34 Medicare will exceed \$65 trillion. This staggering deficit is being
35 financed largely by selling United States securities to China and to
36 other countries still willing to purchase them. If these nations
37 decide to stop underwriting United States deficit spending we will face
38 a currency crisis, a stock market crash, and soaring interest rates.

1 And while this may not happen in the immediate future because these
2 other nations want our economy to remain strong so United States
3 consumers can buy their goods and services, it is no longer our
4 decision to make. We have handed much of our financial future over to
5 some of our major international competitors;

6 (3) Growing Market Instability: Over the last 12 years, the
7 national percentage of private sector employers offering health
8 benefits has dropped 32 percent, and the deterioration is accelerating.
9 Between 1991 and 2000, the average erosion rate was 2.4 percent, but
10 during the recent recession this erosion rate almost doubled, to 4.5
11 percent. Private sector coverage and individual payments for health
12 services have largely cross-subsidized publicly financed coverage over
13 the past few decades, and the escalation of health care costs is
14 forcing states and the federal government to cut back on Medicare and
15 Medicaid allocations, creating a growing conflict between the
16 increasing demand for services and declining resources. Private sector
17 coverage alone expends about half of all health care dollars. As
18 employer-sponsored coverage continues to decline there will be a steady
19 decline in the total amount of money available to buy health care
20 products and services. Over time this will adversely affect the
21 financial outlook of health care companies, negatively impacting their
22 margin, stock price, market capitalization, and credit. And because
23 health care spending accounts for one out of every seven dollars and
24 one out of every 11 jobs in the United States, these disruptions in the
25 nation's health care economy will cascade to the larger United States
26 economy, generating growing market instability; and

27 WHEREAS, It is the goal of the Washington State Legislature to
28 optimize the health of Washingtonians and the value of the public
29 resources spent on health care;

30 NOW, THEREFORE, Your Memorialists respectfully pray that the United
31 States Congress: Amend the Tax Reform Act of 1954, Medicaid, and
32 Medicare to create a sustainable system which allocates the public
33 resources currently being spent on health care according to the
34 following principles; and grant authority for the State of Washington
35 to allocate the public dollars currently being spent on health care
36 within the state to create a sustainable system which will optimize the
37 health of Washingtonians within the context of the following
38 principles:

- 1 (1) Eligibility and Equity: All individuals will be eligible for
2 and have timely access to at least the same set of essential, effective
3 health services;
- 4 (2) Financing: Financing of the health care system should be
5 equitable, broadly based, and affordable to all individuals;
- 6 (3) Population Benefit: The public will set priorities to optimize
7 population health, seeking the greatest health benefit for the largest
8 number of people;
- 9 (4) Responsibility: Responsibility for optimizing health will be
10 shared by the individual, the health care system, and the community.
11 Individual choices that lead to healthy outcomes will be supported by
12 a partnership between all three;
- 13 (5) Education: The system will provide information, resources, and
14 incentives for individuals to actively participate in activities to
15 keep themselves well and take part in decision making about their
16 health;
- 17 (6) Effectiveness: The relationship between specific health
18 services and desired health outcomes will be backed by unbiased,
19 objective medical evidence;
- 20 (7) Efficiency: The administration and delivery of health services
21 will use the fewest resources necessary to produce the highest quality;
- 22 (8) Explicit Decision Making: The criteria for decision making
23 will be clearly defined and accessible to the public, including clear
24 lines of accountability for the decisions themselves;
- 25 (9) Transparency: The evidence used to support decisions will be
26 clear, understandable, and observable to the public;
- 27 (10) Economic Sustainability: Health care expenditures will be
28 managed to ensure sustainability over the long term, using efficient
29 planning, budgeting, and coordination of resources, based on public
30 values and recognizing the importance of public expenditures on private
31 health care;
- 32 (11) Aligned Financial Incentives: Financial incentives will be
33 aligned to support and invest in activities that will achieve the goals
34 stated in this Memorial;
- 35 (12) Prevention: Health promotion and disease prevention efforts
36 should be emphasized and strengthened;
- 37 (13) Community-Based: The delivery of care and distribution of

1 resources will be organized to take place at the community level,
2 unless outcomes or accountability can be improved at regional or
3 statewide levels; and

4 (14) Coordination of Care: Collaboration, coordination, and
5 integration will be emphasized throughout the health care system.

6 BE IT RESOLVED, That copies of this Memorial be immediately
7 transmitted to the Honorable George W. Bush, President of the United
8 States, the President of the United States Senate, the Speaker of the
9 House of Representatives, and each member of Congress from the State of
10 Washington.

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