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By Representatives Morrell, Cody, Darneille, Hankins, Lovick, Linville, Kessler, Morris, Goodman, Clibborn, Williams, Green, Grant, Kagi, Moeller, Conway, Seaquist, Kenney, McIntire, Schual-Berke and Hurst

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

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

WHEREAS, The Washington State Legislature finds and declares that:

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

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

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

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

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

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

WHEREAS, The Washington State Legislature finds that:

(1) The current health care system is unsustainable due to outdated federal policies reflecting the realities of the last century, rather than the realities of today, and is based on a set of assumptions which are no longer valid;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Eligibility and Equity: All individuals will be eligible for and have timely access to at least the same set of essential, effective health services;

(2) Financing: Financing of the health care system should be equitable, broadly based, and affordable to all individuals;

(3) Population Benefit: The public will set priorities to optimize population health, seeking the greatest health benefit for the largest number of people;

(4) Responsibility: Responsibility for optimizing health will be shared by the individual, the health care system, and the community. Individual choices that lead to healthy outcomes will be supported by a partnership between all three;

(5) Education: The system will provide information, resources, and incentives for individuals to actively participate in activities to keep themselves well and take part in decision making about their health;

(6) Effectiveness: The relationship between specific health services and desired health outcomes will be backed by unbiased, objective medical evidence;

(7) Efficiency: The administration and delivery of health services will use the fewest resources necessary to produce the highest quality;

(8) Explicit Decision Making: The criteria for decision making will be clearly defined and accessible to the public, including clear lines of accountability for the decisions themselves;

(9) Transparency: The evidence used to support decisions will be clear, understandable, and observable to the public;

(10) Economic Sustainability: Health care expenditures will be managed to ensure sustainability over the long term, using efficient planning, budgeting, and coordination of resources, based on public values and recognizing the importance of public expenditures on private health care;

(11) Aligned Financial Incentives: Financial incentives will be aligned to support and invest in activities that will achieve the goals stated in this Memorial;

(12) Prevention: Health promotion and disease prevention efforts should be emphasized and strengthened;

(13) Community-Based: The delivery of care and distribution of

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

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

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

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