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Enacting the Basic Health Plan was not as radical a change for the state of Washington as it might be for some states because in Washington we have taken care of the poor and the infirm since our territorial days. In fact, our state's constitution allows for such an exemption; public monies cannot be spent on individuals *except* for the necessary support of the poor and the infirm.

In June 1987 the Washington Basic Health Plan became law. How we reached that end point is a good lesson in practical politics and the legislative process. It started in 1983 when the Chairman of the Washington State Senate Ways and Means Committee was approached by a hospital administrator who was trying to get a program of state funding established for uncompensated care. The questions asked about how much money might be required and the numbers of people to be served could not be answered. Thus, as legislators often do when faced with a difficult problem to which they cannot find a quick and easy answer, a committee was appointed. Chaired by Bill Richardson, who was then Dean of the University of Washington's Graduate School, the committee involved a number of representatives from the health care community as well as the business community. The Richardson Committee report has served us well over the years; the numbers of people lacking access—from 15% to 18% of the population—have proved most reliable; the costs imposed upon segments of the provider community remain somewhat soft, and the overall societal needs that we should address continue to mount. Since then, subsequent study groups, both public and private, helped to build the political support necessary for us to enact a Washington Basic Health Plan.

Adopting this program required a great leap of faith. The idea of a state agency putting together such a health insurance program and competing in the private sector for clients was completely novel. No other state had done it before, and no other state has yet to assume that same task.

We were assisted by the Committee on Affordable Health Care, formed by Gail Warden who was then Chief Executive Officer of Group Health Cooperative of Puget Sound. That committee, which included insurers, the major providers, the hospital association, Blue Cross, and some of the purchasing community, attempted to study some of the same problems of access and give some aid to our efforts in the public sector.

The Richardson Committee found that between 15% and 18% of the state's population did not have health insurance. We estimated that 400,000 of these 700,000 people were at or below 200% of the federal poverty level, at least 40% of them were children, and at least 40% of them lived in rural areas. These data were helpful politically because we have a number of legislators who represent rural areas. The incidence of poverty as a percentage of the population is greater in the rural counties than in the heart of the urban cities, and thus we could make an intellectual and pragmatic as well as a compassionate argument to representatives and senators from rural areas.

In 1984, when our then existing hospital commission was reauthorized and reextended for another five years, we attempted to get an uncompensated care pool in which the gross revenues of hospitals would be taxed and the pooled monies then given back to those with the highest incidence of charity care. Many in the hospital community were convinced at that time that the uncompensated care problem was a Seattle problem—an urban problem—but opinions have changed over the last six years. That Robin Hood plan made it through the Washington State Senate but was amended in the House of Representatives which voted to strike the sick tax from the bill. Thus we did not get an uncompensated care pool in 1984 which was probably for the best because it would surely have lessened the pressure that helped us pass the Basic Health Plan.

In 1984 the state of Washington adopted a definition of charity care. We have a number of legislators who feel some compassion for people in need, but they are not compassionate toward people who can but do not pay their bills. Thus the definition of charity care is strict; it includes necessary hospital health care for those who are unable to pay, not for those who will not pay. The adoption of the word "necessary" in the definition of charity care is also a definition that carried us into the Basic Health Plan. It has helped us to get a program that is affordable.

Between 1984 and 1987 we had those additional commissions looking at the issue of health care for the poor. We had three bills that went back and forth between the Senate and the

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House, and while several times we had a bill passed through the Senate we could never get it to the House floor. However, in 1986, we gained bipartisan support for the Basic Health Plan, which was critical even though the bill wasn't passed until 1987. We were successful in 1987 because of the so-called McPhaden Commission. It was composed of four legislators from each house, two from each caucus; thus we had four Democrats and four Republicans. Those eight legislators selected six public people to join them, and they also appointed a four-member executive committee, with three of the four members being legislators. Thus the legislators kept control.

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We spent approximately $105,000 of the $125,000 budgeted for the commission and had one full-time and one part-time staff. We did a market survey, using a marketing company to assess whether or not people would really buy a state-run health program if it were made available to them. We tried to answer some of the questions that many people had: Would it work? Would it be a black hole? Would people pay? We went as far as is possible without having an actual product on the market. In 1987 the legislature approved of an experimental plan for a 30,000-enrollee prepaid health insurance program.

Washington is now well underway with that real program, in a fairly good number of real communities, and we are starting to gain some hard evidence about just how such a program might work and, more importantly for legislators, how much it might cost.

The legislature did impose some requirements. First, a managed health care system has to provide the care. We also abridged freedom of choice and abolished fee for service in the Basic Health Plan because there is no fee-for-service payment mechanism from the state to the provider group that agrees to provide the services. The providers sign a contract with the state on the basis of a package of services to be rendered and are paid on a capitated basis.

How any of these provider groups divide those state funds among themselves is not controlled by the state or even covered by their contract with the Basic Health Plan. They can pay themselves on a "fee-for-services rendered basis" if they want or upon whatever basis makes their operation successful.

Second, entry into the program by an individual or family is based on their gross income. We are not concerned with assets.

Third, everybody has to pay. Some will pay less than others, but some will pay total cost if they choose to remain in the program after their income increases to 200% of the poverty level.

A most significant issue in our battles during that three-year period was the struggle between the ethics that drive the medical community, the business community, and the government. The medical ethic is to do everything now and not worry about cost. The business ethic is to find a good deal at the best price without additional taxes. The government ethic is to survive, and one method of survival is to keep its population happy. When the people get restless, politicians get nervous. We perceived a certain unrest in the state of Washington and were trying to minister to that when we adopted the Basic Health Plan in 1987. By 1988 we were ready to take this legislative dream and turn it into a real, live program.