SENATE BILL REPORT

ESHB 2590

AS OF FEBRUARY 25, 1992

Brief Description: Enacting comprehensive health care reform.

SPONSORS: House Committee on Health Care (originally sponsored by Representatives Braddock, Winsley, Wang, Brekke, G. Cole, H. Myers, Wineberry, Locke, Paris, Jones, Franklin, Ogden, R. Fisher, Pruitt, Prentice, O'Brien, Nelson, Jacobsen, Belcher, Spanel, J. Kohl and Anderson; by request of Governor Gardner)

HOUSE COMMITTEE ON HEALTH CARE

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Scott Plack (786-7409)

Hearing Dates: February 25, 1992

BACKGROUND:

Despite Washington's status as a bellwether state in health reform, its health service delivery system has grown increasingly dysfunctional with costs rising rapidly while access continues to decline. During the past decade, health costs have risen at an annual rate of more than 11 percent with $4.5 billion in 1980 to $13.4 billion in 1990. During that period, per capita spending escalated at an annual rate approaching 10 percent--increasing from $1,081 in 1980 to $2,737 in 1990. The portion of the state general fund going for health care increased from 14.6 percent from 1981 to 1983, to 21.4 percent from 1991 to 1993.

Presently, between 550,000 to 680,000 Washington residents, 11 to 14 percent of the population, are without health coverage at any given point in time. About one-quarter are children; despite publicly funded programs, over half have income less than 200 percent of the poverty level; and between two-thirds and four-fifths are connected to the work force.

For a thorough discussion of background see: "Need for Health Care Reform [Ch. 1]," Interim Report to Governor Booth Gardner and the Washington State Legislature, Washington Health Care Commission (December 1, 1991).

SUMMARY:

Washington Health Services Commission. Authority to administer the act is given to the Washington Health Services Commission (HSC), consisting of seven members appointed by the Governor with the consent of the Senate. One member must have experience as a health services provider, and another must be an experienced health services administrator. One member

shall be designated by the Governor as chair and shall serve at the pleasure of the Governor. In making such appointments the Governor shall give consideration to the geographical exigencies, and the interests of consumers, purchasers and ethnic groups. An advisory committee representing consumers and the health care community shall be appointed, and ad hoc and special committees are permitted.

Uniform Benefits Package. The HSC shall design the uniform benefits package (UBP) based on the best available scientific health information and weighed against the availability of funding in the state health services budget. The scope of the UBP, initially, should be comparable with the state employees plan and shall include at least the following categories of coverage: inpatient and outpatient services for physical, mental, and developmental illnesses and disabilities including: (a) diagnosis and assessment, and selection of treatment and care; (b) clinical preventive services; (c) emergency health services; (d) reproductive and maternity services; (e) clinical management and provision of treatment; (f) supplies and equipment; and (g) access services.

The HSC shall establish procedures to determine the specific schedule of health services in the uniform benefits package categories of coverage and can appoint panels of experts to assist in this task and shall seek the opinions of the public in doing so.

Other uniform benefits package provisions include: balance billing prohibition; portability; grievance procedure; choice of plans and providers.

Certified Health Plans. To deliver the UBP the commission shall contract with certified health plans (CHP), which are existing insuring entities such as group disability insurers, health care service contractors, and health maintenance organizations. However, the Washington Health Care Authority is designated as a CHP, and the commission may contract directly with local health departments and community health clinics, if necessary, to provide UBP services.

CHPs will receive a capitated payment that is risk adjusted to provide the UBP. CHPs must bear full financial risk and responsibility in delivering the UBP to enrollees, and meet other conditions established by the HSC. The commission is ultimately responsible to ensure enrollee access to the UBP, so if a CHP fails to comply with the requirements, the HSC must take what action is necessary to ensure access.

Financing. The state health services budget shall be derived from the following sources: (a) Medicare, parts A and B; (b) Medicaid; (c) other federal health services funds; (d) state general fund; (e) employer assessment for each employee; however, assessments of employers of small businesses with primarily low-wage employees may be set at a lower rate until July 1, 1997 in order to mitigate the financial burden on such businesses; (f) enrollee premium sharing, which may be paid by the individual directly or through her or his employer. An

enrollee with an income at or below 100 percent of the federal poverty level shall not be required to pay premiums. An enrollee with an income between 100 and 200 percent of the federal poverty level shall pay premiums based on family size and an income level. An enrollee with income over that level shall pay premiums based on family size at a maximum rate established by the commission; and (g) enrollee point of service cost-sharing except to the extent that such cost-sharing would be a significant barrier to receipt of health services within the uniform benefits package.

The amount of the state health services budget is capped and increases shall be limited to the rate of the Consumer Price Index.

The Washington health services trust fund is established in the state treasury, where all financial sources, except for individual point-of-service cost sharing, are deposited. The fund is divided into four accounts: personal health services; public health; improper queuing reserve; and health professional education and research. The HSC must maintain a reserve of 5 percent.

Of the state health services budget, 5 percent is allocated for population-based public health services and shall be deposited in that account. This amount shall be expended through a process involving the state and local departments of health.

Universal Access Mechanism Determination. The HSC shall determine the methods of providing and financing universal access to the uniform benefits package for all residents of Washington State regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment, or economic status. In determining finance methods, the commission shall consider the sources identified in the state health services budget as potential funding sources.

The HSC shall use the following criteria as the basis for its determination: (a) provision of the uniform benefits package to all residents; (b) minimal shift of costs from payer to payer; (c) compliance with health data requirements; (d) accessibility by all residents to the uniform benefits package; (e) efficiency through uniformity in billing, claims, and records procedures; (f) propensity to resist inflationary increases on cost; (g) public accountability; (h) portability of benefits; (i) equity in risk adjustment methods; (k) seamlessness; (l) simplicity and ease with which residents can comprehend the operation of the health services system; and (m) development of appropriate technology.

The commission shall report its findings and recommended methods to the Governor and appropriate committees of the Legislature no later than December 1, 1993. Methods of providing and financing universal access to the uniform benefit package adopted by the Legislature shall be submitted to the people as a referendum.

Long-term Care. Long-term care is to be studied for later inclusion. A provision is set forth urging the Legislature to develop a financing structure for the functionally disabled.

Quality Assurance. A continuous quality improvement and total quality management program is established.

Health Care Liability. The HSC shall report by December 1, 1994 on the status of practice guideline development and the feasibility of a related demonstration project.

Improper Queuing Protection. The HSC shall develop strategies that will reduce or prevent improper-queuing. Funds from the improper-queuing reserve account may be used to implement such strategies.

Health Care Rationing Policy. The HSC shall establish an explicit policy addressing rationing from both the perspective of limitation of financial resources and availability of anatomical gifts. Criteria are set forth. Regional health care ethics committees are established to provide guidance in making rationing decisions.

Federal Waivers. The HSC must apply for the necessary federal waivers and report to the Legislature by December 1, 1993 regarding success of that effort and, if necessary, recommend ways to implement this chapter without waivers.

Key Implementation Dates. The bill takes effect upon enactment.

By May 1, 1992, the director of the Office of Financial Management shall appoint a transition team to study the necessary changes in state government to implement this act.

By December 1, 1992, the commission shall be appointed.

By December 1, 1993, the commission shall submit to the Governor and appropriate committees of the Legislature: (a) draft rules; (b) a report on waivers; (c) recommended financing methods; and (d) uniform benefits package design.

During the 1994 session, the Legislature shall give final approval to the act.

By July 1, 1995, all recipients and enrollees of publicly funded programs shall be enrolled exclusively with a certified health plan.

By July 1, 1998, the Legislative Budget Committee (LBC) completes evaluation of the full act.

Interim Insurance Reform. Pending the full implementation of the residency-based health services system, the enacted insurance reform provision shall have the following effect. Insurers selling group and individual insurance are required to make available to all individuals and business entities in the state a group policy: (a) without medical underwriting,

except for a one-time preexisting conditions limitation of not more than six months; (b) that allows individuals and groups to continue participation on a guaranteed renewable basis; (c) that does not exclude or discriminate in rate making against any individual on any basis, including age, sex or health status or condition; (d) a differential rate based on actual costs that are identifiable on a major geographical basis would be allowed; (e) small business groups with less than 100 employees must be allowed the opportunity to purchase group coverage that is merged into a common pool with all other similar groups and rated on a community basis; and (f) individuals in any policy, having been covered more than 18 months, who terminate their membership must be allowed the option to continue coverage on an individual or family basis, at a cost not to exceed 105 percent of the rate for active members. These provisions take effect July 1, 1992.

When the Health Services Commission adopts the uniform benefits package it will become the minimum benefit package that all insurers will be required to offer and the maximum per capita rate determined by the commission for providing those benefits will be the maximum rate charged by any such insurer for that package. These provisions takes effect January 1, 1994.

The Insurance Commissioner is required to develop a reinsurance mechanism that will enable insurers, on a voluntary basis to share risk.

All interim insurance reform provisions expire July 1, 1996.

Basic Health Plan Modifications. The Basic Health Plan is transferred to the Health Care Authority, where it will be an independent program.

A subscription account is established for payments from those nonsubsidized groups and individuals who may opt into the program at full cost to themselves. Nonsubsidized eligibility is limited to those with gross family income less than 300 percent of the poverty level.

The administrator is required to exercise every precaution to avoid any commingling of funds in these new accounts, with any general fund appropriations or the premiums paid by different categories of enrollees.

Third parties would be allowed to pay the premium, rate or other amounts on behalf of an enrollee.

The original 30,000 maximum subsidized enrollment is deleted; limitation will be determined through appropriations. However, no limitation is set on the number of nonsubsidized enrollees.

Consistent with LBC sunset review recommendations, the purchase of reinsurance, or self-insure for reinsurance, on behalf of participating managed health care systems is allowed.

The sunset review repealers are repealed.

The Basic Health Plan provisions take effect July 1, 1992.

Appropriation:

Revenue: none

Fiscal Note: available

Effective Date: The bill contains an emergency clause and takes effect immediately.