**SENATE BILL REPORT**

**ESB 6089**

**AS PASSED SENATE, MARCH 6, 1992**

**Brief Description:** Enacting comprehensive health care reform.

**SPONSORS:** Senators West, M. Kreidler, Patterson, Bailey, Vognild, Madsen, Talmadge, Johnson and McMullen; by request of Governor Gardner

**SENATE COMMITTEE ON HEALTH & LONG-TERM CARE**

**Majority Report:** Do pass as amended.
Signed by Senators West, Chairman; L. Smith, Vice Chairman; Amondson, and Newhouse.

**Minority Report:** Do not pass as amended.
Signed by Senators M. Kreidler, Niemi, and Wojahn.

**Staff:** Scott Plack (786-7409)

**Hearing Dates:** January 29, 1992; January 31, 1992

**SENATE COMMITTEE ON WAYS & MEANS**

**Majority Report:** Do pass as amended.
Signed by Senators McDonald, Chairman; Craswell, Vice Chairman; Amondson, Bailey, Bluechel, Cantu, Hayner, Metcalf, Newhouse, Saling, L. Smith, and West.

**Minority Report:** Do not pass as amended.
Signed by Senators M. Kreidler, Murray, Niemi, Rinehart, Talmadge, Williams, and Wojahn.

**Staff:** Cindi Holmstrom (786-7715)

**Hearing Dates:** February 11, 1992; February 13, 1992

**BACKGROUND:**

Many view the health care system in the state as increasingly dysfunctional and in a growing state of crisis. The nature of the problem and its causes are complex and involve many interacting factors.

The Office of Financial Management has estimated that health care costs in the state have grown over the past ten years at an annual rate of 11.6 percent, two to three times the general inflation rate for the same period. At the national level, health care costs consumed 11.5 percent of the GNP in 1990 up from 8.5 percent in 1980.

Many factors contribute to this fast-paced growth in costs, including the high cost of medical technology; the expensive

medical care resulting from drug abuse, AIDS, and preventable illness; administrative inefficiencies in the system; increased medical liability and defensive medicine practices; overutilization by consumers who have received highly subsidized health care insurance and have little incentive to control their utilization as well as other factors.

This rate of growth has continued despite government and private efforts to slow it. Since health care is paid for by both the public and private sectors, many believe that if cost increases are not controlled they will be a significant threat to the state budget and business profitability and competitiveness.

At the same time it is estimated that between 11 and 14 percent of persons in Washington State are not covered by some sort of health insurance, which can adversely affect their ability to obtain illness care. Many more fear that as health care costs increase, employers will significantly reduce or eliminate health care benefits for their employees, leaving even more people at financial risk should they need illness care. Employer sponsored health insurance is the primary source of health insurance for most people.

In recognition of this problem, the Legislature created the Washington Health Care Commission (WHCC) and directed it to recommend methods to control health care costs, identify appropriate and effective health services interventions, recommend changes to medical malpractice and liability insurance to reduce associated costs, and propose plans to assure access to health care for all people in the state, including a system for funding the health care system. The WHCC made an interim report to the Legislature in December 1991 and will make its final report in December 1992.

**SUMMARY:**

The study responsibilities of the Washington Health Care Commission are expanded to include: (1) proposing alternative uniform benefit packages and estimate costs of each; (2) analyzing effects of the federal ERISA act on health care costs and need for changes in federal law: (3) proposing optional strategies to a central authority for addressing on an ongoing manner health care issues related to cost, access and quality; (4) investigating a voucher system to allow Medicaid participants to buy private insurance; and (5) proposing optional strategies to establish annual state health expenditure targets.

The Basic Health Plan (BHP) is reauthorized. Enrollment of nonsubsidized individuals and employees of small businesses with incomes under 300 percent of the federal poverty level is allowed. Enrollment of small business groups when 75 percent of the employees have incomes under 300 percent of the federal poverty is allowed. Modifications are made to the BHP that allow additional flexibility to enroll low income people from timber impact areas within current appropriations for such

enrollees. DSHS is directed to seek federal waivers to allow enrollment of Medicaid patients in the BHP.

The State Health Care Authority (HCA) is directed to encourage enrollment of employees and retirees in organized delivery systems (managed health care systems). The HCA is directed to use financial incentives, including employee premium sharing, to encourage a target of at least 75 percent of employee and retiree enrollment in cost-efficient organized delivery systems. The current requirement is deleted that requires a vote of at least five members of the State Employee Benefits Board to allow premium contributions.

The membership and data collection activities of the current Health Care Access and Cost Control Council are expanded. General principles for data collection and use are established. Eight additional public members are added (currently there is one). Appointments are to be made by the Governor and must assure the council has the necessary technical capabilities as well as to reflect the perspectives of users and reporters of data. All health care providers and payors are required to submit data on health care costs, quality and utilization. The council is required to contract for the data collection activities. The data collection and analyses will be paid for by assessments to providers and payers and other fees charged for data requests and special studies.

The Department of Health is directed to report to the Legislature by December 15, 1992 on the possible development and use of practice parameters and risk management protocols for quality assurance.

Four separate strategies for health care malpractice reform are authorized. Limits are established on attorney contingency fees for health care malpractice. Joint and several liability in health care malpractice is limited to recovery of economic damages and only when the plaintiff shares no fault or liability. A certificate of merit is required in lawsuits for health care malpractice. A program is established in DOH to purchase medical liability insurance for retired physicians practicing without compensation in public and nonprofit clinics.

When health care providers inform patients of a financial interest they hold in a laboratory or other services where they are referring a patient, they must also inform them of alternative facilities available to the patient. DOH is required to establish standards prohibiting or restricting such referrals and report to the Health Care Committees in the House and Senate by June 30, 1993 on needed statutory changes to implement standards.

All health care insurers (commercial insurers, health service contractors and HMOs) are required to use the UB 82 and HCFA 1500 claims forms by January 1, 1994. State agencies purchasing health care services are required to do the same by July 1, 1994. The Health Care Access and Cost Control is

required to develop a form to cover health care services that do not use the UB 82 or HCFA 1500 and to make them available for use by insurers.

Health care providers who participate in the state's medical assistance program are permitted to participate in the state's deferred compensation program.

Group commercial plans are exempt from the state insurance premium tax for policies issued under the state's smaller employer basic health plans that are exempt from mandated benefits. (Health service contractors and HMOs are already exempt.)

An allocation risk pooling mechanism is established for insurance carriers who sell health care insurance to small businesses (with between three and 49 employees) and fully insured trade and professional associations. All commercial insurers, health service contractors and HMOs that offer plans to small employers are required to participate. Targets are established as to the number of high risk enrollees for each carrier. A basic health benefit plan is created which all participating carriers must offer. Guaranteed issue and renewability is required. Individual employees in a small business, or the small business itself, may not be denied coverage due to the health status or claims experience of an individual or the small business. Limits on preexisting conditions are limited in most cases to six months. Some restrictions are provided for setting rates. Rates for similar groups in a geographic area may not vary by more than plus or minus 25 percent from the average and limits on rate increases are limited to adjustments not to exceed 15 percent.

Pharmacists and pharmacy assistants are placed under the health professional Uniform Disciplinary Act (UDA). Supervisors of medical test sites licensed by DOH must hold a state health professional credential or be certified by a recognized clinical laboratory science certification program.

**Appropriation:** none

**Revenue:** none

**Fiscal Note:** available

**TESTIMONY FOR (Health & Long-Term Care):**

The measure establishes much needed broad reforms to the health care insurance system. Health care insurance has become too expensive and many middle and low income people are being priced out of the market. It expands access to health care services to individuals who work in small business and currently do not have health care insurance. The health care cost containment features of the bill will provide funding to expand access to health insurance through the BHP. The "pay or play" strategy used in the bill will allow business the option of continuing to provide health care benefits for their employees.

**TESTIMONY AGAINST (Health & Long-Term Care):**

The bill creates another government run bureaucracy that will mismanage health care. The program will be very expensive and will be especially threatening to small businesses because they will not be able to afford to "pay or play". The "pay or play" approach will eventually result in a single or very few payers because only large payers will able to survive. Health care reform should be more incremental in nature and broad reforms may destroy the good things about the health care delivery system.

**TESTIFIED (Health & Long-Term Care):** Tim Smolen, Washington State Public Health Association (pro); Bobbie Berkowitz, Washington State Board of Health; Al Allen, David Lurie, Mary Selecky, Pat Libbey, Washington State Local Public Health Officials (pro); Carrie Bashaw, Washington Association of Comm. Centers (pro); Lee Ozmun, Washington State Retired Teachers Association (pro); Frances Hogan, Washington Assembly of Developmental Disabilities; Eleanor Owen, Washington Advocates for the Mentally Ill; Michael Schlitt (con); Roger Collier (con); Robert Gibb (con); Linda Grant, Association of Alcoholism and Addictions; Pat Thibaudeau, Washington Community Mental Health (pro); James Kelly, Commission on African-American Affairs (pro); Kay Topp (pro); Gary Smith, Independent Business Association (con) George Tyler; John Marshall; Roger Collier (con); Steven Aldrich, H.E.R.E. Local 8 (pro); Todd Schiele (pro); Jean Soliz, Governor’s office (pro); Bob Williams, Evergreen Freedom Foundation

**TESTIMONY FOR (Ways & Means):**

The bill addresses the shortcomings in the current system while building on the strengths, without creating another government-run bureaucracy. The small group reforms represent a substantial step forward, by providing access to standard coverage, at a standard rate, while also providing rate stability.

**TESTIMONY AGAINST (Ways & Means):** None

**TESTIFIED (Ways & Means):** Gary Christenson, Washington Basic Health Plan; PRO: Clif Finch, AWB; Mel Sorensen, Washington Physician Service/Blue Cross; Cliff Webster, Washington State Medical Association; Gary Smith, Independent Business Association

**HOUSE AMENDMENT(S):**

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.

The bill contains an emergency clause and takes effect immediately.