# HOUSE BILL REPORT

# E2SSB 5304

As Reported By House Committee On:
Health Care
Revenue

**Title:** An act relating to health care.

**Brief Description:** Reforming health care cost control and access.

**Sponsors:** Senate Committee on Ways & Means (originally sponsored by Senators Talmadge, Gaspard, Moore, Deccio, Wojahn, Moyer, Snyder, Winsley, Fraser, Haugen, McAuliffe, Drew, Sheldon, Skratek and Pelz).

**Brief History:**
Reported by House Committee on:
Health Care, March 30, 1993, DPA;
Revenue, April 5, 1993, DPA(REV w/o HC)s.

## HOUSE COMMITTEE ON HEALTH CARE

**Majority Report:** Do pass as amended. Signed by 10 members: Representatives Dellwo, Chair; L. Johnson, Vice Chair; Appelwick; Campbell; Conway; Flemming; R. Johnson; Morris; Thibaudeau; and Veloria.

**Minority Report:** Do not pass. Signed by 6 members: Representatives Dyer, Ranking Minority Member; Ballasiotes, Assistant Ranking Minority Member; Cooke; Lisk; Mastin; and Mielke.

**Staff:** Bill Hagens (786-7131).

**Background:** In its 1992 report, the Washington Health Care Commission concluded that although "Washington State residents with adequate resources receive some of the most technologically advanced medical care in the world, the health system is in trouble. Costs are rising out of control; spending for health services is increasing at two to three times the general inflation rate. At the same time, an estimated 550,000 to 680,000 Washington residents -- 11 to 14 percent of the state's population -- do not have health insurance. Moreover, the system emphasizes treating illnesses and injuries rather than addressing the underlying causes of health problems.

The commission recommends comprehensive and fundamental reform, including strong incentives and techniques to control total health system costs, encourage healthy behaviors, enhance the efficient delivery of health services, promote prudent use of services by consumers, and equitably distribute financing.

**Summary of Amended Bill:**

**ADMINISTRATIVE STRUCTURE**

The Commission

The Washington Health Services Commission (WHSC) is created consisting of five full-time members appointed by the governor with the consent of the Senate. The insurance commissioner shall be a non-voting member. The chair will be the chief administrative officer.

The primary powers of the commission are to: endeavor to ensure access to health care for all residents; establish a set of uniform health services, the uniform benefits package (UBP) and several supplemental benefits packages; set the maximum premium for both packages; set individual and employer contribution levels and individual point-of-service cost-sharing levels; determine the lowest price UBP for employers; establish a method of medical risk adjustment; and seek federal waivers from Medicare, Medicaid, ERISA and other laws necessary to implement this bill.

The Insurance Commissioner

In addition to current responsibilities, the insurance commissioner will: sit as a non-voting member of the WHSC; regulate certified health plans (CHPs); establish and regulate health insurance purchasing cooperative (HIPC); and undertake a study of the feasibility of developing a single licensure category for CHPs.

Washington Health Care Authority

New duties of the Health Care Authority are to: administer the Washington State Group Purchasing Association; administer the Basic Health Plan (BHP); purchase health benefits for ferry workers and school district employees -- the State Employee Benefit Board (SEBB) becomes the Public Employee Benefits Board (PEBB); become the primary purchasing agent of publicly-funded health services, through designation as the state health services purchasing agent; and administer funds for community and migrant health clinics.

Public Health Governance

Counties are given full responsibility for public health services. The related portion of the motor vehicle excise tax is adjusted accordingly.

**MAJOR ACCESS ELEMENTS**

The access goal that all residents of Washington State shall receive the uniform benefits packages by July 1, 1998, is established.

A uniform benefits package is established that includes health services that are effective and necessary. The UBP can be expanded as expenditures become under control. The schedule of covered health services shall emphasize proven preventive and primary health care and shall include primary and specialty health services, inpatient and outpatient hospital services, prescription drugs and medications, services necessary for maternity and well-child care, including preventive dental services for children, case managed mental health services, a short-term skilled nursing facility, home health and hospice services, subject to preapproval, and other services deemed necessary by the commission. Several supplemental benefits packages shall be defined by the commission. Only certified health plans can provide the benefits packages.

Long-term care is to be included by 1998, however, a social and health maintenance organization pilot project and long-term care partnership program is added.

State and school employee health benefits would be substantially equivalent to benefits offered on January 1, 1993.

Insuring entities are permitted to offer additional benefits not included in either the UBP or the supplemental packages as may be negotiated in union contracts or other agreements.

The Basic Health Plan (BHP) is modified to enable non-poor individuals to enroll without subsidy. Small businesses with less than 100 employees can enroll their employees if the business pays at least 50 percent of the premium. The premium share of non-wage employees can be subsidized. The subsidized enrollment is expanded. In an effort to maximize federal financial participation, Medicaid eligibles are excluded from the BHP, but will be enrolled in the Medical Assistance Program.

**MAJOR COST CONTROL ELEMENTS**

The UBP shall be offered only by certified health plans (CHP), which are existing insuring entities, or newly created entities that agree to comply with certain conditions regarding premium limits, package design, enrollment, portability, before billing, and health data. As of July 1995, only CHPs can offer the two types of packages. The two types of packages shall be provided through managed health care systems; fee for service and balance billing are not permitted.

A maximum premium cap is established for the uniform and supplemental benefits packages. The cap can be adjusted by the WHSC upon the recommendation of the insurance commissioner. To promote managed competition, the lowest priced certified health plan shall be determined on a regional basis. Employers and government sponsors are not required to pay more than 95 percent of that price but that amount can be negotiated.

To permit employers and individuals to strengthen their purchasing power, the insurance commissioner is charged with authorizing the creation of 10 health insurance purchasing cooperatives with not less than 100,000 members in distinct geographical regions to receive benefits on a group basis from certified health plans.

The Washington State Group Purchasing Association is established within the Health Care Authority for the purpose of coordinating and enhancing the health care purchasing power of the following groups: private nonprofit human service agencies; in-home long-term care providers; chore services providers; day care centers' operators; and foster parents.

To strengthen the state's purchasing power, the Health Care Authority is designated as the single state health services purchasing agent for the ultimate purpose of placing all state-purchased health services in a community-rated, single pool by July 1, 1997, including: the Basic Health Plan; school employee benefits; the Washington Purchasing Group Association, health services provided by the Department of Corrections, and state employee benefits. Assuming federal waivers, it shall also include the Medical Assistance Program (Medicaid) of the Department of Social and Health Services. Local governments, as in present law, have the option of joining.

**MANAGED COMPETITION AND LIMITED ANTI-TRUST IMMUNITY**

The Legislature finds that managed competition rather than unrestrained competition will produce a more efficient and cost effective health care market. A comprehensive system

of oversight of health care markets is established to govern the conduct of health care providers, facilities, and certified health plans.

The insurance commissioner is directed to adopt rules requiring certified health plans to publish general criteria for selection of health care providers. Certified health plans need not reveal proprietary criteria but such unpublished criteria cannot be used to terminate a provider under contract with the plan until the provider is informed of the criteria and given an opportunity to conform to the unpublished criteria. The insurance commissioner must also adopt rules requiring provider contracts to contain binding dispute resolution procedures and a process for provider appeal to the plan of a decision to exclude a provider. In addition, whenever the attorney general determines that a certified health plan's market power reaches the point where exclusion of health care providers would result in reduced consumer access to needed health care services, the plan must include all willing and able providers meeting the plan's published criteria for selection of health care providers.

The Legislature intends to permit anti-competitive conduct that furthers the goal of health care reform to the extent that the anti-competitive conduct creates more advantages than disadvantages in the health care market. However, any activity which would constitute a per se violation of anti-trust law is not permitted unless explicitly authorized by the Health Services Commission. Any health care provider, facility, or certified health plan may request that the attorney general issue an informal opinion as to whether the Health Care Reform Act permits certain conduct. If the attorney general determines that the conduct is not permitted, the party may petition the health services commission for permission to engage in the anti-competitive activity. After public hearing and subject to attorney general approval, the commission may authorize the conduct if the commission finds that the health care reform advantages outweigh the competitive disadvantages.

Subject to the approval of the attorney general, the commission must adopt rules: (a) governing conduct among health care providers, facilities, and certified health plans including the use of certain provider contract restrictions; (b) permitting health care providers within the service area of a plan to negotiate the terms and conditions of contracts with certified health plans; and (c) governing the merger of health care facilities. With the assistance of the Attorney General's Office, the commission must actively supervise any anti-competitive conduct authorized and must modify or prohibit authorized conduct

whenever the commission determines that such conduct no longer outweighs competitive disadvantages.

The insurance commissioner is directed to report to the Legislature by January 1, 1994, on the merits of creating a new licensing and regulatory code for certified health plans that would place all insurers, health care service contractors, and health maintenance organizations under the same regulatory constraints while encouraging new certified health plan entrants into the health care market.

**INDIVIDUAL AND EMPLOYER PARTICIPATION**

All residents of the state of Washington are required to enroll in a certified health plan no later than July 1, 1998; individuals are permitted exemptions from this requirement for religious reasons based on constitutional rights.

Employers are required to offer a choice of three certified health plans, including the lowest priced plan, to all of their qualified employees, working more than 80 hours per month, and their dependents and to pay no less than 50 percent and no more than 95 percent of the premium of the lowest cost available certified health plan within their geographic region as determined by the WHSC. For part-time employees, working less than 80 hours per month, an employer contribution will be set based upon a pro-rata formula. Depositories are established to assist in this compilation.

This requirement shall be implemented as follows:

For businesses with greater than 500 employees, employees are to be included by July 1, 1995 and the employees' dependents are to be included by July 1, 1996;

For businesses with greater than 100 employees, employees are to be included by July 1, 1996 and the employees' dependents are to be included by July 1, 1997;

For the remaining businesses, employees are to be included by July 1, 1997 and the employees' dependents are to be included by July 1, 1998.

In lieu of sponsoring coverage for employees and their dependents through direct contracts with certified health plans, an employer may combine the employer contribution with that of the employee's contribution and enroll in the basic health plan or a health insurance purchasing cooperative.

An exemption from purchasing insurance for employees is permitted based upon constitutional religious grounds, however, the employer must make arrangements to transfer the funding to the employee so as to permit enrollment.

**WASHINGTON HEALTH SERVICES ACCOUNT**

The Washington Health Services Account is established. New revenue in the bill is deposited into the account.

Funds in the account can be used for: Basic Health Plan operation; public health services, such as childhood immunization, teen pregnancy prevention and a media campaign directed at teen risk behaviors; primary care provider recruitment and training; community and migrant health clinics; operation of the Health Services Commission; and operation of the health services data system.

**PUBLIC AND LEGISLATIVE PARTICIPATION AND OVERSIGHT**

The WHSC must seek input from the public in developing the UBP.

The UBP supplemental packages and the employer participation requirements must be submitted to the Legislature before the effective date; the Legislature can reject them by law.

A stakeholder's committee must be appointed by the WHSC chair composed of representatives of the health industry, business, labor and consumers.

**PRACTICE GUIDELINES**

The Department of Health is required to establish a process to identify and evaluate practice guidelines and risk management protocols as they are developed by the appropriate professional, scientific, and clinical communities; and recommend the use of practice guidelines and risk management protocols in quality assurance, utilization review, or provider payment to the WHSC.

**LIABILITY REFORM**

Disciplinary Action

The Department of Health and health care practitioner disciplinary boards are given greater authority to take action against incompetent or unlicensed practitioners through: increased expenditures for investigations and disciplinary actions; and, civil penalties for practicing without a license.

Mandatory Malpractice Insurance

Coverage is mandated for independent health care practitioners whose services are included in the UBP.

Malpractice Reduction