FINAL BILL REPORT

E2SSB 5304

PARTIAL VETO

C 492 L 93

SYNOPSIS AS ENACTED

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)

SENATE COMMITTEE ON HEALTH & HUMAN SERVICES
SENATE COMMITTEE ON WAYS & MEANS
HOUSE COMMITTEE ON HEALTH CARE
HOUSE COMMITTEE ON REVENUE

(NOTE: CONTAINS THE EFFECT OF ESB 5076)

BACKGROUND:

During the 1990 legislative session, House Concurrent Resolution 4443 was passed creating the Washington Health Care Cost Control and Access Commission. The commission was charged with recommending changes to health care financing, payment and legal systems necessary to contain health care costs, changing medical malpractice and liability practices, and ensuring universal access to health services for all Washington residents. The commission's final report was issued on November 30, 1992.

The commission found that Washington residents with adequate health insurance receive some of the most technologically advanced medical care in the world. Yet, they found the health system is in trouble. Costs are rising at two to three times the general inflation rate. At the same time, 550,000 to 680,000 Washington residents (11 to 14 percent of the state's population) do not have health insurance. Moreover, the current system emphasizes treating illnesses and injuries rather than addressing the underlying causes of health problems.

The commission determined that the goal of the state's health system should be to maintain or improve the health of all residents at a reasonable cost. To achieve this goal, the commission recommended comprehensive and fundamental reform. The reformed system should encourage healthy behaviors, enhance the efficient delivery of health services, promote prudent use of services by consumers, and equitably distribute the costs. The commission believed that a substantial

majority of the state’s population should receive health services through managed health care systems, integrated delivery systems that manage care and assume financial risk for providing appropriate health benefits cost effectively.

SUMMARY:

Basic Health Plan Transfer and Expansion. The Basic Health Plan (BHP) is moved, for administrative purposes, to the Health Care Authority. Enrollment is expanded statewide during the 1993-1995 biennium to those not eligible for Medicare whose gross family incomes are below 200 percent of the federal poverty level ($28,700 for a family of four).

Any individual not eligible for subsidized enrollment in the BHP may purchase BHP or have their employer or other sponsor pay no less than 50 percent of the premium to help them purchase BHP enrollment, so long as the full cost of the program, including state administrative costs, are paid.

Prescription drugs and medications are included among the benefits offered by the BHP.

On July 1, 1995, managed care plans within the BHP must become certified health plans as regulated by the Insurance Commissioner under guidelines established by the Health Services Commission. The uniform benefits package established by the commission must be offered to the BHP enrollees, effective on that date.

Any state subsidy provided through the BHP must be for the benefit of an enrollee or dependents. It may not be used to reduce an employer’s obligation to pay 50 percent of the premium. This limitation does not apply to tax credits or other subsidies provided in these acts for small businesses. The BHP must continue the current premium pricing structure of the program. For purposes of determining the financial obligation of an employer who might opt to secure coverage for employees through the BHP the amount will be the per adult, per month cost of the plan, including administration.

Consolidated State Health Care Purchasing. The State Employee Benefits Board is renamed the Public Employee Benefits Board. Effective January 1, 1995, the membership is expanded from seven to nine. One state employee representative is removed, and one school district employee, one retired school district employee, and one additional person with experience in health benefit management and cost containment are added.

School district employees are added to those whose health benefit plans are developed by the Public Employee Benefits Board and purchased by the Health Care Authority.

After December 31, 1996, ferry system employees must enroll in certified health plans.

Public employee eligibility for benefits and benefit plans must remain substantially equivalent to those offered to state employees on January 1, 1993.

The Health Care Authority (HCA) must offer at least two Medicare supplemental insurance policies to retired or disabled public employees by January 1, 1994. In addition, if Medicare waivers are not received to implement this act by January 1, 1995, these Medicare supplemental policies must be made available for purchase at full cost through the Health Care Authority to any state resident eligible for Medicare.

The Health Care Authority is designated as the single state health services purchasing agent. By July 1, 1995, the Basic Health Plan, state employee health benefit plans and school district benefit plans must be placed into a single community rated risk pool. The Governor must seek federal waivers to place all medical assistance programs into the same risk pool at the earliest opportunity. Certain powers to bring uniformity to billing, eligibility procedures, access to service providers and other matters are granted to the HCA.

Washington State Group Purchasing Association. The Health Care Authority must establish a group purchasing association for various health and human services providers who are under contract with the state, and who wish to jointly purchase health insurance for their employees. These include foster parents, nonprofit social service agencies, day care centers, chore services providers and others. No state funds may be used to subsidize the association, and it is terminated in 1998.

Community Health Centers Transfer. State funding for the state's network of community and migrant health centers is transferred from the Department of Health to the Health Care Authority. The Authority must recommend ways of including the centers in certified health plans and ensuring the delivery of health services to persons of color in an amount equivalent to their proportion in the population. The Authority, in consultation with the department, must work with the community health centers regarding expansion of services to persons of color and underserved people through managed care.

Public Health Governance. Effective July 1, 1995, the responsibility of governance of local public health boards is placed solely with counties or groups of counties which may form health districts. City and town membership is removed. Some 2.95 percent of the motor vehicle excise tax currently distributed to cities is redirected to county health departments, based on population.

The city representative on the state board of health is replaced by an additional county official.

The Association of Cities, the Association of Counties and the Association of County Officials are requested to study the changes in local public health governance and to make recommendations by March 1, 1994.

Health Data. The Health Services Commission must provide policy direction and oversight for the state Department of Health's development, implementation and custody of a statewide health care data system. The commission may establish a technical advisory committee on health data and may recommend that the department contract with a private vendor for all or parts of the data system.

The data system must include elements related to the cost, quality and outcomes of health services. All entities providing or financing the provision of health services may be required to report data into the system. The Health Department must produce reports and analyses useful to consumers on the cost, quality and outcomes of health services and certified health plans.

Health data reported to the state for the purposes of the act are protected from disclosure by various confidentiality requirements.

Disclosure of Hospital, Nursing Home and Pharmacy Charges. Requirements are established for the disclosure of all hospital, nursing home and pharmacy charges to patients and health care providers.

Health Provider Shortages and Primary Care. The Higher Education Coordinating Board and certain other agencies may establish award amounts and locations for the health professions scholarship and loan repayment program. The Department of Health may make financial awards to urban and medically underserved communities to recruit and retain health professionals. The Department of Health may develop a mechanism for rural and medically underserved communities to contract for health professions with training and education programs.

The Department of Health program to pay medical malpractice premiums for retired physicians practicing in community clinics is expanded to include other primary care providers, including, dentists, physician assistants, advanced registered nurse practitioners, naturopaths and other health professionals deemed to be in short supply in the health personnel resource plan developed according to Chapter 28B.125 RCW.

The University of Washington must prepare a primary care shortage plan with a goal of increasing to 50 percent the number of Washington residents who enter primary care residencies in Washington by the year 2000. Other goals related to improving the education and practice of primary care providers from the University of Washington are also required. These include establishing a joint American Medical Association and American Osteopathic Association training track for primary care providers, in conjunction with a community health center.

Short-Term Health Insurance Reforms. Until the restructuring of health insurance required under certified health plan

requirements is implemented, the act provides several immediate changes in health insurance practices.

Current insurance practices are modified, effective January 1, 1994, to: restrict the use of pre-existing condition limitations; permit coordination of health benefits while retaining cost-sharing features; improve disclosure to people whose policies are cancelled or modified; prohibit cancellation or nonrenewal policies because a person's health deteriorates; and prohibit insurers from offering a new policy to only healthy people for the purpose of isolating unhealthy people in older and subsequently more expensive policies.

Health Services Commission. The Washington Health Services Commission is created as a five member, full-time body, reflecting racial and ethnic diversity, appointed by the Governor with the consent of the Senate. The state Insurance Commissioner is an additional, nonvoting member. The Governor must select the chair who serves at the Governor's pleasure.

The commission chair must appoint four advisory committees including committees on technical services, small business, labor and a general advisory committee. Committee sizes, duties and membership requirements are defined.

The commission must ensure that all state residents are enrolled in a certified health plan, and that all state residents have access to appropriate and effective health services. The commission may modify the boundaries of certified health plans or authorize state agencies to contract for health services not available through certified health plans in order to assure access to services for all residents.

The commission must adopt rules related to the coordination of benefits where a resident or any dependent may have duplicate coverage.

The commission must establish, and after January 1999, may periodically modify the uniform health benefit package. Until then, the package must be the benefit and actuarial equivalent of the Basic Health Plan with additions specified for medications, reproductive services, children's preventive dental care, and managed mental health care, and chemical dependency treatment. The package must be offered to all enrollees in certified health plans for no more than the maximum premium established by the commission.

The initial maximum premium for the uniform benefit package and its initial growth rate are established. Thereafter, the premium's rate of growth is reduced by 2 percentage points each year until it reaches the growth rate in the five year rolling average of personal income in Washington. Procedures are established for adjusting the maximum premium to account for changes in services within the uniform benefit package.

In addition, the commission must establish a set of uniform health services to which all residents should be ensured

access including the uniform benefit package and public health services.

The commission must establish standards for capital expenditures among certified health plans, health care facilities and providers which must be used after June 1, 1995 to approve projects for funding under the Health Care Facilities Authority.

The commission must establish limits on maximum enrollee financial participation related to enrollee household income, set standards for certified health plans and health insurance purchasing cooperatives, establish requirements for uniform billing and claims processing, and establish other guidelines and requirements. A preliminary set of such rules must be submitted to the Legislature by December 1, 1994.

The commission must develop and recommend a medical risk distribution scheme for certified health plans by December 1, 1994. If not disapproved by the Legislature, the scheme may become effective.

The commission must study Taft-Hartley health care trusts and recommend ways of bringing them under the provisions of this act when it is fully implemented. Pending future legislation these trust are exempt from the provisions of this act.

The commission must establish guidelines for providers dealing with treatment for terminal or static health conditions.

The commission must develop rules governing the application of this act for persons who live or work in this state, but who work or live outside of this state.

Upon advice from the technical services advisory committee, the commission must adopt rules governing how certified health plans, disability insurers, health maintenance organizations and health care service contractors determine whether a procedure, treatment, drug or other health service is no longer experimental or investigative.

The commission must evaluate and develop strategies regarding access to health services by racial and ethnic minorities.

The commission must establish standards and monetary penalties prohibiting health care provider investments and referral practices which constitute a conflict of interest.

If the commission finds the economic viability of a significant number of the state's certified health plans is threatened, it may adjust the maximum premium these plans may receive on an emergency basis. Procedures are established for legislative and the Governor's review and approval of such an emergency adjustment.

The commission must study the feasibility of a residency based, single or limited payer system, and report its

recommendations to the Governor and the Legislature by July 1, 1995.

The commission must study and report on the feasibility of offering employer-funded medical care savings accounts and high deductible insurance policies as a choice for public employees.

Seasonal workers and their employers are exempt from the act. Seasonal workers are those working for one or more employers for six months or less; and at least half-time per month in the same industry sector, including food processing, agricultural production or harvesting, plantation Christmas tree planting, and tree planting on timber land. The commission will make recommendations, December 1994, as to how seasonal workers and their employers may be brought under the act.

Medical Malpractice and Liability. A series of changes are made regarding medical malpractice. Providers within certified health plans must have malpractice insurance and risk management training. Other changes include: increasing penalties for unprofessional conduct and practicing without a license; strengthening medical malpractice prevention programs; quality assurance committees within health facilities; and improving sanction and grievance procedures.

The Administrator for the Courts must coordinate a voluntary effort to establish medical malpractice reviews of cases prior to filing. All malpractice cases must complete such reviews and are subject to mandatory mediation, prior to trial.

If multiple parties are at fault in a malpractice suit, judges or juries may assign liability severally to guilty parties, within limitations and exceptions provided in the act.

Health Insurance Purchasing Cooperatives. The commission must designate four geographic regions in the state. Within each region a single health insurance purchasing cooperative may be designated, provided that it will serve no less than 150,000 persons.

Each cooperative must admit any individual or group within their region wishing to join, offer every certified health plan within its region to all co-op participants, be operated as a member owned and governed nonprofit cooperative, provide for centralized enrollment, billing and premium collection, and serve as an ombudsman for co-op members.

Cooperatives must assist their members in selecting certified health plans by establishing rating systems or other evaluative tools. Cooperatives must be self-sustaining through fees charged to participants. They may not bear financial risk for the delivery of health services.

Certified Health Plans. The state Insurance Commissioner must issue a certificate to and regulate an entity seeking to meet requirements as a certified health plan. These requirements

include meeting certain financial solvency and liquidity requirements and other specified items.

However, disability insurers, health maintenance organizations and health care service contractors are certified health plans under the act, so long as they comply with the general standards established.

Notwithstanding any provisions of Title 48 RCW which may conflict, all certified health plans must meet a series of requirements including (a) offering the uniform benefit package through managed care arrangements for the maximum premium on an open enrollment basis to any state resident within their chosen geographic area, (b) prohibiting balance billing, (c) permitting, within certain limits, every category of provider within whose scope of practice uniform benefit services fall to provide services, (d) providing coverage regardless of pre-existing or prior conditions, and (e) reporting the salaries of their executive officers.

Limited certified health plans for dental services are created. They must meet certified health plan requirements for managed care, community rating, portability and nondiscrimination. However, they may offer dental service directly to employees of an employer. If they do, the employer need not provide required dental services within their uniform benefit package. In addition, limited certified health plans for dental services may offer the dental services under a contract with a certified health plan.

Certified health plans must submit rates for the uniform benefit package and for supplemental benefits prior to use. Rates, enrollee point of service cost sharing, maximum enrollee financial participation levels and other information must meet standards established by the commission. The Insurance Commissioner may disapprove filings within time periods specified in the act.

Registered Employer Health Plans. An employer of more than 7,000 full-time employees in this state may meet the requirements to become a registered employer health plan if they (a) provide the uniform benefit package to their employees on a prepaid, community rated, capitated basis for no more than the maximum premium established by the commission, (b) offer supplemental benefits on a community rated basis according to rules adopted by the commission, (c) do not discriminate in the offering on account of age, sex, family structure, ethnicity, health condition, socioeconomic status or other condition, (d) prohibit balance billing by providers and meet other conditions similar to those established for certified health plans.

Contracts Between Certified Health Plans and Providers. The commission must establish rules requiring certified health plans to publish general criteria for selection and termination of providers. If a certified health plan uses unpublished performance criteria to reject a provider participating in a plan, the provider may not be rejected

until informed of the criteria and given an opportunity to conform.

The Attorney General and the Insurance Commissioner must periodically assess the market power of certified health plans to determine when the plans' exclusion of providers may result in the providers' substantial inability to continue practice, thereby reducing access to care. In such cases, plans must contract with all providers within their area, unless the plans can show the Attorney General and the commission that such a requirement would substantially lessen their ability to control costs. If such a showing is made, the plans need not include all providers within their areas.

Managed Competition and Limited Anti-Trust Immunity. Legal actions taken under the act which may reduce competition in the health care market are protected under state law and, under the state action doctrine, from federal prosecution of anti-trust laws. Certain specific anti-trust activities are proscribed.

The commission must adopt rules governing conduct among providers, facilities and certified health plans to protect competition and ensure choice, especially in rural areas. These shall include rules permitting providers in a given area to collectively negotiate the terms and conditions of their contracts with certified health plans, including the right to meet and communicate for the purpose.

Procedures are established for providers, facilities and plans to receive advice from the state regarding the legality of specific acts they are contemplating which may violate anti-trust laws.

Small Business Economic Impact Statement. The commission, with consultation from their small business advisory committee, must submit a small business impact statement in December 1994, outlining the economic impact of the employer mandate to help purchase insurance for employees in businesses with less than 25 employees. The statement must include the results of a survey of small businesses.

If the statement indicates a need to address the economic impact on small business, the commission must submit recommended strategies to address the need including changing the level of coverage provided, employer participation, coverage requirements for dependents or other strategies.

Household Income Analysis. The commission must also submit an analysis of the impact of employee premium contributions on households with family incomes below 200 percent of the federal poverty level.

Supplemental and Additional Benefits, Negotiations. Nothing in the act precludes insurers, health maintenance organizations, health care service contractors or certified health plans from insuring, providing or contracting for

benefits not included in the uniform benefit package or in supplemental benefits.

Nothing precludes an entity from negotiating for services or levels of service not included within the uniform benefits package including negotiating for up to 100 percent of the premium price of the lowest priced certified health plan in a geographic area. However, only certified health plans may offer insurance for supplemental benefits.

Nothing in the act shall be construed to affect the bargaining rights of employee organizations as may be provided under federal law.

After July 1, 1999, no property or casualty policy may provide first-party coverage for health services within the uniform benefit package.

Conscience or Religion. Certified health plans or health care providers who object to delivering uniform benefit package services on grounds of conscience or religion need not do so, and may not be discriminated against for this reason. Certified health plans must provide information to enrollees if such refusals might occur and direct enrollees to other providers who provide such services.

Certified health plans may not discriminate against providers in offering uniform benefit package services, but may use the most cost effective and clinically efficacious treatments.

Long-Term Care. The commission must submit a plan to integrate long-term care within health care reform by January 1, 1995. The plan must include two social and health maintenance pilot projects.

In addition, the Department of Social and Health Services must seek federal waivers for a long-term care partnership program in which private funds and Medicaid funds will be used. Under terms of the waiver, private insurance may be used to shield an individual’s assets from the spend down provisions which the federal Medicaid program now requires before persons can be eligible for Medicaid.

Individual and Employer Participation Requirements. No later than July 1, 1999, all state residents must be enrolled in a certified health plan which may include the Basic Health Plan, unless they claim an exemption on grounds of religious conviction.

Beginning on July 1, 1995 all employers with more than 500 full-time employees must offer a choice of three certified health plans to all employees including the lowest price plan in the area. Employers must pay no less than 50 percent of the cost of the lowest priced plan. Employers must pay a pro-rated share of this amount for employees working less than full-time (30 hours per week). The actual employer percentage of the premium may be determined by employer/employee

negotiations. On July 1, 1996, dependents of the full-time employees in these firms must be offered the same coverage.

On July 1, 1996, employers with more than 100 full-time employees must offer the same choice of certified health plans to their employees meeting the same standards. By July 1, 1997, coverage must be extended to all dependents of full-time employees in these firms.

On July 1, 1997 all employers must offer the same choice of enrollment in certified health plans to all employees. By July 1, 1999, this requirement is expanded to include all dependents of full-time employees.

In lieu of offering a choice of certified health plans, an employer may offer the Basic Health Plan. In this case, the employer share is limited to a 50 percent of the per adult, per month, average BHP cost, including administration.

Exemptions from the employer mandates are provided for dependents and seasonal workers who are covered under a full-time employee’s coverage.

An exemption is provided for employers who have religious objections to these requirements.

Part-Time Worker Depository. The Health Care Authority must develop a depository where the pro rata share payments made by employers on behalf of less than full-time employees may be held. The authority must establish procedures under which individuals working less than full-time may access such funds deposited for them in order to purchase the Basic Health Plan or a certified health plan.

Small Business Financial Assistance. Beginning in July, 1997, firms of less than 25 workers that face barriers to providing health coverage to their employees may apply for assistance through the commission. Preference must be given to new firms; those with low average wages; those with low profits, and those in economically distressed areas. The total amount available shall be the lesser of (a) $150 million or (b) 25 percent of the cost of the uniform benefits package per the eligible applicants’ insured employees and dependents.

Business and Occupations Tax Credit. No later than January 1, 1997, the commission must recommend legislation to establish a business and occupation tax credit for employers with fewer than 500 employees who purchase coverage for dependents of their employees. The credit may be up to 40 percent of the employer’s cost for dependent coverage.

Studies, Plans and Administrative Directives. The Department of Health must develop a public health improvement plan to include minimum standards, budget and staffing plans, cost benefit analyses, recommended strategies for improving public health programs, suggested timing for increasing public health funding, a percentage of total health spending which should be available for public health activities and a funding formula

for grants to local health departments. The plan must be submitted to the Legislature in December 1994, and updated biennially.

The Health Care Authority must establish an advisory group on American Indian Health, and recommend a plan for joint ventures with the Indian Health Service, including methods to improve Indian health and the meeting of unmet health needs.

The commission must seek waivers from federal Medicaid, Medicare and other program laws and rules to implement the provisions of the act. The Governor must seek changes in the federal Employee Retirement Income Security Act of 1974 (ERISA) to ensure that all employees and their dependents in the state comply with the requirement to enroll in and have their employers participate in financing their enrollment in certified health plans.

Initially, the medical aid portion of the workers' compensation program, the residential portions of the various long-term care programs with the Department of Social and Health Services, and various federal programs are excluded. These programs must be studied for later inclusion.

Several studies are authorized by the Legislative Budget Committee on the inclusion of certain programs and on the implementation of the act.

The Department of Health may contract for studies of hospital and nursing home regulation to include recommendations on the consolidation of duplicative activities and rules.

The commission, in conjunction with the Department of Labor and Industries must study means of integrating the workers' compensation medical aid fund with the provisions for certified health plans. A plan to accomplish this must be completed by January 1995. Specific conditions which must be met before the plan may be implemented are outlined in the act.

Revenue: Increased taxes on cigarettes, tobacco products, spirits, beer (except micro-breweries), prepayments for health care received by health maintenance organizations (HMOs), health care service contractors (HCSCs), certified health plans (CHPs), and hospitals will raise an estimated $251.4 million during the 1993-95 biennium, which will be deposited in the health services trust account. These tax rates are increased in future biennia to levels estimated to generate some $1.04 billion in the 1997-1999 biennium, and will also be deposited in the health services trust account.

VOTES ON FINAL PASSAGE:

Senate	30	16	
House	56	42	(House amended)
Senate			(Senate refused to concur)

Conference Committee		
House	56	42
Senate	28	21

EFFECTIVE: July 1, 1993
July 1, 1995 (Sections 234-257)
January 1, 1996 (Sections 301-303)

Partial Veto Summary: Section 424, which authorizes courts to assign liability severally to guilty parties in malpractice cases, is vetoed. (See VETO MESSAGE)