SENATE BILL REPORT

2SSB 5304

AS PASSED SENATE, MARCH 12, 1993

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

Majority Report: That Substitute Senate Bill No. 5304 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Talmadge, Chairman; Wojahn, Vice Chairman; Deccio, Franklin, Fraser, McAuliffe, Moyer, Niemi, Prentice, Quigley, Sheldon, and Winsley.

Staff: Don Sloma (786-7319)

Hearing Dates: January 21, 1993; January 28, 1993; January 29, 1993; February 10, 1993; February 11, 1993; February 15, 1993; February 16, 1993; February 18, 1993; February 19, 1993

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 5304 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Rinehart, Chairman; Spanel, Vice Chairman; Bauer, Gaspard, Hargrove, Jesernig, Niemi, Owen, Pelz, Quigley, Snyder, Sutherland, Talmadge, Williams, and Wojahn.

Staff: Steve Lerch (786-7715)

Hearing Dates: March 2, 1993; March 8, 1993

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, change medical malpractice and liability practices, and ensure 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 resources 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 who are not fulltime employees, not eligible for Medicaid, and whose gross family incomes are below 200 percent of the federal poverty level ($27,800 for a family of four).

The Legislature intends to increase subsidies for enrollment in the BHP to all of those below 300 percent of poverty, however, specific limits on subsidized enrollment must be expressed as a percentage of the federal poverty level in the biennial Appropriations Act.

Any individual not eligible for subsidized enrollment in the BHP may purchase or have their employers or other sponsors pay up to 80 percent of the premium to help them purchase the 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, 2001, managed care plans within the BHP must be 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 July 1, 2001.

The BHP administrator may arrange for reinsurance or may self-insure for reinsurance on behalf of its participating managed health care systems.

The Department of Social and Health Services must negotiate with Congress and the federal Department of Health and Human Services to obtain a waiver from Medicaid rules and laws to require Medicaid-eligible individuals to enroll in the BHP, receive its services and pay its co-pays and deductibles, so long as this is not a barrier to receiving needed medical care.

Consolidate State Health Care Purchasing. The state Employee Benefits Board is renamed the Public Employee Benefits Board. Its 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.

On or after July 1, 1995, the uniform benefits package, its premiums and individual cost-sharing requirements adopted by the Health Services Commission must be implemented by the Health Care Authority for public employee benefit plans.

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

The Health Care Authority 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 through the Health Care Authority at full cost by any state resident eligible for Medicare.

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

The Health Care Authority is designated as the single state health care purchasing agent. The Governor must submit legislation to place all state subsidized health benefits programs into a strictly community rated, single risk pool by July 1997. Certain powers to bring uniformity to billing, eligibility procedures, access to service providers and other matters are granted to the purchasing agent.

Public Health Governance. Effective July 1, 1994, 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 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 December 31, 1993.

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 Provider Shortages and Primary Care. The Higher Education Coordinating Board, the State Board for Community and Technical Colleges and the Department of Health may establish award amounts and locations for the health professions scholarship program, and community based recruitment and retention programs. 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, and other health professionals as 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 physician 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.

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.

Health Services Commission. The Washington Health Services Commission is created as a five member, fulltime body comprised of the state Insurance Commissioner, the state Health Officer and three other members appointed by the

Governor with the consent of the Senate. The Governor must select the chair from the three public appointees.

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.

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 periodically modify a uniform health benefits package. The benefits package must be offered to all enrollees in certified health plans for no more than the maximum premium established by the commission.

The uniform benefits package is intended to be comparable in scope to health benefits offered to state employees, and should be adequate to maintain the health of the citizens of the state, weighed against funds available in the state health services budget. Twelve categories of service, such as diagnostic services, emergency services, preventive services and therapeutic services must be included but the commission may place limitations on the scope and duration of services. Infertility services and cosmetic surgery are specifically excluded.

The initial maximum premium for the uniform benefits 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 of the Consumer Price Index. Procedures are established for adjusting the maximum premium to account for changes in services within the uniform benefits package.

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

The commission must establish limits on maximum enrollee financial participation related to gross family income, set standards for certified health plans and health care purchasing cooperatives, establish requirements for uniform billing and claims processing, and establish other guidelines and requirements.

The commission must adopt standards governing negotiations between certified health plans and providers, including a dispute resolution mechanism. Providers may organize and communicate in order to negotiate with certified health plans.

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.

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.

If the Governor finds the economic viability of a significant number of the state's certified health plans is threatened, he or she may adjust the maximum premium these plans may receive on an emergency basis. Procedures are established for legislative 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.

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.

In addition, the standard of care used in determining malpractice and awarding damages is defined as following a course of treatment accepted by recognized and competent health care professionals experienced in the treatment at issue, even if other competent and knowledgeable professionals do not accept the course of treatment followed.

Certified Health Plans and Purchasing Co-ops. The state Insurance Commissioner must issue certificates to and regulate any entity meeting requirements as a certified health plan. These requirements include offering the uniform benefits package for the maximum premium on an open enrollment basis to any state resident within a chosen geographic area, meeting certain financial solvency and liquidity requirements, offering a supplemental policy of long term care insurance to all enrollees and other specified items.

Dental services meeting all of the requirements of a certified health plan, except the requirement to offer a supplemental policy of long-term care insurance, may be granted a waiver from the uniform benefits package.

Nothing precludes an entity from offering, insuring, providing, receiving payment for or negotiating for services or levels of service not included within the uniform benefits package.

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 occur and direct enrollees to other providers within the plan.

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.

Additional requirements and procedures are established to regulate certified health plans, set penalties for noncompliance, and govern state action in the event of insolvency or other failure of any individual plan.

The state Insurance Commissioner may regulate employers' cooperative health care purchasing groups.

Hospital administrators, nursing home administrators, and pharmacists must establish and implement procedures to notify physicians and patients of the cost of services ordered by health care providers and used by patients.

Immunity is granted from state and federal anti-trust laws for lawful activities undertaken by certified health plans, purchasing cooperatives and other entities created or regulated under the act. The state Attorney General must study and recommend a process of state regulation of prohibited provider cooperative activities which might be precluded under current anti-trust laws, but which might be needed to implement this act.

Individual Opportunities and Employer Mandates. No later than July 1, 1997, all state residents must be provided the opportunity to participate in the basic health plan or a certified health plan.

Beginning on July 1, 1995 all employers with more than 500 fulltime employees must offer a choice of certified health plans to all employees. Employers must pay no less than 50 percent and no more than 95 percent of the cost of the lowest priced plan offered. The actual percentage may be determined by employer/employee negotiations. On July 1, 1996, dependents of the fulltime employees in these firms must be offered the same coverage.

On July 1, 1996, employers with more than 100 fulltime employees must offer certified health plans to their employees meeting the same standards. Less than full time employees, (less than 80 hours per month, 240 per quarter, or 960 hours per year) must receive pro rata payments based on hours

worked. By July 1, 1997, coverage must be extended to all dependents of fulltime employees.

On July 1, 1997 all employers must offer enrollment in a choice of certified health plans to all employees. By July 1, 1998, this requirement is expanded to include all dependents of fulltime employees.

In lieu of offering a choice of certified health plans, an employer may offer the basic health plan.

Under the guidance and direction of the commission, not more than two depositories must be established where the pro rata share payments made by employers on behalf of less than full time employees may be held. The commission 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.

Business and Occupations Tax Credit. On or after July 1, 1997, employers with less than a total of 25 fulltime and parttime employees, who purchase the basic health plan or a certified health plan for their employees and their dependents, may take a credit on the business and occupations tax. The credit must be no greater than a percentage of premiums paid, according to a formula in the act. The overall average tax credit may not exceed $400 per year per state resident for whom a credit is claimed.

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. The plan must be submitted in December 1994, and updated biennially.

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 possible inclusion at a later date.

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 and elimination of duplicative activities and rules.

An employer who self funds for health benefits insurance or workers compensation, and who participates in a certified health plan may receive an exemption to allow consolidation of the medical aid portion of workers' compensation with his or her certified health plan, if certain specified conditions are met. The Department of Labor and Industries must study means of integrating the remainder of the workers' compensation medical aid fund with the provisions for certified health plans. A plan to accomplish this by July 1997 must be completed by January 1995.

Appropriations: For the 1993-1995 biennium, from the various accounts within the newly created Washington health services trust account:

$173.9 million for a phased expansion of the Basic Health Plan to an estimated 94,000 additional enrollees with gross family incomes below 200 percent of the federal poverty level by July 1995 and to continue present enrollment levels;

$20 million for immediate improvements in public health programs;

$5 million for expanded primary care through community health centers;

$6.5 million for health data collection and for the operation of the Health Service Commission;

$4 million to the Department of Health for the health professional resource plan, health professional recruitment and retention programs, the retired primary care provider malpractice insurance program, training for volunteer medical services personnel, and for required studies;

$2.3 million to the University of Washington for the family medicine program; and

$2 million to the Higher Education Coordinating Board for health professional scholarships.

Revenue: It is estimated that increased taxes on cigarettes, tobacco products, spirits, prepayments for health care received by health maintenance organizations (HMOs), health care service contractors (HCSCs), certified health plans (CHPs), and hospitals will raise $230 million during the 1993-95 biennium, to be deposited in the health services trust account. The effective date of the HMO/HCSC/CHP tax is January 1, 1994, with tax rates of 0.07 percent in calendar year 1994, 0.6 percent in calendar year 1995, 1.0 percent in calendar years 1996 and 1997 and 1.1 percent thereafter. The business and occupation tax on hospitals is made effective July 1, 1993 at a 0.5 percent rate, which increases to 1.5

percent on July 1, 1995. Surtaxes on spirits are 8.8 percent during the 1993-95 biennium, 50 percent during the 1995-97 biennium, and 75 percent during the 1997-99 biennium. These tax rates are estimated to generate some $632.8 million during the 1995-1997 biennium, and $883.4 million during the 1997-1999 biennium.

Fiscal Note: available

Effective Dates: The public health governance and financing sections take effect on July 1, 1994. Prepayment taxes on health maintenance organizations, health care service contractors and certified health plans take effect in January 1994. Hospital business and occupation taxes and related sections take effect on July 1, 1995. The other tax provisions take effect July 1, 1993. The remainder of the act takes effect immediately.

TESTIMONY FOR (Health & Human Services):

The bill implements the thoughtfully developed recommendations of the Health Care Commission. It will contain costs using managed competition in which state government is a leader and model by consolidating no less than 20 percent of the health care market in an aggressive effort to forge a better health care bargain for teachers, state employees, low income persons and any other citizen who may wish to participate. The bill offers the same consolidated purchasing advantages within the private sector.

If this is not successful, the bill absolutely controls costs at the level of insurance premiums for a uniform, and relatively comprehensive set of benefits. This is low enough in the system to be effective and yet high enough to be comprehensive and avoid administrative complexity and gaming by providers and others. The bill preserves choice, emphasizes competition, requires cost effective managed care, expands and revitalizes public health, expands access through direct subsidies for the working poor and the unemployed, alleviates the shortage of primary care providers, takes steps to reduce medical malpractice costs and contains other needed reforms.

It is honest in providing a level of funding really needed to implement such a broad package of reforms. It provides the needed funds by taxing items which are known to cause health problems (tobacco and alcohol), and by redistributing funds already flowing into the health care system (premium taxes and hospital taxes). It levels the playing field for all businesses by requiring their participation in financing care for all. It also encourages cost consciousness and individual responsibility by requiring all residents to pay at least a portion of the cost of their care.

TESTIMONY AGAINST (Health & Human Services):

The bill establishes a complex and unworkable regulatory framework in the name of managed competition, and then undermines it with a rigid and unrealistic set of caps on insurance premiums. It establishes a new state agency, diverting precious resources away from needed care. It undermines the private health insurance market by placing the state's Basic Health Plan in direct competition with private carriers.

It could force state employees and teachers to subsidize care for the poor by placing all of these groups in the same community rated risk pool.

Its requirement that self funded employer health benefit plans participate in certified health plans violates federal law. It is unrealistic to think this federal law can be changed. The entire scheme is dependent on obtaining waivers and special exceptions from federal rules and laws that are difficult to obtain.

It adds a total of more than $2 billion in new taxes to a system that most agree is already too expensive. It raises the money largely on the narrow base of smokers and drinkers, who are already economically disadvantaged. Other revenues are added to the health care system itself, further inflating health care costs.

The federal government and the Clinton administration should be and are planning to address health care as a nationwide issue. State-by-state reforms will cause incentives to migrate to states with good plans, will be difficult for multistate businesses to contend with and may have to be scrapped for a national policy when it comes.

TESTIFIED (Health & Human Services): Linda Tanz, Coalition on Smoking or Health (pro); Jackie McFayden, Association of Washington Cities; John Wessmon, Washington State Association of Counties; Dave Broderick, Washington State Hospital Association (pro); Steve Wehrly, Chiropractors; Karen Davis, WEA; Grace Popoff, Washington Advocates for the Mentally Ill; Margaret Shepherd, Home Care Association of Washington (pro); Lucy Homans, Washington State Psychological Association; Bonita Hickman, President, Washington Association of Marriage and Family Therapists; Cris Kessler, Co-Chair, Legislative Committee, Washington Chapter, NASW; Michael Doctor, Washington Mental Health Counselors Association (pro); Gary Smith, Independent Business Association; Carolyn Logue, National Federation of Independent Business; Dan Colegrove, Grocery Manufacturers of America; Enid Layes, Association of Washington Business; Marthe Butzen, Midwives Association of Washington State; Dorothy Jane Youtz, health professional; Jill A. Floberg, Washington State Physical Therapy Association; Jim Halstrom, Seagrams; Kit Hawkins, Restaurant Association; Vito Chiechi, Licensed Beverage Association; Bill Fritz, Tobacco Institute; Vicki Chiechi, Wine Institute; Steve Wehrly, Miller Beer, Smokeless Tobacco; Tom Huff, Washington

Retail Association; Larry Kenney, State Labor Council; Jeff Larsen, Washington Osteopathic Medical Association; Dr. Bob Day, Karen Lane, Fred Hutchinson Cancer Research Center; Elizabeth Swain, Washington Association of Community Health Centers; Liz Smith, Northwest AIDS Foundation; Mel Sorensen, Washington Physicians Service/Blue Cross; Don Sacco, Pierce County Medical; Stan Finkelstein, AWC; Steve Lindstrom, Washington State Podiatric Medical Association; Theresa Conner, Planned Parenthood Affiliates of Washington (pro)

TESTIMONY FOR (Ways & Means):

The bill increases cigarette taxes, which is important as a way to discourage smoking. Tobacco and liquor taxes are an appropriate source of revenue to fund health care. The prepayments tax is supported, but it should not apply to payments from the federal government. An income tax would be a more appropriate revenue source than the taxes in the bill. The data collection requirements of the bill are needed, but make the existing Department of Health assessment on hospitals unnecessary.

Universal access is important and the funding level in the bill must be high enough to support universal access. It is important to include long-term care in the uniform benefits package. The expansion of public health funding is an important part of health care reform.

TESTIMONY AGAINST (Ways & Means):

Wine taxes are already very high, and additional wine tax increases would have a negative impact on a growing industry which also encourages tourism. A differential retail tax on beer and wine would impose substantial costs on many retailers for computer reprogramming, and many scanning devices are not able to add an additional tax rate. Washington spirits taxes are already the highest in the nation and additional taxes are unfair. The tax rate on smokeless tobacco is already the highest excise tax rate imposed, and the additional taxes on smokeless tobacco represent a much higher percentage of the wholesale price than do the increases in cigarette taxes contained in the bill. Higher cigarette taxes will lead to increased smuggling and out-of-state purchases. Because of compliance problems and potential for federal tax increases, tobacco and alcohol taxes are unlikely to meet revenue expectations. Taxes on beer hurt the middle class, brewery workers, and hop growers. Although the intent of the bill is desirable, the level of taxes in the bill is too high.

Although health care reform is desirable, the impact of the employer mandate on small businesses is too severe and threatens their viability. The pooling of health care purchasers and creation of the Uniform Benefit Package could eliminate insurance brokers. An exemption to the individual and employer mandate should be granted on religious grounds.

TESTIFIED (Ways & Means): Tim Coleman, Washington Coalition for a Healthy Future; Bob Fox, Fresh Air for Non-Smokers; Sharyl

Hudson, Garfield High Senior; Linda Tanz, Manager, Washington State Coalition Assn. American Cancer Society; Simon Siegl, Washington Wine Institute; Gary Hogue, Hogue Cellars; Jan Gee, Jim Boldt, Washington Retail Assn., Washington Food Dealers Assn. (con); Red Meyer, AARP (pro); Steve Wehrly, Smokeless Tobacco Council (con); Bob Beatty, broker (con); John Gracey, Plymouth Brethren IV (con); Frank Warnke, Discus (con); Brian Harris, Distilled Spirits Council (con); Bob Meyer, Washington Education Assn. (pro); Dr. Anna Chavelle, Washington State Medical Assn.; Ken Bertrand, Group Health Cooperative; Pat Davis, EMS (pro); Patrick Libbey, Washington State Assn. of Local Public Health Officials (pro); Ed Tveden, People for Fair Taxes (pro); Matt Ryan, WSALU (con); Stu Halsan, Bill Fritz, Tobacco Institute, Anhauser Busch (con); Dave Broderick, Hospital Assn. (pro); Jeff Larsen, Washington Osteopathic Medical Assn, Washington Naturopath Physicians, Washington Academy of Physician Assistants (pro); Steve Michael, Act Up (pro); Carolyn Logue, NFIB; Gary Smith, Ind. Business Assn.; T. K. Bentler, Washington Assn. Small Brewers (con)