SENATE BILL REPORT
SB 5807

As Reported By Senate Committee On:
Health & Long-Term Care, March 4, 2003
Ways & Means, March 10, 2003

Title: An act relating to the basic health plan.

Brief Description: Revising the basic health plan.

Sponsors: Senators Parlette, Deccio, Brandland, Mulliken, Carlson, Honeyford, Hewitt, Stevens, Oke, Sheahan and Winsley.

Brief History:
Committee Activity: Health & Long-Term Care: 2/19/03, 3/4/03 [DPS-WM, DNP]. Ways & Means: 3/7/03, 3/10/03 [DPS (HEA), DNP].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5807 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.
Signed by Senators Deccio, Chair; Winsley, Vice Chair; Brandland and Parlette.

Minority Report: Do not pass.
Signed by Senators Franklin, Keiser and Thibaudeau.

Staff: Jonathan Seib (786-7427)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Substitute Senate Bill No. 5807 as recommended by Committee on Health & Long-Term Care be substituted therefor, and the substitute bill do pass.
Signed by Senators Rossi, Chair; Hewitt, Vice Chair; Zarelli, Vice Chair; Hale, Honeyford, Johnson, Parlette, Roach, Sheahan and Winsley.

Minority Report: Do not pass.
Signed by Senators Brown, Doumit, Fairley, Fraser, Poulsen, Regala and B. Sheldon.

Staff: Tim Yowell (786-7435)

Background: The Basic Health Plan (BHP) was created in 1987 to provide access to health insurance for low-income Washington residents. It now provides state-funded subsidized coverage, through contracts with managed care plans, to approximately 132,000 enrollees statewide.

The BHP is administered by the state Health Care Authority (HCA) pursuant to guidelines established in statute. Any person not eligible for Medicare, with a gross family income of up to 200 percent of the federal poverty level, is eligible for subsidized coverage. Dependent on a federal match, the law would allow coverage of those with a gross family income of up to 250 percent of the federal poverty level.

Individual premiums are between $10 and $250 per month, depending primarily on income and age. Such premiums may be paid by a third-party sponsor, including the enrollee's employer. The plan also includes co-pays, but no deductible.

In designing the benefit plan, the HCA is directed to cover "services that may be necessary for basic health care," including physician and hospital services, and prescription drugs. The law also explicitly allows, to the extent funds are available, the BHP to cover chemical dependency, mental health and organ transplant services, as long as doing so does not increase the value of the plan by more than 5 percent.

Once enrolled in the BHP, a person whose premiums are delinquent may be disenrolled. Disenrollment may be contested pursuant to the Administrative Procedure Act before an administrative law judge.

The subsidized BHP is funded primarily through the state's Health Services Account using a number of revenue sources, including liquor and tobacco taxes. That account is in deficit, and there is concern that as currently structured and administered, the BHP is not sustainable.

The law also allows those with family incomes above 200 percent to enroll in the BHP on an unsubsidized basis. However, beginning in 1999, rising costs associated with the plan made carriers reluctant to provide such coverage, and in 2000 it was de-linked from the subsidized program. Unsubsidized BHP coverage is now not available.

Summary of Substitute Bill: Numerous changes are made in the structure and operation of the Basic Health Plan.

Eligibility criteria are changed to add the requirements that an individual be ineligible for Medicaid (with some exceptions), have no more than $7,500 in assets, and not have been enrolled in the BHP for a total of more than five years. "Assets" is defined to exempt, among other things, a person's home, and a car valued at less than $5,000. The five-year time limit begins to run on the effective date of the act, and an exception is provided for those who, at the time they would be disenrolled for reaching that limit, are receiving medical treatment such that disenrollment would be an immediate threat to their health. The income threshold is lowered to 150 percent of the federal poverty level. The HCA must verify income initially and on an ongoing basis.

The minimum enrollee premiums are increased, and may be varied based on wellness activities.

The HCA is authorized to disenroll persons to avoid overspending its appropriation. When doing so, those with higher incomes and who have been on the plan the longest are to be disenrolled first. Repeated failure to pay co-pays is also added as a reason for disenrollment. Disenrollment may no longer be appealed before an administrative law judge.

Changes are also made to the BHP benefit design, which must be developed using an evidence-based approach. Preventive care services are to be covered with no enrollee cost sharing. The HCA must include other benefits and enrollee cost sharing reasonably expected to result in a plan with an actuarial value 25 percent less than the value of the current plan.

In its contracts with managed care plans, the HCA must assure that the plans are actively engaged in specified efforts to promote wellness activities and quality care of their enrollees. The contracted rate must be expected to result in a loss-ratio to the contracting plan of no less than 87 percent.

Current law calling for an expedited application and enrollment process, and which authorizes commissions for agents and brokers enrolling people in the BHP, is repealed. Other obsolete language is removed.

The unsubsidized BHP is eliminated.

Substitute Bill Compared to Original Bill: The original bill made additional changes to the structure and operation of the BHP that are not in the substitute, including limiting enrollee sponsorship to no more than two years, removing the explicit authorization to include chemical dependency, mental health and organ transplant services in the benefit package, and removing the requirement that BHP procurement follow the formal request for proposal (RFP) process.

The substitute clarifies when the five-year limit begins to run, and provides for the exception to the limit based on needed medical treatment.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available on original bill.

Effective Date: The bill contains an emergency clause and takes effect immediately, except that benefit design changes and eligibility standards are not required to be implemented until January 1, 2004.

Testimony For (Health & Long-Term Care): There are provisions of the bill that are justified given the current budget deficits and that make sense as a starting point for discussion. The change in eligibility to include only those below 150 percent of the poverty level and not Medicaid eligible, and moderate increases in monthly premiums are acceptable. The emphasis on wellness and prevention is appropriate, as is initial and on-going eligibility confirmation. Any changes in the benefit structure needed to meet budget concerns should not be so drastic as to undermine the purpose to be served by the BHP.

Testimony Against (Health & Long-Term Care): The five-year lifetime limit on participation is not acceptable, since it would not work for persons with chronic disease. There is no other insurance plan to which the BHP population can transition. Elimination of chemical dependency, mental health and organ transplant coverage is not a good idea; these benefits do not contribute much to the cost of the plan, and eliminating them will have serious consequences beyond the BHP. Persons should not be targeted for disenrollment; attrition should be sufficient to keep enrollment at necessary levels. Restricting sponsorships will save

the state little and could dramatically impact enrollees. The bill fails to include an opportunity for local BHP demonstration projects, which could better leverage state dollars.

Testified (Health & Long-Term Care): PRO: Nancee Wildermuth, Regence Blue Shield; Amber Balch, Association of Washington Business; Tom Jones, Community Choice; CONCERNS: Nick Federici, Lung Association; Darnell Dent, Community Health Plan of Washington; Gloria Rodriguez, Washington Association of Community & Migrant Health Centers; Lonnie Johns-Brown, Washington State Society for Clinical Social Workers; Vicki Austin, Northwest Kidney Centers; Jim Stephens, Spokane Alliance; Len McComb, Washington State Hospital Association; Gail McGaffick, Washington State Psychological Association; Dan Baumgarten, Health Improvement Partnership; Kristen West, CHOICE Regional Health Network; Karen Merrikin, Group Health; Diane Walkup, BHP enrollee; Kris Locke, Jamestown and Port Gamble S'Klallam Tribes; Randy Scott, Quinault Indian Nation; CON: Sheryl Belcher, American Cancer Society.

Testimony For (Ways & Means): In difficult times, reducing eligibility to 150 percent of poverty is preferable to not covering people such as childless adults at all. Increasing the minimum premium amounts is also reasonable, for the same reason.

Testimony Against (Ways & Means): If premiums are increased and benefits reduced, Native Americans will have less access to affordable health care. The $7,500 asset limit would be problematic for people with sporadic income from seasonal work. It would also be difficult and expensive to administer. Because so many people have lost employer-sponsored coverage in the recession, maintaining BHP enrollment levels is particularly important right now. Although the non-subsidized BHP has been inactive for some time, with some changes it could become viable again, and so shouldn't be eliminated. With the 25 percent reduction in benefits, many younger and healthier people would probably choose not to enroll, because they wouldn't view the reduced benefit as worth the premium. That could destroy the program's viability, because it would only service the oldest and sickest. A better solution than cutting enrollment and benefits by the amount proposed would be to raise the new revenues.

Testified (Ways & Means): CON: Ron Charles, Port Gamble S'Klallam Tribe; Randy Scott, Quinault Nation; Nick Federici, American Lung Association of Washington. WITH CONCERNS: Len McComb, WA State Hospital Association and Community Health Plan of Washington.