SENATE BILL REPORT
SB 5945

As of February 13, 2009

Title: An act relating to creating the Washington health partnership plan.

Brief Description: Creating the Washington health partnership plan.

Sponsors: Senators Keiser, Franklin and Kohl-Welles.

Brief History:
Committee Activity: Health & Long-Term Care: 2/12/09.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Mich'l Needham (786-7442)

Background: The 2008 Legislature passed ESSB 6333 calling for an analysis of five health care reform proposals, including the Washington Health Partnership as outlined in legislation. The Legislature contracted with Mathematica Policy Research, Inc. to model the coverage and economic impacts of each proposal, and their initial analysis is available.

Summary of Bill: The Washington Health Partnership is created as a public-private entity to provide comprehensive health coverage for all eligible residents of the state beginning January 1, 2011. The Partnership is governed and administered by the public-private Washington Health Partnership Board (Board) with 14 members appointed by the Governor.

The benefits, or covered services, are a standardized, comprehensive package modeled after the Public Employees Benefits Board program. The Board determines the cost-sharing for copayments, deductibles, and maximum out-of-pocket expenses; however, no copayments exist for preventive services and approved chronic care management programs. Premiums begin with a "zero" premium plan for the lowest-cost plan or benchmark plan, and increase for higher-cost plans. Unions and employers may bargain to pay for additional benefits and cost-sharing.

The Partnership must follow a competitive procurement process with insurance carriers and networks of providers that follow Title 48 RCW requirements. One or more carriers or networks must be available in every service area, as well as a fee-for-service option. Networks or carriers must demonstrate they spend at least 88 percent of revenue on health care services or investments that improve overall quality or lower overall cost of patient care.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

All state residents with permanent residence for at least 12 months are eligible for the Partnership, unless they are eligible for federal programs including Medicare and Medicaid, or in a state institution. Children and pregnant women are not subject to the 12-month residency requirement. All public employees, including employees of the state, higher education institutions, school districts, educational service districts, and political subdivisions of the state, transition into the partnership beginning January 1, 2011, subject to collective bargaining.

The Department of Social and Health Services (DSHS) is directed to submit a proposal to the federal government to expand the Medicaid categorically needy eligibility up to 200 percent of federal poverty level for families, and the aged, blind and disabled population, and submit a request to cover additional individuals with incomes up to 200 percent of federal poverty level that are not otherwise categorically eligible. DSHS must review reimbursement rates and may modify the rates to more closely reflect those paid by the Partnership for the fee-for-service option.

The Washington Health Partnership Trust Fund is created in the State Treasury, and the Department of Revenue is directed to begin collecting assessments January 1, 2011, as calculated by the Board based on anticipated revenue needs. Each employee under age 65 will be assessed between 1 and 2 percent of social security wages; self-employed individuals under age 65 will be assessed between 5 and 8 percent of social security wages; and employers will be assessed between 5 and 9 percent of aggregate social security wages.

The Office of Financial Management, strategic health planning section, is directed to develop a plan to increase the number and availability of primary care providers, and report to the Legislature by November 1, 2010. The Board is directed to complete a study on establishing a long-term care benefit and submit recommendations by December 1, 2010. By December 1, 2012, the Board must submit a report which includes a cost-benefit analysis on the inclusion of other state-funded health care programs, such as those offered by the Department of Labor and Industries.

Appropriation: None.

Fiscal Note: Requested on February 9, 2009.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: This bill achieves our goal of having health care for all residents by 2012; it completes the Blue Ribbon Commission vision and it does it with significant savings for the state, consumers, and most employers. In surveys, the people of Washington confirm they want everyone covered with health care and they want access to comprehensive coverage. The recent Mathematica study confirmed that this approach extends coverage to all residents and is a responsible step to reform that includes key elements that improve health outcomes and reduce cost-shifting. There are some questions that would need further clarification on the provider networks and the level of Medicaid

reimbursement. Our current system is not sustainable, with premiums projected to increase rapidly and equate to over 40 percent of the average income by 2016. Voters want affordability, choice, and a guarantee that coverage will still be available if they lose their job or their life circumstances change. The cost-shifting in our current system creates a hidden tax, and this bill eliminates that when all residents have coverage.

This approach is consistent with the vision and goals for health care reform adopted by the medical association. Access to family planning services is critical and it needs to be called out in the description of the medical home and added to the services that require no copay. Family planning services should also be added to the description of services available for those eligible for pregnancy services. The standardized comprehensive benefit package is a good design, and the goal of 88 percent of premium revenue being spent on medical care is ambitious but appropriate. The payroll tax is appropriate but the percentages are too disparate between employees, employers, and the self-employed. Employees should bear a larger portion of the payroll tax, at least equal to the employer's share.

CON: This does not help a recently laid-off employee about to lose coverage.

OTHER: A single payer approach to health reform is the gold standard but this approach includes many of the single payer goals and ensures universal access to coverage. The benefits need to be sufficiently comprehensive to ensure the system does not devolve into a tiered approach where those with money can buy what they need. The networks need to be managed and have considerable oversight with careful auditing. Evidenced-based guidelines need to be developed for everyone and implemented equitably across all networks. The technical advisory committee should be chaired by a physician, and some thought should be given to the competitive disadvantage medium and small groups of providers may have, and some flexibility should be added for small providers that may not be able to accommodate the technology requirements.

Persons Testifying: PRO: Senator Keiser, prime sponsor; Len McComb, Washington State Hospital Association and Community Health Network; Robby Stern, Bob Crittendon, Healthy Washington Coalition; Ingrid McDonald, AARP; Bev Spears, Washington Community Action Network; Cynthia Markus, Washington State Medical Association; Jennifer Allen, Planned Parenthood; Randy Bolerjack, Northwest Physicians Network.

CON: Jeanne Perrin, citizen.

OTHER: Sarah Weinberg, Donald Mitchell, Physicians for National Health Plan and Health Care for All; Kent Davis, Washington Health Security Coalition.