HOUSE BILL REPORT
ESHB 1311

As Passed House:
March 4, 2011

Title: An act relating to establishing a public/private collaborative to improve health care quality, cost-effectiveness, and outcomes in Washington state.

Brief Description: Improving health care in the state using evidence-based care.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Cody, Jinkins, Bailey, Green, Clibborn, Appleton, Moeller, Frockt, Seaquist and Dickerson).

Brief History:
Committee Activity:
Health Care & Wellness: 1/27/11, 2/10/11 [DPS];
Health & Human Services Appropriations & Oversight: 2/17/11, 2/21/11 [DPS(HCW)].
Floor Activity:
Passed House: 3/4/11, 62-35.

Brief Summary of Engrossed Substitute Bill

- Establishes a collaborative to identify and review certain high-variation or high-utilization health care services and develop best practices guidelines related to those services and strategies to promote the use of those guidelines.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 7 members: Representatives Cody, Chair; Jinkins, Vice Chair; Clibborn, Green, Kelley, Moeller and Van De Wege.

Minority Report: Do not pass. Signed by 4 members: Representatives Schmick, Ranking Minority Member; Hinkle, Assistant Ranking Minority Member; Bailey and Harris.

Staff: Chris Blake (786-7392).

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.

HOUSE COMMITTEE ON HEALTH & HUMAN SERVICES APPROPRIATIONS & OVERSIGHT

Majority Report: The substitute bill by Committee on Health Care & Wellness be substituted therefor and the substitute bill do pass. Signed by 8 members: Representatives Dickerson, Chair; Appleton, Vice Chair; Johnson, Ranking Minority Member; Cody, Green, Kagi, Pettigrew and Walsh.

Minority Report: Do not pass. Signed by 3 members: Representatives Schmick, Assistant Ranking Minority Member; Harris and Overstreet.

Staff: Erik Cornellier (786-7116).

Background:

The Health Care Authority (Authority) administers state employee health benefit programs through the Public Employees Benefits Board, as well as health care programs targeted at low-income individuals, such as the Basic Health Plan and the Community Health Services Grants. In addition, the Authority coordinates initiatives related to state-purchased health care, such as the Prescription Drug Program and the Health Technology Assessment Program. Through the Prescription Drug Program, the state contracts for independent reviews of prescription drugs to compare the safety, efficacy, and effectiveness of drug classes from which recommendations are made by a clinical committee for the development of a preferred drug list. The Health Technology Assessment program reviews scientific, evidence-based reports about the safety and effectiveness of medical devices, procedures, and tests and a clinical committee determines whether or not the state should pay for them.

Chapter 258, Laws of 2009 (Engrossed Substitute House Bill 2105) established a work group to be appointed by the Authority. The work group included physicians and private and public health care purchasers. The work group was responsible for identifying evidence-based best practices guidelines and decision support tools related to advanced diagnostic imaging services. All state-purchased health care programs that purchase services directly were required to implement the guidelines by September 1, 2009. The work group expired on July 1, 2010.

Summary of Engrossed Substitute Bill:

Legislative findings are established related to the need for public and private health care purchasers to work together to improve the quality and cost-effectiveness of health care services and that substantial variations in practice patterns or high utilization trends are indicators of poor quality and potential waste. Legislative declarations are made regarding the need for state and private health care purchasers to collaborate to identify strategies to increase the effectiveness of health care and to provide immunity from state and federal antitrust laws. It is stated that it is not the Legislature's intent to mandate payment or coverage decisions by private health carriers or purchasers.

The Robert Bree Collaborative (Collaborative) is established. The Collaborative consists of 20 members appointed by the Governor. The members include:

- two representatives of health carriers or third party administrators;
- one representative of a health maintenance organization;
- one representative of a national health carrier;
- two physicians, one of which is a primary care provider, representing large multispecialty clinics with 50 or more physicians;
- two physicians, one of which is a primary care provider, representing clinics with fewer than 50 physicians;
- one osteopathic physician;
- two physicians representing the largest hospital-physician groups in the state;
- three representatives of hospital systems, at least one of which is responsible for quality;
- three representatives of self-funded purchasers;
- two representatives of state-purchased health care programs; and
- one representative of the Puget Sound Health Alliance.

The Collaborative shall add members or establish clinical committees to acquire clinical expertise in particular health care service areas under review. No member may be compensated for his or her service. Members of the Collaborative and clinical committees are immune from civil liability for any decisions made in good faith while conducting work related to the Collaborative or its clinical committees. The Collaborative's proceedings must be open to the public and notice of meetings must be provided at least 10 days in advance. The Collaborative may not begin its work unless there are sufficient federal or private funds or state funds available through other ongoing health care service review efforts.

The Collaborative shall annually identify up to three health care services for which there are substantial variations in practice patterns or high utilization trends in Washington. In addition, the services must not produce better care outcomes and be indicators of poor quality and potential waste in the health care system.

Upon the identification of such health care services, the Collaborative shall identify evidence-based best practices to improve quality and reduce variation in the use of the service. The Collaborative shall also identify data collection and reporting for the development of baseline utilization rates and ways to measure the impact of strategies to promote the use of the best practices. To the extent possible, the reporting should minimize cost and administrative effort and use existing data resources.

Lastly, the Collaborative must identify strategies to increase the use of the evidence-based practices. The strategies may include: goals for appropriate utilization rates; peer-to-peer consultation; provider feedback reports; use of patient decision aids; incentives for the appropriate use of health services; centers of excellence or other provider qualification standards; quality improvement systems; and service utilization and outcome reporting. In the event that a health care service lacks adequate information about its benefits, the Collaborative may endorse coverage with evidence development to allow for the collection of additional data to inform patient-oriented outcomes. The Collaborative must strongly consider the efforts of other organizations when developing strategies. The Collaborative must report its findings and recommendations to the Governor and Legislature annually.

All state-purchased health care programs, including health carriers and third party administrators that contract with state programs, must implement the evidence-based practice guidelines and strategies by January 1, 2012, and every subsequent year. If the Collaborative does not reach consensus, state purchased health care programs may implement evidence-based strategies on their own initiative.

The Health Care Authority work group that was established to identify evidence-based practices related to advanced diagnostic imaging services that would apply to all state-purchased health care programs and its duties are repealed.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) This bill is consistent with prior Health Care Authority efforts to manage health care costs. This process allows physicians to direct the care to be provided. There is support for evidence-based techniques, but there should be an appeal process. Spine surgery evaluations under the bill should be leveraged through the Surgical Care and Outcomes Assessment Program registry to provide the comparative effectiveness outcomes.

(In support with concerns) It is estimated that 30 percent of health care costs are due to inefficient care and problems in the delivery system. There is widespread overutilization and variation in the use of services across the system. This bill provides a forum to discuss these variations.

(Opposed) This bill goes too far by taking physician judgment out of health care and interferes with the doctor-patient relationship. In Washington there is a perinatal work group that is working collaboratively to reduce variations and improve outcomes for cesarean sections and early induction of labor. The data collection method is flawed because it depends on the person filling in the data and varies from hospital to hospital. The Joint Commission is making the reduction of early deliveries one of its quality indicators. There should be an obstetrician-gynecologist (OB-GYN) in the Collaborative. Studies have attempted for decades to calculate the appropriate cesarean section rate with minimal success. Factors that influence the rate of cesarean sections include obesity, diabetes, maternal age, and high blood pressure — all of which have been increasing in the population recently and vary from region to region. The bill is redundant because some hospitals have already implemented the strategies to meet the identified goals. The efforts described in the bill have already been occurring voluntarily. Washington does not need to duplicate efforts. Anti-trust exemptions violate laws designed to protect the public. Traditional methods of determining the standard of care and the input of subspecialty experts are being abandoned. This bill interferes with physician rights to enter into contracts.

Staff Summary of Public Testimony (Health & Human Services Appropriations & Oversight):

(In support) There is already an Advanced Imaging Work Group, and this is a continuation of that group's work. The health plans and providers participating in that work group want the Legislature to move forward to spread best practices and bend the cost curve in health care. This bill brings everyone from all sides together to look at underlying cost drivers and reduce the costs of health care for citizens. It will help the state focus on procedures that actually work rather than spending money on practices that do not work. No new state money will be spent to implement this bill.

(Opposed) None.

Persons Testifying (Health Care & Wellness): (In support) Representative Cody, prime sponsor; Dennis Martin and Jeff Thompson, Health Care Authority; Greg Devereux, Washington Federation of State Employees; and Neal Shonnard.

(In support with concerns) Joe Gifford, Regence BlueShield; and Lisa Thatcher, Washington State Hospital Association.

(Opposed) Judy Kimelman, Washington State Medical Association; Emily Norland; Annie Iriye; Jane Dimer, American Congress of Obstetricians and Gynecologists; and Joseph Jasper.

Persons Testifying (Health & Human Services Appropriations & Oversight): Joe King, Group Health Cooperative; and Carrie Tellefson, Regence Blue Shield.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): None.

Persons Signed In To Testify But Not Testifying (Health & Human Services Appropriations & Oversight): None.