FINAL BILL REPORT
ESHB 1046

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Synopsis as Enacted

Brief Description: Amending the health services act of 1993.

Sponsors: House Committee on Health Care (originally sponsored by Representatives Dyer, Carlson, Kremen, Cooke, Horn, Schoesler, Buck, Johnson, Thompson, Beeksma, B. Thomas, Radcliff, Hickel, Chandler, Backlund, Mastin, Mitchell, Foreman, Sehlin, Ballasiotes, Clements, Campbell, Sheldon, L. Thomas, Huff, Mielke, Talcott, McMahan, Stevens and Lisk).

House Committee on Health Care
Senate Committee on Health & Long-Term Care
Senate Committee on Ways & Means

Background: The Washington Health Services Act, enacted in 1993, includes the following elements: universal access by 1999; employer mandates, which will require an exemption from the federal Employee Retirement Income Security Act (ERISA) to implement; a uniform set of health services, including the uniform benefits package (UBP) and population-based public health services; assistance for low-income persons through expansion of the Basic Health Plan (BHP) and Medicaid; reformed insuring entities (Certified Health Plans--CHPs) and health purchasing insurance cooperatives (HPICs or alliances); capitated-managed care; a maximum premium (cap); state-wide health data system; a full-time Washington Health Services Commission to administer the act; and taxes on tobacco, alcohol, hospitals and certified health plans dedicated to the implementation of the act.

Since passage of the act, the state's private health insurance and service delivery system has experienced several major mergers, expanded outpatient care, and developed more integrated health care delivery systems. Inflation rates have moderated. State spending on public employee health benefits is below originally budgeted levels. More than 20,000 people are estimated to be newly enrolled in private insurance who had been excluded by private insurance "pre-existing" health condition limitations, and more than 50,000 children and working poor adults have enrolled in the Basic Health Plan or Medicaid.

The exemption from ERISA, however, was not obtained prior to the 1995 legislative session, preventing implementation of the requirement for employers to provide some assistance to employees in the purchase of health insurance.

Summary:

BASIC HEALTH PLAN/MEDICAID EXPANSION

The Basic Health Plan (BHP) and Medicaid for children are identified as effective methods of expanding coverage for uninsured residents. The goals of 200,000 adult subsidized Basic Health Plan enrollees and 130,000 children covered through expanded Medicaid by June 30, 1997, are established. Beginning January 1, 1996, BHP enrollees whose income is less than 125 percent of the federal poverty level are required to pay at least a $10 premium share.

By July 1, 1996, the Health Care Authority (HCA), in coordination with the Department of Social and Health Services (DSHS), must implement procedures whereby hospitals, health carriers, rural health care facilities, and community health clinics may expeditiously assist patients in applying for BHP and Medicaid. Similar procedures must be established for enrollee assistance from health insurance agents and brokers who may receive an enrollment commission, as determined by HCA, but the commission may not result in a reduction in the premium amount paid to health carriers.

HEALTH CARE SAVINGS ACCOUNTS

Health Care Savings Accounts, identified as an option to provide incentives for consumers to be responsible for the use and cost of their health care services and to promote savings for long-term care needs, are authorized by law. The Governor is directed to seek necessary federal waivers and exemptions to allow contributions toward all health plans offered in the state to be fully tax deductible.

PORTABILITY OF BENEFITS

To establish portability of benefits from job to job, health carriers are required to waive preexisting condition exclusions or limitations for persons or groups who had similar health coverage under a different health plan (including self-funded plans) at any time during the three-month period immediately preceding the date of application for the new health plan if the person was continuously covered under the immediately preceding health plan. If the person was continuously covered for at least three months under the immediately preceding health plan, the carrier may not impose a waiting period for coverage of preexisting conditions. If the person was continuously covered for less than three months under the immediately preceding health plan, the carrier must credit any waiting period under the immediately preceding health plan toward the new health plan.

PREEXISTING CONDITION LIMITATIONS

The use of preexisting condition limitations is restricted. Health carriers may not reject, exclude, or deny a person coverage because of preexisting conditions, but health carriers are permitted to impose a three-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment within three months before the effective date of coverage.

RENEWAL OF HEALTH INSURANCE

Guaranteed issue and renewability of health insurance is established by requiring, with certain exceptions, health carriers to accept for enrollment any state resident within the carrier's service area and provide or ensure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, and socioeconomic status. Cancellation or nonrenewal is only permitted under the following circumstances: nonpayment of premium; violation of published policies of the carrier approved by the insurance commissioner; the failure of covered persons entitled to become eligible for medicare benefits by reason of age to apply for a medicare supplement plan or medicare cost, risk, or other plan offered by the carrier pursuant to federal laws and regulations; the failure of covered persons to pay any deductible or copayment amount owed to the carrier and not the provider of health care services; the commission of fraudulent acts as to the carrier; material breach of the health plan; or change to the implementation of federal or state laws that no longer permit the continued offering of such coverage.

HEALTH CARE PROVIDER INCLUSION IN HEALTH PLAN DELIVERY

Health carriers, after January 1, 1996, must permit every category of health care provider to provide health services included in the BHP to the extent that such services are within the providers' scope of practice and the providers agree to abide by standards related to cost containment requirement, management and administrative procedures and cost-effective and clinically efficacious health services.

THE WASHINGTON HEALTH CARE POLICY BOARD

The Washington Health Care Policy Board is established consisting of five full-time members appointed by the Governor and four legislators, one legislator from the majority and one from the minority caucus of the Senate and House of Representatives. The chair is designated by the Governor. The Legislative Budget Committee will study the necessity of continuing the board after the year 2000. The board has the following powers and duties (see also the antitrust duties assigned to the board in SHB 1589):

1) periodically make recommendations to the Legislature and the Governor on issues including, but not limited to, the following: the scope, financing, and delivery of

health care services; long-term care services; the use of health care savings accounts; rural health care needs; immigration into Washington as a result of health insurance reforms; medical education; community rating and its impacts on the marketplace including costs and access; quality improvement programs; models for billing and claims processing forms; guidelines to health carriers for utilization management and review, provider selection and termination policies, and coordination of benefits and premiums; and Medicare supplemental insurance.

2) review rules prepared by the insurance commissioner, HCA, DSHS, Department of Labor and Industries, and Department of Health;

3) make recommendations on a system for managing health care services to children with special needs;

4) develop sample enrollee satisfaction surveys that may be used by health carriers.

ADJUSTED COMMUNITY RATING

An adjusted community rate standard is established to spread the risk across the carrier's entire individual product population. The rate may vary for geographic area differences, family size, age, and wellness activities. The adjustment for age may not use age brackets smaller than five-year increments which must begin with age 20 and end with age 65. Ratios for the highest to lowest rates may not exceed 4.25 to 1 beginning in January 1996, 4.0 to 1 beginning in January 1997, and 3.75 to 1 beginning in January 2000. A discount for wellness activities is permitted to reflect actuarially justified differences in utilization or cost attributed to such programs, not to exceed 20 percent.

HEALTH INSURANCE COVERAGE OPTIONS

Beginning January 1, 1996, the following insurance coverage framework is established for individuals and employers who do not self-fund their employees' health coverage:

1) Individuals must be offered the Basic Health Plan schedule of services as a mandatory offering, which means that although all health carriers must offer it, no one is obliged to buy it. (BHP services include the following: physician; hospital; emergency; lab and x-ray; ambulance; preventive care; maternity care; pharmacy; mammograms; reconstructive breast surgery; podiatry; phenylketonuria; home health care; hospice care; and prenatal diagnosis of congenital disorders.) Also, individuals may buy any insurance coverage that includes statutorily mandated benefits affecting individual coverage. (Mandates required for individual coverage include mammograms; reconstructive breast surgery; chiropractic services; podiatry; optometry; phenylketonuria; and prenatal diagnosis of congenital disorders.)

2) Employers with one to 25 employees can purchase any insurance coverage, and are exempt from mandated benefits (similar to current law).

3) Employers with 26 to 50 employees must be offered the Basic Health Plan schedule of services as a mandatory offering, but may purchase any insurance coverage that includes statutorily mandated benefits affecting group coverage. (The mandated benefits that affect group coverage include: mammograms; reconstructive breast surgery; chemical dependency; neurodevelopmental therapies; chiropractic services; podiatry; optometry; RNs/advanced RNs; phenylketonuria; home health care, hospice care; mental health treatment (offering); temporomandibular joint disorders; and prenatal diagnosis of congenital disorders.)

4) Employers with more than 50 employees may purchase any insurance coverage that includes statutorily mandated benefits affecting group coverage (similar to current law).

5) The adjusted community rate standards apply to all health insurance coverage for individuals and to coverage for groups under 50 enrollees.

6) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not deemed small employers for the purpose of these coverage options.

HEALTH CARE COMPLAINTS AND WHISTLEBLOWER PROTECTION

The identity of a person who complains, in good faith, to the Department of Health about the improper quality of care by a health care provider or in a health care facility is confidential. The person is protected from reprisal or retaliatory action under the government whistleblowers law and, as a worker, has remedies under the Law Against Discrimination.

Health carriers are required to establish an explicit process to deal with enrollee complaints.

CONSCIENCE CLAUSE

The conscience clause in the 1993 act is clarified. Providers are not required to provide, carriers are not required to cover, and employers are not required to purchase health services that conflict with religious or moral beliefs.

MEDICAID WAIVERS

The HCA, DSHS, and Office of Financial Management (OFM) are required to jointly seek necessary Medicaid waivers to increase efficiencies in public health care expenditures.

REPEALERS

Several major elements of the 1993 act are terminated or repealed, including: the Washington Health Services Commission and its powers and duties; employer and individual mandates; maximum premium (cap); maximum enrollee financial participation; a mandatory managed care requirement; the statutory limitations on the legislative uniform benefits package approval process; uniform benefits package and community rating; anti-trust provisions (see anti-trust provisions in ESHB 1589); point-of-service cost-sharing; small business assistance program; health service information system; ERISA waiver request; registered employer health plan; premium depository for part-time workers; seasonal workers benefits; and limited dental health plan.

Votes on Final Passage:

House	71	27	
Senate	39	7	(Senate amended)
House	77	19	(House concurred)

Effective: January 1, 1995
January 1, 1996 (Section 13-18)