HOUSE BILL REPORT
ESHB 1046

As Passed Legislature

Title: An act relating to health care reform improvement.

Brief Description: Amending the health services act of 1993.

Sponsors: By 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).

Brief History:
Committee Activity:
Health Care: 1/17/95, 1/19/95, 1/20/95, 1/23/95, 1/24/95, 1/31/95, 2/2/95, 2/3/95 [DPS].
Floor Activity:
Second Reading: 2/10/95;
Passed House: 2/13/95.
Senate Amended.
House Concurred.

HOUSE COMMITTEE ON HEALTH CARE

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 7 members: Representatives Dyer, Chairman; Backlund, Vice Chairman; Hymes, Vice Chairman; Casada; Crouse; Sherstad and Skinner.

Minority Report: Do not pass. Signed by 4 members: Representatives Dellwo, Ranking Minority Member; Cody, Assistant Ranking Minority Member; Conway and Morris.

Staff: Bill Hagens (786-7131).

Background: The Washington Health Services Act was enacted into law in 1993 and includes the following elements: universal access by 1999; employer/individual mandates, which 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 Plan's--CHP's) and health purchasing insurance cooperatives (HPIC's or Alliances); capitated-managed care; a maximum premium (cap); a state-wide health data system; a full-time Washington Health Services Commission to administer the act; taxes upon tobacco, alcohol, hospitals and certified health plans dedicated to the implementation of the act.

Since passage of the act, this 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.

However, the failure of the federal government to waive the federal preemption of our state's ability to regulate employer provided fringe benefits (ERISA) has made the employer mandate to provide some assistance to employees in the purchase of health insurance impossible to enforce.

This, coupled with growing concern expressed by businesses, insurers and consumers of health care about the changes occurring in the health insurance market, the role for government outlined in the Health Services Act of 1993 and other factors have given rise to a need and desire to amend the act in several ways.

Summary of Bill: 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. Effective January 1, 1996, BHP enrollees whose income is less than 125% of poverty 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) shall 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 enrollee authority is provided health insurance agents and brokers who may receive an enrollment commission, as determined by HCA, but the commission cannot result in a reduction in the premium amount paid to health carriers.

Health Care Savings Accounts are identified as an option to provide incentives for consumers to be responsible for the use and cost of their health care services, to preserve provider choice, and to promote savings for long-term care needs and 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 from job to job is established whereby 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 such 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.

The use of preexisting condition limitations is restricted whereby health carriers cannot 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.

Guarantee issue and renewability of health insurance is established whereby health carriers must 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; covered persons entitled to become eligible for medicare benefits by reason of age who fail to apply for a medicare supplement plan or medicare cost, risk, or other plan offered by the carrier pursuant to federal laws and regulations; covered persons who fail to pay any deductible or copayment amount owed to the carrier and not the provider of health care services; covered persons committing fraudulent acts as to the carrier; covered persons who materially breach 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 providers are given an opportunity for inclusion in health plan delivery whereby a health carrier 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 is established consisting of five full-time members appointed by the Governor and four legislators -- one from each political caucus. The chair is designated by the Governor. The Legislative Budget Committee shall study the necessity of the board's continuation after the year 2000. The board shall have the following powers and duties:

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 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.

An adjusted community rate standard is established. 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 shall begin with age 20 and end with age 65 with ratios of 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 shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs not to exceed 20 percent.

The following insurance coverage framework is established for individuals and employers who do not self-fund their employees' health coverage:

1) Individuals are offered the Basic Health Plan[1] schedule of services as a mandatory offering, (i.e., all health carriers must offer it, but no one is obliged to buy it). Also, individuals may buy any insurance coverage that includes current mandated benefits affecting individual coverage (the latter is similar to current law).

2) Employers with 1 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 are offered the Basic Health Plan as a mandatory offering, but can purchase any insurance coverage that includes current mandated benefits affecting group coverage.

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

5) The adjusted community rate standards apply to all health insurance coverage for individuals and 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 this act.

A health care whistleblower provision is established whereby a worker may complain, 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, without fear of reprisal or retaliatory action.

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

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

The HCA, DSHS, and Office of Financial Management (OFM) are required to jointly monitor the enrollee level in the basic health plan and the medicaid caseload of children funded from the health services account.

Several major elements of the 1993 act are terminated or repealed, they are: 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 UBP approval process; uniform benefits package and community rating; anti-trust provisions; 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.

The following sections of RCW are repealed:

18.130.320 Provider investments and referrals--Conflict of interest standards.

18.130.330	Malpractice insurance coverage mandate--Rules--Report.
43.72.005	Intent.
43.72.010	Definitions.
43.72.020	Washington health services commission--Generally.
43.72.030	Chair--Powers and duties.
43.72.040	Commission powers and duties.
43.72.050	Economic viability of certified health plans threatened--Modification of maximum premium--Submission to legislature.
43.72.060	Advisory committees and special committees.
43.72.070	Continuous quality improvement and total quality management.
43.72.080	Health insurance purchasing cooperatives--Designation of regions by commission--Information systems--Minimum standards and rules.
43.72.090	Uniform or supplemental benefits--Provision by certified health plan only--Uniform benefits package as minimum.
43.72.100	Certified health plans--Duties.
43.72.110	Limited certified dental plan.
43.72.120	Registered employer health plans.
43.72.130	Uniform benefits package design.
43.72.140	Small business economic impact statement.
43.72.150	Household income analysis.
43.72.160	Certified health plan benefit packages--Offering, filing, and approval of forms.
43.72.170	Uniform and supplemental benefits--Rates--Filing and approval.
43.72.180	Legislative approval--Uniform benefits package and medical risk adjustment mechanisms.
43.72.190	Supplemental and additional benefits negotiation.
43.72.200	Conscience Clause
43.72.210	Individual participation.
43.72.220	Employer participation.
43.72.225	Seasonal employment.
43.72.230	Depository.
43.72.240	Small firm financial assistance.
43.72.300	Managed competition--Findings and intent.
43.72.310	Managed competition--Competitive oversight--Attorney general duties--Anti-trust immunity.
43.72.800	Long-term care integration plan.
43.72.810	Code revisions and waivers.
43.72.820	Reports of health care cost control and access commission.
43.72.830	Legislative budget committee evaluations, plans, and studies.
43.72.840	Reform effort evaluation.
43.72.850	Workers' compensation medical benefits.
43.72.860	Managed care pilot projects.
43.72.870	Tax credits--Recommend legislation.
48.01.200	Washington health services act of 1993--Conflict with Title 48 RCW.

48.01.210	Coverage for dental services--Uniform benefits package--Certified health plan.
48.20.540	Preexisting condition exclusion or limitation.
48.21.340	Preexisting condition exclusion or limitation.
48.43.010	Certified health plans--Registration required--Penalty.
48.43.020	Eligibility requirements for certificate of registration--Application requirements.
48.43.030	Issuance of certificate--Grounds for refusal.
48.43.040	Premiums and enrollee payment amounts--Verification--Filing of premium schedules and cost-sharing amounts--Additional charges prohibited.
48.43.050	Annual financial statement filing--Penalty.
48.43.060	Provider contracts to be in writing--Enrollee liability--Commissioner's review.
48.43.070	Minimum net worth--Requirements.
48.43.080	Funded reserve requirements.
48.43.090	Examination of certified health plans--Independent audit reports.
48.43.100	Insolvency--Equitable distribution of insolvent plan's enrollees--Continuation of benefits, allocation of coverage.
48.43.110	Financial failure, supervision by commissioner--Priority of distribution of assets.
48.43.120	Grievance procedure.
48.43.130	Application--Certified health plans.
48.43.140	Enforcement authority of commissioner.
48.43.150	Annual report to the health services commission.
48.43.160	Health insurance purchasing cooperatives-Certification.
48.43.170	Health care providers--Opportunity for inclusion.
48.44.480	Preexisting condition exclusion or limitation.
48.44.490	Unfair practices.
48.46.550	Preexisting condition exclusion or limitation.
48.46.560	Unfair practices.
70.170.100	State-wide health care data system--Design requirements--Reporting requirements--Data availability.
70.170.110	Analyses, reports, and studies.
70.170.120	Confidentiality of data.
70.170.130	Health services commission access to data.
70.170.140	Personal health services data and information system.

1. Presently, 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.

2. The following are mandates as required for individual coverage: Mammograms; reconstructive breast surgery; chiropractic services; podiatry; optometry; phenylketonuria; and prenatal diagnosis of congenital disorders.

3. The following are mandated benefits that affect group coverage: 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.

Appropriation: None.

Fiscal Note: Requested on January 23, 1995.

Effective Date of Bill: The bill takes effect on January 1, 1996.

Testimony For: The Washington Health Services Act was summarily rebuked in the November 1994 elections. The people want to reform health care in a more rational way, one which will limit government's intrusion in their lives, one which will not sacrifice jobs for unneeded health benefits, one that will not limit peoples' choice of providers and facilities, one that does not move the entire state health system precipitously into an unmanageable bureaucracy. This bill is a "no nonsense" approach to reform. It keeps the provisions of the original act that are needed, jettisons the unworkable parts, and gives policy-makers adequate time to complete the reform. Major issues not addressed in HB 1046 will be addressed in the other parts of the Health Reform Improvement Package.

Testimony Against: This measure repeals the Washington Health Services Act of 1993--an act that was five years in the making--and replaces it with practically nothing. Expansion of the Basic Health Plan and Medicaid was encompassed in the current act and could be done without additional legislation. Authorization of Health Care Savings Accounts is unnecessary because they are permitted by law presently. The portability, preexisting conditions, and guarantee issue provisions are greatly limited because of the lack of a uniform benefits package. The repeal of the Anti-trust provisions places an unfair advantage with the insurance industry which will be especially difficult for rural communities that are attempting to put in place an adequate network of providers. It is foolhardy to adopt this measure with no assurance that the other parts of the act will be addressed.

Testified: Stephen Barchet, WA Medical Savings Account Project; Tony Lee, WA Association of Churches (con); Bernie Dochnahl, Pam MacEwan, and Don Brennan, WA Health Services Commission (con); Greg Tisdel, Tiz's Doors (pro); Jeff Selburg, WA State Hospital Association; Lis Merten, WA Retail Association; John Britton,

Les Schwab; Dr. Peter McGough, WA State Medical Association; Cassie Sauer, Children's Alliance (con); Laura Groshong, WA State Coalition of Mental Health Consumers; Mary Lou Bresee, Home Care Association of WA; Dr. Michael Schlitt, Association of American Physicians & Surgeons (pro); Jim Halstrom, Health Care Purchasers Association (pro); Cliff Slade, Simpson Investment Company (pro); Greg Devereaux, WA Federation of State Employees (con); Steven Aldrdich, WA State Labor Council AFL-CIO (con); Pete Spiller, Fire Districts (pro); Mel Sorensen, WA Physicians' Service and Blue Cross/Blue Shield (pro); Scott DeNies, Pierce County Medical Association; Bill Waterworth, Heal Washington (pro); Vito Chiechi, WA State Licensed Beverage Association; Carolyn Logue, National Federation of Independent Business (pro); Gary Smith, Independent Business Association; Dr. Eckstoo (con); Carol Monohon, Association of WA Business; Mr. Wilson; Ray Hardee, Engineered Software (pro); Gloria McBain, P. Robert Brown, Inc. (con); Priscilla Terry, Prime Locations, Inc. (pro); Susan Morehead (con); David and Patty Mock (pro); Thomas P. Knorr (con); Bill Sellars, The Assembly (con); Kit Hawkins, Restaurant Association (pro); Jim Justin, Association of Washington Cities; Jim McGatlin (pro); Mary Iverson (pro); Steve Wehrly, Chiropractors (pro); Melanie Stewart and Frank Morrison, WA State Podiatric Medical Association; David and Charlotte Geddis; Bob First, American Association of Retired Persons (con); Krista Eichler, Seattle Chamber of Commerce (pro); Randy Scott, Quinault Indian Tribe; Margaret Stanley, Health Care Authority (con/Amendment #17); Ken Bertrand, Group Health Cooperative (con/Amendment #17); Andy Dolan, WA State Medical Association (pro/Amendment #16); and Verne Gibbs, Department of Health.