SENATE BILL REPORT

ESHB 1046

As Reported By Senate Committee On:
Health & Long-Term Care, March 30, 1995
Ways & Means, April 13, 1995

Title: An act relating to health care reform improvement.

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).

Brief History:
Committee Activity: Health & Long-Term Care: 3/23/95, 3/24/95, 3/30/95 [DPA-WM]. Ways & Means: 4/13/95 [DPA (HEA)].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass as amended and be referred to Committee on Ways & Means. Signed by Senators Quigley, Chair; Wojahn, Vice Chair; C. Anderson, Fairley, Franklin and Winsley.

Staff: Don Sloma (786-7319)

Background: The Washington Health Services Act was signed into law in May 1993. Its goals were to stabilize health care costs which had been running some 2.5 times the Consumer Price Index, to provide universal access to health insurance for all Washington residents by enrolling the 550,000 Washingtonians with no health insurance by 1999, and to improve the health status of the state's population while retaining quality within the health care system.

Major elements of the act included establishment of an employer and individual mandate to purchase health insurance by 1999, and the establishment of a Health Services Commission to set minimum standards for the content, terms of offering and pricing parameters of health insurance.

Medicaid coverage was expanded for all children with family incomes below 200 percent of the federal poverty line, and the Basic Health Plan was expanded statewide and opened to employers or individuals of any income who might wish to join on an unsubsidized basis.

Since passage of the act, our state's private health insurance and service delivery system has experienced several major mergers, expanded outpatient care and the development of 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 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 Amended Bill: The Legislature intends to protect quality in health care and protect an individual's right to health care choices; eliminate pre-existing condition exclusions in health insurance, prevent cancellation because of sickness, and allow people to change jobs without losing coverage; minimize the role of government in the health care system; protect individuals', families, and businesses' ability to maintain their health insurance and allow the uninsured to purchase insurance by making it more affordable; and advance the fundamental goal that all Washingtonians have access to health insurance by developing incentives rather than pursuing an employer mandate.

I. Protection of Choice and Quality

The definition of managed care, as it applies to certified health plans (CHPs), is expanded to allow traditional indemnity insurers to qualify as CHPs, as long as they agree to abide by universally applicable CHP standards intended to promote access and eliminate certain practices.

Except for health maintenance organizations, each certified health plan must offer at least one plan in which enrollees have direct access to any health provider willing to accept the plan's payment levels and other conditions. Enrollee payments may differ under this option to encourage the use of the most cost-effective providers. However, balance billing of patients is still prohibited and no patient is restricted from direct access to any provider willing and able to meet a plan's terms and conditions of participation.

Medical savings accounts are authorized.

Confidentiality and anti-reprisal protection is provided for "whistleblowers" who bring evidence of improper quality of care by a health care provider, a certified health plan or in a health facility to the attention of the Department of Health. Improper quality of care regarding each of the health professions must be defined by each health professional disciplinary authority as part of standards of practice. With regard to certified health plans, CHP rules adopted by the Health Services Commission serve to define further improper quality of care.

All certified health plans, facilities, and providers must develop and disclose their staffing plans for professional and nonprofessional staff, including direct nurse to patient ratios.

Certified health plans must provide enrollees, and upon request, potential enrollees, with easily understandable information on benefits, policy coverage limits, exclusions and limitations.

Certified health plans must conduct annual patient satisfaction surveys in a form prescribed by the Department of Health and make the results available to their enrollees.

Certified health plan standards, including quality standards, developed by the Health Services Commission must be re-submitted for adoption under the Administrative Procedure Act. Once CHP quality standards are adopted plans must comply with them within four years of their approval to offer the minimum list of health services.

Nothing in law restricts the right of an employer to offer, an employee to negotiate for, or an individual or an employer to purchase any benefits not included in the minimum list of health services.

Nothing in law restricts an employer to offer or an employee to negotiate for employer payment of the entire health insurance premium for any health insurance or for employer reimbursement of any point of service cost sharing amounts.

While no patient may be denied any service for which they may have insurance coverage, no individual, health provider, or religiously sponsored certified health plan must participate in the provision of, or payment for any health service to which they have a religious or conscientious objection. The Health Services Commission must develop rules to implement these requirements.

II. Insurance Reforms

Any disability insurer, health care service contractor or health maintenance organization practice that illegally changes access to health services is specifically named as unfair and deceptive, may be fined and punished by the state Insurance Commissioner.

III. Limitation of Government's Role in the Health Care System

Various Health Services Commission powers and duties are abolished including ensuring that all residents are enrolled in certified health plans, establishing the uniform benefits package or minimum list of health services, proposing medical risk adjustment mechanisms, establishing rules for employers, employees and state residents in relation to the employer and individual health insurance mandates, adopting rules for CHPs regarding determining when certain medical procedures are no longer experimental or investigative, developing recommendations regarding school district health insurance purchasing through health insurance purchasing cooperatives, establishing guidelines for dealing with static or terminal conditions, and recommending how to treat Taft-Hartley trusts under health reform.

The commission's statutory advisory committees are all abolished.

Several new commission duties are added including commenting on other agency rules to implement health reform, conducting studies of medical savings accounts, and studying the needs of children with special medical needs.

The Health Service Commission's draft rules to establish the uniform benefits package and medical risk adjustment mechanisms are each disapproved by the Legislature. The Legislature indefinitely suspends the application of the uniform benefits package and the medical risk adjustment mechanism as described in current law.

The uniform benefits package is replaced with a minimum list of health services. This is the minimum that must be sold by all health insurers (certified health plans). The minimum list of health services is the schedule of services available to Basic Health Plan (BHP) enrollees on July 1, 1994, plus services of licensed midwives, limited chiropractic care, limited chemical dependency services, limited mental health services and limited medical rehabilitation. This expansion may not increase the average per member per month cost, excluding adjustments for inflation and utilization, by more than 5 percent. Once these adjustments are made, the BHP package may not be further modified in a way that increases the average per member per month cost except by an act of law.

The Legislature adopts the Health Services Commission draft rules regarding enrollee point of service cost sharing for the minimum list of health services.

A separate, free standing, category of licensure for certified health plans is repealed. The dual process of certified health plan registration and certification is replaced with a single approval process integrated with existing licensing requirements for health care service contractors, disability insurers and health maintenance organizations. The process includes a provisional approval for up to two years for those who initially submit documentation of a capability to achieve full compliance.

The CHP requirements apply to any insurer, health maintenance organization or health care service contractor wishing to do business in Washington after December 31, 1995. The requirements include: the requirement to offer the minimum list of health services; the prohibition against billing enrollees in excess of pre-agreed prices (balance billing); the requirement to issue a policy for the minimum list of health services to any group or individual in a chosen service area; and the requirement to guarantee every category of provider is available who offers a covered service within each plan. Existing provider relations and anti-trust exemption procedures are retained as in current law.

IV. Affordable Insurance

The definition of community rate is restricted in its application only to the minimum list of health services, and is expanded to allow adjustments of 300 percent until 1996 and 250 percent thereafter for age related cost differences, and a factor of plus or minus 10 percent for wellness factors. Wellness factors may include participation in wellness activities described in the bill.

Certified health plans need not sell at a community rate to employers who are self insured after December 31, 1995, or to their employees, as long as those employees are employed by the self insured employer.

In addition to the health insurance purchasing cooperatives already authorized by law, any group of individuals may form a cooperative health care purchasing group.

V. Universal Access Through Incentives

The health care authority must study and report on the feasibility of including long term care services in the medicare supplemental benefits products now offered through that agency.

An unspecified amount of funds is appropriated from the health services account to expand enrollment in the Basic Health Plan to a total of 200,000 subsidized enrollees by July 1997, including at least 100,000 employed persons with incomes below 200 percent of the federal poverty level whose employers help to subsidize their BHP enrollment.

An unspecified amount of funds is appropriated from the health services account to the state's Medicaid program to cover an additional 125,000 children whose family incomes are below 200 percent of the federal poverty level by July 1997.

Any person, firm or organization bidding to do business with the state of Washington must be given a preference equal to 10 percent of the total bid points awarded in the bid process, if they provide at least 50 percent of the premium for health insurance to at least 95 percent of their employees.

The Department of Labor and Industries must allow firms wishing to enroll in the Basic Health Plan to make premium payments as part of their workers' compensation payments.

Private insurance agents, brokers and solicitors who sell the Basic Health Plan may receive a 3 percent commission on individual sales and a 1 percent commission on group sales. No commission may be received on renewals.

The employer mandate and the individual mandate to purchase health insurance coverage are both repealed. Specific direction for the Governor to seek waivers from various federal acts and agencies including ERISA, the federal Medicare program, the Medicaid program, the Public Health Services Act and the Internal Revenue Code is repealed.

Separate standards for registered employer health plans (larger, self-funded health insurers) is repealed, removing state statutes that might have regulated them had federal waivers from ERISA been obtained.

Authority to establish a small firm financial assistance program to assist firms of 25 employees or less in complying with the employer mandate is repealed.

Amended Bill Compared to Substitute Bill: ESHB 1046 is stricken and Substitute Senate Bill 5935 is placed on ESHB 1046 with the following changes: A requirement that nurse staffing ratios be required of all health facilities by the Department of Health is replaced with a study. The definition of improper quality of care is limited to violation of statutory and regulatory requirements. Limitations on collective bargaining by K-12 employees for health benefits beyond those funded by the state are deleted. The Health Services Commission's authority to study and recommend the role of medical research in a reformed health system is eliminated.

Appropriation: None.

Fiscal Note: Requested on January 23, 1995.

Effective Date: 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 policymakers adequate time to complete the reform. Major issues not addressed in ESHB 1046 can be addressed in other legislation.

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: Dr. Michael Schlitt, Dr. Glenn Dromheller, Assoc. of American Physicians & Surgeons (pro); Denise Holland (pro); Steven Aldrich, WSLC AFL-CIO (con); Virgil Clarkston, American Diabetes Assoc. (con); Peter McGongh, M.D., WA State Medical Assn.; Bill Kyle, S. King County Coalition of Chambers of Commerce (pro); Hugh Hendrickson, WA Assn. of Health Underwriters (pro); Carol Monohon, AWB (pro); Lis Merten, WRA (pro); Mike Bailey, City of Everett; Jim Halstrom, Health Care Purchasers Assn. (pro); Cliff Slade, Simpson Inv. Co. (pro); Steve Kelley (pro); Linda Grant, AAP (con); Edward McLeary, Troutlodge (pro); Marshall Paris, Northshore Chamber AWB (pro); Bob First, Bob Lynch, AARP (con); Bernie Dochnahl, George Schneider, Health Services Commission (con); Cheryl Metcalf, WACD (con); Diane Michalek, Aviation West (pro); Diane Stollenwerk, Sisters of Providence Health System (con); Tony Lee, Childrens Alliance (con); Gene Goosman, Equal Justice; Carolyn Logue, NFIB (pro); Dr. Phil Nudelman, Group Health Cooperative (pro); Jeff Larsen, WOMA, WAND, WSDHA, WADA (con); Gary Smith, Indep. Bus. Assoc. (pro); Laura Groshong, BCD, Coalition of Mental Health Professionals (con); Greg Tisdel, Tiz's Doors (pro); Greg Seifert, Tri-County of Health Underwriters (pro); Don Scott, Scott Publishing (pro); Bruce Bishop, Kaiser Permanente; Jan Norman, WA State Dietetic Assoc. (con); Frank Haberlach (pro); John Rathison, WA State Life Underwriters Assoc. (pro); Diane Symms, Lombardi's Cucina (pro); Patty Hayes (con); Gail McGuffish, WA State Psychological Assoc. (con); Nick Federici, WSNA (con); Mary Clogston, Pam Martin, OIC.

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass as amended by Committee on Health & Long-Term Care.

Signed by Senators Rinehart, Chair; Loveland, Vice Chair; Drew, Fraser, Gaspard, Hochstatter, Long, McDonald, Moyer, Pelz, Sheldon, Snyder, Spanel, Strannigan, Winsley and Wojahn.

Staff: Steve Lerch (786-7474)

Testimony For: None.

Testimony Against: None.

Testified: No one.