SENATE BILL REPORT

SB 5935

As Reported By Senate Committee On:
Health & Long-Term Care, February 28, 1995
Ways & Means, March 30, 1995

Title: An act relating to consumer protection in the purchase of health care.

Brief Description: Enacting the consumer protection in the purchase of health care act.

Sponsors: Senators Quigley, Wojahn, Franklin, C. Anderson, Fairley, Gaspard, Haugen, Snyder, Pelz, Spanel, Sheldon, Loveland, Fraser, Kohl, Hargrove, McAuliffe, Prentice, Heavey, Drew, Rasmussen, Bauer, Rinehart, Sutherland, Smith, Owen and Winsley.

Brief History:
Committee Activity: Health & Long Term Care: 2/22/95, 2/23/95, 2/28/95 [DPS-WM, DNS].
Ways & Means: 3/17/95, 3/30/95 [DP2S].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5935 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Quigley, Chair; Wojahn, Vice Chair; C. Anderson, Fairley, Franklin, Winsley and Wood.

Minority Report: Do not substitute.

Signed by Senators Deccio and Moyer.

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 Substitute 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. Premiums and enrollee payments may be higher under this option, and provider payment levels may be varied 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 registered nurse to patient ratios, in a format established by the state Department of Health. In addition, the state Health Department must develop nurse to patient staff ratios for hospitals to be used as part of licensure, considering both acuity and general patient care needs.

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.

Nothing in law affects K-12 employee organizations from negotiating or collectively bargaining with school districts to provide benefits in excess of state budgeted amounts, as long as such additional funds are derived from local levies.

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.

Substitute Bill Compared to Original Bill: The substitute bill is reformatted to remove several amendments by reference that were done in the original bill. In addition, several substantive changes were made to the original.

The transformation of the Health Services Commission into an advisory committee contained in the original bill is deleted in the substitute. The transfers of many of the commission's powers and duties to the Insurance Commissioner and the Board of Health is deleted.

The requirement that specific nurse to patient ratios for hospitals be required by the Department of Health as part of hospital licensure is added. Certain health provider, health facility and certified health plan information disclosure requirements are modified.

The definition of improper quality of care is expanded to include certified health plan standards.

The minimum list of health services is expanded by adding other forms of medical rehabilitation such as speech therapy and occupational therapy to the physical therapy specified in the original bill.

The process for approving insurers as certified health plans is streamlined in the substitute, and modified to provide for provisional approval of entities documenting an ability to fully comply with CHP rules within two years of initial application.

Community rating requirements are removed from all but services within the minimum list of health services. After 1996, the maximum age related adjustment to community rating for the minimum list is expanded from 200 percent in the original bill to 250 percent in the substitute.

Regulation of cooperative health care purchasing groups which appears in the original bill is deleted in the substitute.

The preference for state contracts to vendors who provide health insurance to their employees is modified so that the preference is 10 percent of bid points awarded in the bid process for those who provide at least 50 percent of the premium for minimum list of health services to their employees at the time they submit their bids.

Appropriation: Appropriations sections are included which appropriate unspecified amounts from the health services account to the basic health plan and to the Medicaid program.

Fiscal Note: Requested on February 17, 1995.

Effective Date: The bill contains an emergency clause and takes effect immediately.

Testimony For: This bill is needed to adjust a generally successful and nationally recognized state level effort to contain health care costs while promoting universal access to health care. It retains an exemplary public agency that has achieved the widest respect for the thoughtfulness and responsiveness of its work. It adjusts reform to a voluntary system in the absence of federal approval of the employer mandate. It promotes access to a universally needed public good -- health care -- while preserving a largely private financing and delivery system. It repeals the employer mandate and so eliminates the government's intervention in business's ability to continue using health insurance as a means of recruiting and retaining employees, or as a means of compensating employees. It protects health care consumers by preserving choice, allowing the purchase of any health services a person might want, allowing direct access to all providers through insurance plans, adding needed disclosure and quality requirements, preserving insurance reforms including certified health plan standards and more. It continues to control costs and protect affordability by promoting competition between comparable insurance products and by reserving the state's ability to intervene if costs rise above growth in personal income. It promotes access through subsidized health products as well as through the encouragement of various, unregulated purchasing groups.

Testimony Against: The bill retains too strong a role in the private health care industry in the name of promoting universal access. It retains a large government health regulation bureaucracy called the Health Services Commission. It restricts the market by requiring unneeded standards for the cost, content, quality and terms of offering of this consumer commodity. The standards will result in product price increases that will reduce both economic profits and the market penetration of health insurance products. As fewer people have health insurance, a central goal of the legislation will be defeated. When health care costs rise as a result of this government interference, employers will be forced to lay off workers, resulting in greater unemployment. The regulations themselves will unnecessarily add to the already onerous regulation of this market and will stifle innovation and the proliferation of new products. Consumer protection provisions will hamper efficiency in managing health care, which will lead to higher costs. Premium caps and other forms of price regulation in the bill will lead to health care rationing. The "one size fits all" benefits package represents an abridgement of our freedom to consume health services as we have the means to do so. The bill retains a government takeover of our private health care system.

Testified: Bob Anderson, Home Services (pro); Gail McGaffick, Home Care Association of Washington (pro); Mike Wolfe, insurance sales (con); Dr. Margaret Heldring, Washington State Psychological Association (pro); Evan Iverson, Senior Lobby (pro); Susan Waggener, Washington Occupational Therapy Association (con); Georgetti Logan; Bernie Dochnahl, Washington Health Services Commission; Don Brennan, Washington Health Services Commission; Bob First, AARP (pro); Dessey Wolfrom (pro); Bill Keown (pro); Sarah Huntington, Leslie Schear, Midwives Association of Washington State (pro); Suzan Watanabe, ARNPs United (pro); Susan Coverly, AAPPN (pro); Dr. Sarah Murdock (pro); Virgil Clarkston (pro); Melanie Stewart, WSMPA (pro); Steve Lindstrom, AAP/AMTA (pro); Bob Dorse, FNIB (con); Jill Foster (pro); Deana Knutsen (pro); Linda Grant, Association of Alcoholism and Addiction Programs (pro); Elaine King, Metalcraft Fabricators; Rod Bailey, Evergreen Services Corp.; Gail Seyl, Winslow Auto Parts; Gary Smith, Independent Business Association; Dr. Robert Crittenden, UW School of Medicine (pro); Donald Scott, Scott Publishing; Mary Jo Wilcox, Washington Assembly for Citizens

with Disabilities (pro); Cherie Tessier, People First/Disabilities (pro); Doug Vliet, CH20 Inc. (con); Dr. G.G. Randolph; Jane Johnson, Freestanding Ambulatory Surgery Centers of Washington State; Nick Federici, WSNA (pro); Jon Hendrix, Travelers Insurance Co. (con); Gary A. Edwards, QCM Company (con); Florence Stier, Coalition of Retired Higher Education Employees; Bob Gault, Pat Conner, Jules Grele, WSLBA (con); Denise Gibbard, Need to Know Coalition (pro); John Heelan, South Sound Licensed Beverage Association (con); Greg Tisdel, Tiz Door (con); Tom Parker, National Association of the Self Employed; Rosalinda Guillen, United Farmworkers of Washington AFL-CIO; Dr. Rory Laughery, WAFP (pro); Pat Gabrielse (pro/amendments); Margaret and Michael Jones (pro/amendments); Rick Slunaker, Associated General Contractors of WA (con); Diane Stollenwerk, Sisters of Providence Health System (pro/amendments); Jeff Larsen, WOMA/WANP/WACA/WSDHA (pro); Thomas P. Knorr (con); Michael Bernstein, Pizza Time (con); Theresa Conner, Sam Stockton, Physical Therapists Association (pro); Don McGaffin; Elaine Kaufmann, Olalla Guest Lodge (pro/amendment); Lynn McKinnon, PSE (pro); Margaret Hinshaw, Washington Dance Club, Inc. (pro); Kathleen O'Connor, Women for Health Care, Education, Reform and Equity (COHERE); Randy Ray, PSPA/WATS; Lincoln Ferris, Services Group of America (con); Kathleen Albrecht, American Diabetes Association; Jim Halstrom, Health Care Purchasers (con); Jacque Ives, The Boeing Co. (con); Iris Hodge, WA Natural Gas (con); Julia Porter, Weyerhaeuser Co. (con); Peter McGough, WSMA (pro); Rick Wickman, Jack McRae, Blue Cross (con); Mel Sorensen, WA Physicians Service/Blue Cross-Blue Shield of Oregon/PACC Health Plans (con); Susan Hahn, Cascade Diesel and Truck Repair (con); Bill Sellars, King County Parent Coalition; Steve Wehrly, Dr. Dave Midgdendorf, Dr. Jim Caviell, chiropractors (pro); Michael and Caroline Kinley (pro); David Geddis (con); Dr. Neal Shonnard, Tim Schellberg, Association of American Physicians and Surgeons; Ann Simons, WA Women United (pro); Pam Martin, Insurance Commissioner's Office (pro); Rev. Dan Comsia, Lutheran Public Policy (pro); Bishop Paul Bartling, NW Synod Evangelical Lutheran Church (pro); Dave Broderick, WA State Hospital Association (pro); Lis Merten, WA Retail Association; Val Storrs, Bartell Drug Stores; Stacey Hendrickson, A&H Stores; Cassie Sauer, Children's Alliance/Health Coalition for Children & Youth (pro); Cynthia Shurtleff, Healthy Mothers, Healthy Babies/Health Coalition for Children & Youth (pro); Pat Marshall, Kitsap Chambers' Alliance (con); Silvia Klatman, Vanguard Office Systems (con); Sherill Hendrick, Instrumentation Northwest, Inc. (con); Cris Kessler, National Association of Social Workers (pro); Karen Davis, WEA (pro); Hugh Hendricksen, SW Washington Association of Health Underwriters (con); Rod Wagner, CORE recipient (pro); Maureen Robertson, Par Enterprises, Inc.; Carol Monohon, AWB (con); Rose Marie Lewis, Unique Impressions (con); William Imhoff, William Imhoff Co. (con); Kim Ward, The Fence Connection, Inc.(con); P. Robert Brown, insurance broker; Hanahn Korman, medically intensive homecare provider; Bob Bentley, WA Association of Health Underwriters (con); Dottie Nelson, WA State Physical Therapists Association (pro); Greg Deverex, WFSE (pro); Diane Symms, Restaurant Association of SW; Alan Aman, Tom Ranken, WA State Biotechnology and Biomedical Association; Arlene Oliver, RN; Ellie Menzies, District 1199 NW/SEIU (pro); Cindy Zehnder, Teamsters; Krista Eichler, Greater Seattle Chamber of Commerce; Carolyn Logue, National Federation of Independent Business; Patti Carter, Pony Mailing and Business Center; Lonnie Johns-Brown, NOW (pro); John Evans, CNA Computer Systems Eng.; Allen D. Lamb, Al Lamb Insurance; Tom Kwieciak, Ed Barker, BIAW; Mary McGregor, WA diabetes educator (pro); Dave Knutson.

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 5935 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Rinehart, Chair; Bauer, Drew, Fraser, Gaspard, Hargrove, Pelz, Quigley, Sheldon, Snyder, Spanel, Sutherland, Winsley and Wojahn.

Staff: Steve Lerch (786-7474)

Second Substitute Bill Compared to Substitute Bill: Consideration of medical research funding as part of the health care system is no longer a Health Services Commission duty.

Certified health plans, as part of their requirement to have at least one plan available which includes any willing provider, may encourage enrollees to use cost-effective providers through variable enrollee participation incentives rather than through variable reimbursement rates.

Provisions affecting collective bargaining for health benefits are altered as follows: (1) language referring to a limitation on bargaining for no more than 100 percent of the lowest price health plan is eliminated rather than altered to allow for bargaining for additional premiums or for point-of-service cost sharing; (2) language stating that this act will not affect health plan collective bargaining rights for any employee organization is restored to state that this act will not affect health plan collective bargaining rights of private sector employee organizations; and (3) language allowing for K-12 employee organizations to bargain for additional health benefits using local levy funds is eliminated.

Whistleblowers may be identified if it is determined that a complaint concerning a health care provider was not made in good faith. Language concerning improper quality of care is broadened to include all state-licensed health providers. The definition of improper quality of care is clarified to state that it does not include personnel actions related to employee performance.

Health provider staffing plans are clarified to require inclusion of direct registered nurse to patient ratios.

The hospital staffing plans to be developed by the Department of Health are not required unless a specific appropriation is made for this purpose.

The source of funding for insurance brokers' commissions for sale of the Basic Health Plan to first-time enrollees is changed from the Basic Health Plan Trust Account to the Health Services Account.

Language allowing for the transfer of Health Services Account funds between the Health Care Authority and DSHS-Medical Assistance so as to maximize enrollment of adults in the Basic Health Plan and children under 200 percent of the federal poverty level in Medicaid is clarified.

The requirement that the Health Care Authority and the Department of Labor and Industries develop an easy employer payment mechanism for the Basic Health Plan and workers' compensation insurance is clarified to be a study, with recommendations to be reported to the Legislature by March, 1996.

The legislative directive for DSHS-Medical Assistance to seek federal waivers to allow for more efficient and cost-effective provision of health care to low-income residents, including means-tested point-of-service cost sharing for Medicaid recipients, is restored.

Sections containing appropriations to the Health Care Authority, DSHS-Medical Assistance, and the Department of Health are removed.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill contains an emergency clause and takes effect immediately.

Testimony: Please refer to Senate Committee on Health & Long-Term Care testimony.