Washington State's Health Reform Proposals:

A Human Rights Assessment

NoHLA *Northwest Health Law Advocates, January 2009*

Massachusetts Model

This proposal is modeled on health reform enacted in Massachusetts in 2006. It would require all individuals to enroll in commercial health insurance, with an affordability exemption if the cost of coverage exceeds 5% of income. It would maintain the presence of private insurance companies but require them to offer their products through a state Connector board, the Health Care Authority, which would establish and enforce rules. Each carrier must offer a variety of plans designated by the Connector board, including a comprehensive plan. The proposal would use adjusted community rating, with rates based on age, geography, family size and wellness activities.

The mandate to enroll in commercial health insurance would apply to individuals and small groups (up to 50 persons). Large groups offering health insurance and self-insured employers would be exempt, as would state employees, individuals receiving health insurance through Medicaid, Medicare or the military, and institutionalized individuals. Current enrollees in Basic Health and WSHIP would switch over to the Massachusetts Model and receive health insurance through the Connector board

Recognition of Right to Health Care for Everyone

This proposal does not recognize the right to health care for everyone. It offers a way for everyone to obtain health insurance, but creates a duty on individuals to purchase it.

Access

Health care is not considered a public good, but an individual duty. Individuals are not guaranteed access to care, but they are guaranteed that some type of insurance plan will be available for purchase: the Connector board must approve four or five standardized benefit plans ranging from high-deductible to comprehensive, based on the Public Employee Benefit Plan. Those who purchase the least comprehensive plans may not have access to preventive or routine care. Private insurance companies are not held accountable for securing universal access to care, but they are regulated with the intention of making coverage more accessible.

Affordability

There would be an affordability exception to the individual mandate to purchase health insurance, which Mathematica assumes will apply when the cost of health insurance exceeds 5% of gross income. Premium assistance is provided up to 200% of the federal poverty level, based on the Basic Health model (a surcharge would be imposed for Connector administrative expenses). Employer contributions do not lower an employee's premium assistance subsidy.

The Connector would not regulate carriers to maximize revenue spent on health services, versus administration and profits. Risk pools would be slightly broader than in the current market because there would no longer be a Standard Health Questionnaire that excludes individual with the most costly risks (these individual are currently referred to WSHIP). Premiums could still be age-rated, allowing plans to charge older people up to 3.75 times as much as younger people. The comprehensive plan may not be very affordable to some, such as an older person who has high premiums and greater cost sharing.

Equity & Non-Discrimination

The proposal would not increase equity in access to care, as people would continue to access care very differently depending on their financial resources. Some people may forgo regular access to care because they may only be able to afford a high deductible or high cost-sharing plan. There is an explicit provision that all individuals must be offered all insurance products; however, rates may vary based on age, geography and employment status. This tends to separate the sick from the healthy (adverse selection), leading to an inequitable distribution of resources.

KEY: ● clearly meets principles ◒ partially meets principles ○ fails to meet principles

The proposal does not address elimination of health disparities, culturally appropriate care, or monitoring of discriminatory practices.

Comprehensiveness	

Individuals may choose a comprehensive plan based on the Public Employee Benefit Plan, but those doing so may experience adverse selection and higher costs. Subsidies are based on the less-comprehensive Basic Health benefit package.

Availability	

The Massachusetts model does not address health care infrastructure or recruitment of health care professionals to assure that care is available.

Quality	

All plans offered through the Connector must improve quality and health outcomes, but plans outside the Connector are not subject to these requirements. It is expected that the Connector would share information on best practices with providers.

Information and Transparency	

All insurance would go through the Connector, which is expected to create transparency and standardize the information available to Washington residents.

Accountability	

The health system established by this proposal would be accountable to the Connector board. Private insurers are not accountable for protecting health; their main obligation is to operate profitably. The accountability burden instead rests on individuals, who must prove that they have purchased an insurance product.

Participation	

Participation is not address in this proposal.

Public Health	

Health plans are encouraged to offer wellness incentives, and preventive and chronic care services. However, population-based public health is not addressed in the proposal.

Principles Related to Low-income Populations[1]	

Medicaid and SCHIP would remain unchanged, and no changes in financial eligibility are contemplated. Basic Health and HIP enrollees would be transitioned to Connector plans, and it is not clear whether and how their costs would be affected. While they could choose low-cost, high deductible plans and place the premium assistance "savings" in a Health Savings Account, such arrangements have been shown to reduce access to care.[2]

The proposal does not address language access or transportation for low-income residents. Enrollment assistance in applying for the connector would be offered, but barriers to other public programs are not addressed. It is likely that people remaining on DSHS medical programs will continue to have problems accessing providers.

1 This is a combined rating for all the low-income principles. For a breakout of individual ratings, see "Quick Look" chart comparing Washington's health reform proposals.

2 "National Survey of Enrollees in Consumer Directed Health Plans," the Kaiser Family Foundation, November 2006 (available at: www.kff.org/kaiserpolls/upload/7594.pdf).