

Washington State's Health Reform Proposals: A Human Rights Assessment

NoHLA Northwest Health Law Advocates, January 2009

WASHINGTON HEALTH PARTNERSHIP (WISCONSIN MODEL)

This proposal is based on a model developed, but not yet enacted, in Wisconsin. It would maintain the presence of private insurance companies but require them to offer a standardized benchmark health plan to all state residents. It would establish a public-private entity called the Washington Health Partnership (WHP), which would provide the insurance through health care networks. This partnership would be governed by a board, which would be the rule-setting and enforcement entity to ensure that all provisions in the proposal are met. The WHP would offer fairly comprehensive coverage. In order to receive this coverage, a person must meet all eligibility criteria, some of which are outlined in the bill and some of which would be later determined or refined by the board.¹ Cost sharing would be required, but the proposal asserts that this should not pose a barrier to care.

Recognition of Right to Health Care for Everyone



This proposal states that the WHP board will establish a patient bill of rights, but there is no explicit recognition of the right to health care. Certain groups are excluded from the Washington Health Partnership (WHP): those eligible for Medicaid and SCHIP, federal employees, those insured through the military, and institutionalized persons. The intent is that these programs, combined with the WHP, would cover all Washington residents who have lived in the state for at least one year.

Access



This proposal states that “[b]y 2012, every resident of this state shall have access to affordable, comprehensive health care services,” but it excludes residents until they have lived in Washington for one year. The proposal would leave it up to the board to determine standards of access to be met by WHP health networks, and there is no assurance these standards would result in universal access to care.

Affordability



The plan aims to provide affordable coverage for everyone, expands Medicaid to 200% FPL, and also asserts that cost shall not pose a barrier to care. Enrollees in the lowest-cost WHP network pay no monthly premium; however, they may not be able to afford health care due to deductibles and cost-sharing. Those who do not enroll themselves would be assigned to the lowest-cost network. WHP is funded by a sliding scale payroll tax on employers and employees. It is not known whether the tax would be more affordable than current health care costs for most or all state residents.² The proposal does not address whether and how unemployed individuals contribute to the cost of coverage.

Equity & Non-Discrimination



WHP networks must enroll and provide benefits to all, regardless of age, sex, race, religion, national origin, sexual orientation, health status, marital status, disability status, or employment status. However, individuals may enroll in higher-cost networks if they can pay, suggesting that inequities may remain related to comprehensiveness of coverage, availability of providers, etc. The proposal does not address elimination of health disparities, culturally appropriate care, or monitoring of discriminatory practices.

Comprehensiveness



WHP coverage is modeled on the state public employee benefits package, which provides reasonably comprehensive services, but does not include dental coverage. Enrollees are responsible for meeting a deductible. Cost sharing would not apply to adult



¹ Exact bill language and provisions can be found online at: <http://apps.leg.wa.gov/documents/billdocs/2007-08/Pdf/Bills/Senate%20Bills/6221.pdf>.

² A study of the Wisconsin health reform plan by The Lewin Group, Inc., concluded that the vast majority of employers and residents would pay less, with the exception of those employers who currently pay little or nothing for such benefits. “The Wisconsin Health Care Plan (WHCP) for Workers and Dependents in Wisconsin: Const and Coverage Impacts,” p. 18, The Lewin Group, Inc., September 2003 (available at: www.lewin.com/content/publications/2769.pdf).

KEY:

● clearly meets principles

◐ partially meets principles

○ fails to meet principles

preventive, prenatal, well-child or chronic care services; otherwise, the proposal states that any cost sharing must promote appropriate use but not pose a barrier to receiving appropriate care. The board may limit some services, which could be problematic for high needs individuals.

Availability



Primary care physicians would be recruited to increase their availability. The proposal relies on the market (in this case networks of providers) to address availability of infrastructure, goods and services.

Quality



The board assesses and classifies networks based on quality measures. Rates must assure access to quality services. The proposal requires that everyone have a medical home, even if they choose a fee-for-service coverage option. All care would be “evidence based,” which can assure quality, but at times can also be used as a mechanism to deny care.

Information and Transparency



Participating WHP networks must have programs to increase transparency of health care cost and quality information. There would also be outreach and information regarding preventive care and chronic disease management programs. The proposal does not address patient-provider communication.

Accountability



The overall WHP system is accountable to the board. Private insurance companies are not accountable for protecting health care or providing accessible, quality services; their main obligation is to operate profitably. There are financial audits to ensure that the provisions and goals established in the proposal are being met. Enrollees can file complaints and the WHP shall investigate and attempt to resolve the complaint. However, audits and complaint procedures may not ensure accountability.

Participation



The proposal gives patients a chance to interact with the Board through complaint procedures and appeals. The board would include members from consumer organizations. Other than this, individuals and communities have no real part in the planning and implementation process.

Public Health



There are no public health provisions in this proposal.

Principles Related to Low-income Populations³



The Medicaid income level would increase to 200% of federal poverty and BH families could qualify for Medicaid. SCHIP would remain unchanged. The board could modify provider payment rates in these programs to more closely reflect non-subsidized fee-for-service rates paid by the board. There are two main concerns. First, the new payroll taxes required by WHP would be imposed even on current Medicaid and SCHIP low-income enrollees who are employed – effectively, a reduction in income without an increase in benefits. Second, Basic Health (BH) enrollees who do not qualify for Medicaid would be rolled into WHP, and cost-sharing might exceed BH cost-sharing. The proposal says that the board shall ensure that deductibles are not a barrier to receipt of medically necessary services and that cost sharing would be reduced for those with income below 200% of the federal poverty level. However, evidence shows that any cost-sharing, however small, reduces access to care among low-income and elderly populations.⁴ Until these costs are known, we cannot tell whether Basic Health clients would benefit from the change.

The proposal does not address language access or transportation for low-income residents. People remaining on Medicaid may have fewer problems accessing providers if the board raises provider rates to match unsubsidized rates.

³ This is a combined rating for all the low-income principles. For a breakout of individual ratings, see chart comparing Washington’s health reform proposals.

⁴ Goldman, Joyce and Zheng, “Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health,” p. 5-8, JAMA, Vol. 298, No. 1, July 2007 (available at: <http://jama.ama-assn.org/cgi/content/full/285/4/421?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=%22Prescription+Drug+Cost+Sharing%3A+Associations+With+Medication+and+Medical+Utilization+and+Spending+and+Health&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT>); Tamblyn, Rejean, et. al., “Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons,” p. 7-8, JAMA, Vol. 285, No. 4, January 2001 (available at: <http://jama.ama-assn.org/cgi/content/full/285/4/421?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=%22Prescription+Drug+Cost+Sharing%3A+Associations+With+Medication+and+Medical+Utilization+and+Spending+and+Health&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT>).