Washington State Health Services Act: Implementing Comprehensive Health Care Reform

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In 1993, Washington State enacted the Health Services Act of 1993 (HSA) to guarantee universal access to health care through an employer mandate, with caps on premiums as the primary cost-control mechanism. The HSA represents the Nation's first formal experiment with managed competition. This article reports the results of a case study of the HSA's implementation. The study concludes that the Washington State initiative can be replicated in other States, but that implementation is complex, requires sustained public education, and requires cooperation from the Federal Government through program waivers. A major implementation challenge is to facilitate competition and minimize regulation.

INTRODUCTION

State legislators face difficult policy choices in seeking to control rapidly escalating health care spending while simultaneously expanding access to needed care for the poor and the uninsured. While these goals are not mutually exclusive, they are certainly difficult to balance given the realities of State budgets and Federal Medicaid coverage mandates.

As the recent debate over the Clinton Administration's proposed Health Security Act demonstrates, there is very little consensus on exactly what form the health care financing and delivery system should take in the future. Although there is widespread agreement about the problems and consequences of maintaining current health care policy, consensus solutions have remained frustratingly elusive.

In 1993, the Washington State legislature enacted the HSA (E2SSB 5304) to guarantee universal access to health care for all Washington residents, with caps on premiums as one of the primary cost-control mechanisms. Enactment of the HSA culminated a lengthy process of commission studies and public debate that provided a structure, managed competition, for substantial reform of Washington's health care system. In retrospect, that process, as difficult as it may have seemed at the time, might well have been the easy part. Many of the key design decisions, including defining the uniform benefits package and the role of health purchasing alliances, were delegated to the newly created Health Services Commission (HSC). The success of this complex legislation, therefore, is largely dependent on the implementation details the HSC and other State agencies add to the legislative structure.

This article reports the results of a case study of the enactment and implementation of the HSA. In conducting this case study, project staff reviewed available documents, both published and unpublished, that describe or assess the legislative and regulatory processes. This material included published health services research findings,

NOTE: In early 1995, the State House Health Care Committee approved legislation that would repeal most of the HSA. The legislation, if approved through a referendum, would repeal the employer mandate, the insurance premium cap, and the mandate for universal coverage. The legislation would continue expansion of the Basic Health Plan (BHP).

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authorizing State legislation, and other State reports related to program design, operation, or evaluation. Extensive in-person interviews were conducted with key individuals. The persons interviewed included:

- Key State policymakers from both the executive and legislative branches.
- Representatives of the State medical and hospital associations.
- Insurers and health providers.
- Business, labor, and community leaders.

In general, these interviews sought to obtain the parties' perspectives concerning:

- Factors contributing to the enactment of the HSA.
- Key issues that must be addressed in designing and implementing the legislation.
- Factors that officials from other States should consider when assessing the feasibility and desirability of implementing similar initiatives in their own jurisdictions.

The interviews were conducted at an early stage in the implementation process. Where possible, updated implementation details are included, but this article does not describe the sequential decisionmaking process. Instead, this study provides information about the issues and challenges other States can expect to encounter in implementing comprehensive health care reform through managed competition. For example, a State interested in managed competition can benefit from understanding the political context in Washington State, what is required before a similar initiative can be implemented (including data needs), and what the anticipated response from consumers, insurers, and providers is likely to be.

Before discussing HSA implementation, this article first reviews the Washington health care environment and some of the important programs leading to the HSA. The article then summarizes the HSA's major provisions. After discussing the political context in which the HSA was debated, the article provides a description of important design and implementation decisions that were considered. The article concludes with a discussion of the lessons that other States can apply in considering a similar approach.

BACKGROUND

From 1974 to 1989, Washington State used hospital ratesetting as the primary regulatory mechanism to control hospital costs. By 1989, however, the political center had shifted away from regulatory approaches and toward deregulation, and the legislature refused to renew the ratesetting commission. Instead, in 1990 the legislature created the Washington Health Care Commission to recommend a comprehensive reform strategy. This was a recognition that hospital ratesetting had not adequately restrained health care costs.

Like most States, health care costs in Washington escalated through the 1980s at roughly three times the rate of inflation. In particular, the State's costs for Medicaid and related health care programs for the uninsured were rising at a rapid rate, and there were approximately 600,000 uninsured residents, constituting about 11 percent of the State's population (Washington State Office of Financial Management, 1992).

When the HSA was enacted, there was already considerable movement in the market toward managed care and systems integration. Health maintenance organizations (HMOs), primarily Group Health Cooperative of Puget Sound, had captured about 18 percent of the market, and the percentage of traditional fee-for-service coverage was only about 15 percent of the market by the early 1990s. The remainder of the insured population was shared by Blue Cross and preferred provider organizations.

Basic Health Plan of 1987

To address the growing problem of the uninsured, Washington enacted the BHP in 1987 as a 5-year pilot program of contracted managed care for residents with incomes below 200 percent of the Federal poverty level. By the early 1990s, approximately 24,000 previously uninsured residents were covered under the BHP (Washington Health Care Commission, 1992). Even though the BHP covered only a small portion of the State's uninsured population (it had a capped enrollment of 27,000), several opponents of the HSA suggested in the study interviews that they considered the BHP to be a successful program that could be expanded to cover more of the uninsured population instead of enacting the HSA.

In conjunction with the BHP, the State's Medicaid population was already being shifted into managed care prior to enactment of the HSA. Through the Healthy Options program run by the Medical Assistance Administration (Department of Social and Health Services), each participant is assigned to a primary-care provider. Two models are being tested: full capitation and primary-care case management. The goal is to enroll all Medicaid recipients in one of these models.

Washington Health Care Commission

In response to the continuing crises of increasing costs and larger numbers of uninsured residents, the legislature convened the Washington Health Care Commission in May 1990 to recommend a consensus approach to comprehensive reform. The Commission's report in November 1992 formed the basis for the HSA. For example, the Commission recommended a managed competition approach to control costs along with policies to ensure universal coverage based on a uniform benefits package. The primary unresolved issue was what financing mechanism should be used. An almost evenly divided Commission recommended residency-based single-sponsor coverage (similar to a single payer system), with a substantial minority favoring a multiple-sponsor "play-or-pay" system (similar to an employer mandate). For cost containment, the Commission recommended premium caps, price competition among health plans, and beneficiary cost sharing, instead of reinstituting the more limited ratesetting system. To monitor implementation, the Commission recommended the appointment of a permanent independent State commission.

Each of the respondents credited this Commission with providing the necessary public consensus on universal coverage and the structure of managed competition to enact the HSA. Acceptance of the Commission's recommendations, except for the financing mechanism, was facilitated by the success of the BHP and cost savings attained by the Health Care Authority (HCA) in negotiating lower health care premiums for State employees.

HSA'S PRIMARY PURPOSES

The HSA has five primary purposes: (1) to stabilize and reduce unwarranted health care costs; (2) to provide universal access; (3) to improve the public's health (by emphasizing public health promotion and prevention strategies); (4) to address the health care needs of minorities; and (5) to preserve the viability of businesses by lowering health care costs.[1] An unstated goal, stressed by several respondents, is to

[1]For a succinct summary of the Act, see Crittenden (1993).

restructure the health care delivery system by emphasizing managed care.

The Act's underlying conceptual framework is managed competition, although the introduction of premium caps certainly varies from managed competition theory (Enthoven, 1993). As originally conceived, managed competition combines consumer choice of competing health care plans (usually offering a standardized benefits package) with price competition based on the ability of large purchasing alliances to purchase health care services on behalf of numerous subscribers. Other theorists (Starr and Zelman, 1993) have argued that health care reform should be based on the framework of managed competition and an employer mandate, with a cap on premium costs as a cost-control mechanism "back-up" to competition. In concept, the HSA appears to adopt the balance between competition and regulation instead of relying on competition alone to achieve its purposes. This combination results in a somewhat mixed conceptual approach, relying on employer mandates to increase access, managed competition and insurance premium caps to control costs, and managed care to reshape the delivery of health care. Proponents of the Act justify the juxtaposition as a "creative tension" (in the words of one legislator) between competition and regulation. To the extent that competition between health plans for subscribers results in lower health care costs, regulation through premium caps will not be necessary.

The legislature imposed premium caps to place insurers or Certified Health Plans (CHPs) at risk as an incentive to discipline the market. The prevailing sentiment appeared to be, in the words of one legislator, that, "Absent financial risk by insurers, managed competition won't work." The Act establishes a complex set of regulatory interrelationships and requirements that were delegated to the HSC to organize and coordinate.

Restructuring the Health Care Insurance System

The HSA imposes three major changes in health care insurance. Taken together, these three elements constitute a major restructuring of the State's health care delivery system.

The HSA first requires that all health care be purchased through CHPs, which, similar to HMOs, combine financial risk with health care delivery. Beginning in July 1995, each CHP, which can be an indemnity insurer, HMO, or risk-bearing provider network, must offer at least the HSC-mandated uniform benefits package (UBP) for no more than the maximum community-rated premium set by the HSC. CHPs will negotiate fees with providers, but must use some form of scheduled rate-setting, such as capitation, prospective payment, or relative value scales. Each employer must offer at least three CHPs, one of which must be the lowest cost plan in the region, and can offer supplemental benefits beyond the UBP. Employers with more than 7,000 employees can self-insure under regulation as a registered employer health plan.

Secondly, consistent with the theory of managed competition, the HSA establishes four regional, voluntary, non-competing Health Insurance Purchasing Cooperatives (HIPCs) through which employers and individuals may join together (voluntarily) to purchase health care. Each HIPC must offer all CHPs within the HIPC's region. Each CHP must offer the UBP at a single, established community rate. CHPs will compete on price, subject to the premium cap and quality. Regulation and monitoring

of both CHPs and HIPCs falls under the Insurance Commissioner's jurisdiction, subject to requirements established by the HSC.

The State's HCA, operating as a consolidated State purchasing agency, will purchase health care for all State employees, school employees (kindergarten through 12th grade teachers), the BHP, and eventually Medicaid and Medicare beneficiaries (pending Federal waivers). Any employer or individual may enroll in the BHP at an unsubsidized premium rate. While not technically a HIPC, because it is not required to offer all CHPs in the State, the HCA will operate functionally as a HIPC for its subscribers.

Thirdly, the Act contemplates a significant expansion of managed care. In fact, CHPs will only be able to offer managed care plans—no traditional fee-for-service option will be available after July 1995.[2] While the specific operational and performance requirements of managed care are to be determined by the HSC, the statute contemplates a broad definition to include any risk-sharing arrangement (i.e., provider networks) based on capitation, prospective payment, or similar payment controls. However, many of the Act's opponents suggested that the managed care requirement would inevitably lead to HMO coverage as the dominant model. Indeed, many of the respondents suggested that indemnity coverage was unlikely to survive the HSA's implementation.

Access

Universal access is to be achieved through both employer and individual mandates as well as State benefits. First, between July 1, 1995, and July 1, 1999, an employer mandate (requiring an Employee Retirement Income Security Act [ERISA] waiver) will be phased in, beginning with large employers. Second, individuals not covered through employment are required to obtain the BHP or the UBP directly from a CHP or through an HIPC by July 1, 1999. Thus, all individuals and employees will be covered by the UBP by July 1, 1999. The HSA requires employers to pay at least 50 percent of the premium for workers and their dependents (based on the lowest priced UBP available), with part-time workers covered on a prorated basis. Annual health insurance subsidies of $50 million will be available to assist businesses with fewer than 25 employees.[3] Under recent legislation, seasonal workers are now covered by the HSA.

Third, for those unable to afford health insurance, the State will expand BHP coverage for adults, and Medicaid will be expanded to cover children below 200 percent of the Federal poverty level. Federal waivers will be sought to allow placement of Medicare and Medicaid populations into the same purchasing pool as State employees. In addition, existing access programs, such as the State's health insurance risk pool for uninsurable residents, are scheduled to be rolled into the BHP. The number of adults enrolled in the BHP is to increase from 24,000 to 58,000 by June 30, 1995. The BHP, shifted to the HCA in 1993, will be rolled into the statewide purchasing alliance along with other State programs; this might also be done to the medical component of worker's compensation.

[2]Technically, a CHP can offer a fee-for-service option if a network of providers using some risk-sharing is provided. Additionally, the HSC is recommending changes to point-of-service cost-sharing rules (copayments and deductibles) that will facilitate the use of point-of-service options.

[3]The $50 million amount for small business subsidies still needs legislative authorization and is actually a placeholder, pending subsequent analysis, rather than an estimate of the anticipated cost of the subsidies. The Small Business Advisory Committee to the HSC is expected to produce a more precise estimate of the subsidies by 1997.

Cost Controls

The HSA has contemplated two primary cost-control mechanisms among nearly one dozen cost-containment approaches included in the Act. One is that CHPs will compete for business by lowering premiums (that is, offering competitive premiums) for the UBP. In theory, managed competition will encourage people to choose the most efficient plans by providing them with information on quality and costs, and will encourage price competition among CHPs based on the HIPC's consolidated purchasing power. The rules regarding CHPs and the UBP should allow easier comparisons for consumers.

In addition, the HSA mandates the HSC to set a maximum premium that CHPs will be allowed to charge. The maximum premium will be established each year, with the base year being 1995, based on the estimated actuarial costs of the UBP. Beginning in 1996, the growth rate for the maximum premium will be the average growth rate in the costs of the UBP from 1990 to 1993, reduced by 2 percent annually until premium growth is reduced to the rate of growth of the Consumer Price Index plus population (real per capita growth of zero). Premiums will be on a modified community-rated basis; that is, each plan must offer every subscriber the same coverage at the same price, except for adjustments for geography and family size. As discussed later, however, important details about community rating and permissible premium rate and risk adjustments are to be determined by the HSC. Also, employer premium contributions for the UBP are to be tied to the lowest cost plan, as determined by the HSC. Individual subscribers will be responsible for copayments and deductibles as determined by the HSC.

Underlying these primary cost-containment mechanisms was the legislature's belief that universal access, through the employer mandate, would be a precondition for eliminating cost shifting and reducing cost increases. By tying the employer premium contribution to the lowest priced plan available in the region, employees will have incentives to choose low-cost CHPs or bear the higher costs of more expensive plans.

The shift to managed care is expected to change health care delivery incentives and encourage more efficient medical practice. Other cost controls include medical malpractice reforms, such as mandatory nonbinding claims mediation, and the suggested development of clinical practice guidelines.

One potential limitation on the ability of CHPs to control their costs is that the HSA contains a modified any-willing-provider provision designed to protect physicians, other practitioners, and categories of providers from being excluded from a plan. Providers may not be prevented from participating in a plan if the exclusion "...would result in the substantial inability of providers to continue their practice, thereby unreasonably restricting consumer access to needed health services..." Although generally opposed by payers as restricting their ability to control costs, the burden for any individual provider or provider category to meet these conditions seems quite substantial.

Public Health

Unlike other State-level comprehensive health care reform initiatives, the HSA includes an explicit commitment to combine traditional population-based public health programs and providers, such as health promotion and prevention services, improved access to immunization and screening services, and environmental health and safety protections with the new system. The Department of Health (DOH)

is required to develop a public health improvement plan in cooperation with local public health departments. Five percent of HSA-related tax revenues are to be allocated to public health matters, such as teen pregnancy abatement programs.

In addition, the DOH is mandated to develop and implement a statewide Health Service Information System to provide information on utilization patterns, costs, quality indicators, and outcomes. Uniform administrative and billing procedures are also to be developed. The HSC is responsible for policy development and oversight of the DOH's information system.

Financing

The primary financing mechanism for expanding access is an employer mandate to contribute at least 50 percent of employee health insurance premiums for the lowest priced plan. Revenue to finance the subsidies to expand access for low-income and uninsured individuals will be raised through an assortment of increased taxes on cigarettes, tobacco products, liquor, and beer. A 2-percent business and occupational tax will also be imposed on HMOs, CHPs, and non-profit hospitals beginning January 1996. Other savings are anticipated from improved public health measures and administrative efficiencies. A ballot initiative to roll-back these and other 1993 tax increases was defeated in November 1993.

Regulation

It seems clear from this summary that a complex and interrelated regulatory structure will emerge once the Act is implemented. The HSC will coordinate overall health care reform, but other regulatory agencies will have important roles. For example, the Insurance Commissioner, an elected official, retains regulatory responsibility for overseeing the operation of the HIPCs and the CHPs once the HSA is implemented. The HCA retains overall responsibility for the State-operated purchasing group, while the DOH will develop and operate the data and public health components. An interagency coordinating group, chaired by the Governor's office, has been established to ensure close working relationships. As discussed later, these segments are interdependent.

POLITICS OF HEALTH CARE REFORM

Political Debate

According to the study interviews, which largely confirm Crittenden's (1993) analysis, political pressure for significant reform had been building during the late 1980s, culminating in the elections of 1992. Democrats gained or retained control of all the major offices, including the Insurance Commissioner and Governor, and both houses of the legislature. Since most Democrats had campaigned promising universal health insurance, some form of comprehensive reform seemed inevitable. A coalition to support health care reform included the Washington State Hospital Association, consumer groups, organized labor, and the Washington State Medical Association (WSMA). Known as the Committee for Affordable Health Care, the coalition was instrumental in negotiating compromises among reform proponents.

A crucial aspect of the political debate, according to many respondents, was the role of the WSMA. In the late 1980s, WSMA was roundly criticized in the media for opposing health care reform efforts. By the early 1990s, under the leadership of family practitioners, the WSMA decided to actively support universal coverage, as

long as patients had a choice of plans and physicians could participate in as many CHPs as they wished. By all accounts, WSMA support was critical to enacting the HSA. But as a concession to the WSMA, the Act includes limitations on CHPs' ability to reject individual providers or categories of providers, as previously described.

On the other side, business groups and the insurance industry, initially including Blue Cross of Washington and Alaska, vigorously opposed comprehensive reform. These groups were willing to agree to small group insurance reforms designed to expand coverage for previously uninsured small firms, but rejected the need for universal coverage and an employer mandate. Although business and insurance groups never formed a unified opposition coalition (their interests were similar, though not entirely congruent), they uniformly opposed premium caps, community rating, the employer mandate, and the lack of competing HIPCs (Association of Washington Business, 1994). According to several respondents, the WSMA attempted to cooperate with these groups, but could not agree on a compromise position.

As in the national debate, business and insurance groups and their legislative allies argued that costs should be controlled before providing universal access. Business groups argued that the increased costs would result in substantial job losses, although they cited no studies or estimates of anticipated job losses. Along with legislative supporters, they also argued that the BHP could be extended to the 11 percent of the State's population lacking health insurance without the extensive changes contemplated by the HSA. Large businesses were also concerned that they would lose savings derived from their health prevention efforts and experience-rating arrangements as a result of community rating, and that the HSA would eliminate employer flexibility to negotiate lower prices. Finally, these groups, especially small business, objected on conceptual grounds to governmental intervention in the marketplace.

One of the most interesting aspects of the general political debate was that support for a single payer system had declined before the 1992 elections and was not a factor in the legislative debate. Despite the narrow Washington Health Care Commission majority recommendation for a single payer system, there was little public pressure by 1993, aside from labor, for a single payer system. In fact, a single payer voter initiative did not obtain enough signatures to get on the ballot. The political reality, according to most observers, was that the legislative leadership was unwilling to recommend the up-front tax increases that would be required to support a single payer system. One legislator estimated that insuring the State's 600,000 uninsured population would cost $6 billion over 6 years, resulting in a steep tax increase. Given that a single-sponsor model initiative failed to obtain enough signatures, public support for such tax increases seems unlikely. In addition, the post-HSA Blue Cross focus groups found little support for a single payer system outside of Seattle. Nor did Governor Lowry support a single payer system. Instead, the primary legislative debate centered on employer mandates.

Legislative Debate

Two issues dominated the legislative debate over the HSA: incremental reform (i.e., small group insurance reforms) versus systemic changes (i.e., universal coverage), and the appropriateness of the employer mandate. According to project interviews, there was little disagreement

about the need for small group insurance reforms, such as removing preexisting condition limitations and including guaranteed issue/guaranteed renewal provisions. Even the insurers agreed to these reforms. What was much harder to decide was the financing mechanism for expanded health care coverage.

Both the Governor and legislative leaders were committed to an employer mandate as the only effective means of extending health insurance to all citizens within the managed competition framework. An unregulated managed competition approach commanded only limited support in the legislature, and was never seriously considered as an alternative. Similarly, former Governor Booth Gardner had favored a play-or-pay system, but had garnered only limited legislative and public support in 1992.

Having rejected a single payer system as politically unfeasible, employer mandates seemed to be the natural alternative, essentially building on the existing system. By all accounts, Governor Lowry's strong support and arm-twisting as the vote neared made a crucial difference in the outcome. Many respondents suggested that had the HSA not passed during the 1993 session, no comprehensive reform would have been enacted in the near future. As two different respondents put it, "The stars were in alignment," meaning that the window of opportunity for enacting legislation was present in 1993, but the political momentum for change might not have been sustainable.

This is consistent with Kingdon's (1984) model of the legislative process. According to Kingdon, legislation results from three process streams: problem identification, the development of politically acceptable policy alternatives, and windows in the political process (such as a change in administrations). Windows in the political process, such as a shift in national mood, present opportunities for linking problems, policy proposals, and politics. When these streams come together, legislation can be enacted.

One reason for enactment was that the primary opponents, the business and insurance coalition, never presented an effective alternative. According to several respondents, business groups were not well-organized in opposition to the HSA, and were unable to develop a unified position. For many businesses, health insurance was a low priority. Business groups also appeared to misread the political climate. In the past, business interests were accustomed to their singular ability to defeat legislation they opposed. Either because they entered too late (and with too little emphasis), or because the legislature was now controlled by Democrats, large businesses were unable to block the HSA on their own. As a result, business was essentially frozen out of the legislative debate.

The absence of a credible alternative beyond small group insurance reforms left the business-insurance alliance vulnerable to charges that its approach would neither reduce costs nor ensure access to sufficient numbers of uninsured residents. The legislature's unwillingness to raise taxes sufficiently to expand the BHP to the State's uninsured population effectively doomed the business-insurance position. In the end, most respondents agreed that the public simply demanded more comprehensive changes than the incrementalist approaches favored by the business-insurance coalition.

Subsequent Legislation

In the 1994 elections, Republicans gained a majority in the Washington State Assembly. The Assembly may introduce legislation to reconsider the employer mandate, the premium cap, and the UBP benefits

level. In any event, if the ERISA waiver is not granted by July 1995, the legislature may be forced to reconsider alternatives to the employer mandate, such as a single payer system.

In addition, the HSC is recommending several statutory changes. One change would allow health plans to modify community rating by adjusting for age differences among subscribers. Another statutory change recommended by the HSC would allow a plan to modify its premiums by plus or minus 10 percent to reflect wellness programs or healthy lifestyles.

PROGRAM IMPLEMENTATION

As previously noted, many of the key design decisions were delegated to the HSC. Although many important decisions remain, the HSC has begun to resolve what it considers to be its highest priority issues. Ultimately, the HSC is accountable to the legislature for its implementation decisions. While the legislature delegated considerable autonomy to the HSC, certain key issues, such as the scope of the UBP, must be presented to the appropriate legislative committees for review.

Implementation Process

Regulatory Cooperation

By design, the HSC was established as the primary decisionmaker during implementation, and presumably beyond, but with staffing limitations that require considerable interagency coordination. The HSC has limited staffing ability to conduct data analyses, and must rely on the Office of Financial Management, the HCA, the DOH, the Insurance Commissioner, or outside contractors for sophisticated analyses. For example, the HSC will set the overall policy for the new Health Services Information System, while the DOH will have administrative responsibility for data collection and analysis. One respondent argued that this created a balance of powers, but disagreements are inevitable.

The HSC has 80 tasks in 10 functional areas to be completed between January 1994 and June 1995. Of these, 36 are listed as highest priority. There are three interactive task clusters that cannot be separated easily, such as benefits and costs, along with interdependencies requiring input from other task groups. For example, designing the UBP requires input from fiscal and risk-adjustment task groups. In turn, the UBP will be input for defining CHP networks. This necessitates a complex set of regulatory mechanisms and interactions during and after the initial design decisions.

Analyses Conducted

To prepare for the implementation process, the Office of Financial Management conducted analyses of the anticipated coverage and cost-containment goals of the HSA (Washington Office of Financial Management, 1992). Estimates were that the employer mandate will cover two-thirds (or 462,000) of what would otherwise be an estimated 660,000 uninsured by the year 2000, the expanded BHP will cover an additional 172,000, and the individual mandate will account for the remaining 19,000 uninsured. Although aggregate health care spending will increase in the short-run because of integrating the Medicaid and uninsured populations, it is estimated that aggregate system savings by 2005 will be $7.87 billion, compared with what the costs would have been absent reform. Most of the savings will accrue to large and medium size businesses, with little savings for small business and

individual households. One problem with the cost estimate is that it assumes a 14-percent annual growth rate in health care costs, absent reform (similar to recent trends), over the forecast period.

In a related analysis (Kessell, 1994), the Insurance Commission estimated that the additional costs of removing preexisting condition limitations for persons currently insured will be 0.6 percent, on average, for the entire health insurance industry. The cost of enrolling high-risk persons currently uninsured will increase insurance premium rates by 3.3-5.0 percent. Since not everyone will enroll at once, the estimate assumes gradual premium increases.

Although some Washington State business groups expected large job losses from the HSA, especially in small businesses such as food processors, other studies contradict these expectations. For example, Klerman and Goldman (1994) estimated that implementation of the Clinton Administration's Health Security Act would have cost 100,000 jobs nationally, a much lower estimate than business groups suggest. Indeed, the effects may be greater on wages than on employment, but may be minimized if reforms are phased in gradually.

Health Care Authority's Experience

The HCA selectively contracts with HMOs, provider groups, and insurers for a managed care benefit plan for members of the statewide purchasing group. In recent contractual bidding, Blue Cross surprisingly underbid Group Health Cooperative, at a considerable savings to the State. To some respondents, this suggests that a broad definition of managed care will stimulate competition and reduce health care costs. Some reasons offered for this result include improved negotiating skills by the HCA, a desire by Blue Cross to expand its presence in this market, and Group Health Cooperative's complacency while operating in a relatively competition-free HMO environment. Several respondents indicated that the HCA has increasingly used its market power and experience to negotiate lower prices with providers, similar to the purchasing-pool experience in California. Like the California purchasing-pool experience, though addressing a smaller portion of the market, the HCA has begun to use its purchasing power to solicit and obtain lower bids for serving this population. Thus, legislators viewed the result as a demonstration that managed competition can work.

Insurance Reform

Through regulations promulgated in 1994, the Insurance Commissioner put in place certain health insurance reforms. These include required portability, guaranteed issue and renewal, and limits on preexisting condition provisions. These regulations appear to have widespread support.

Key Design Issues

The following discussion represents the consensus of the project interviews about the design questions that must be addressed before the system can operate. The HSC has not established a hierarchy among the highest priority issues, though some deadlines have been established by the HSA. Regardless of legislatively imposed deadlines, the system cannot be implemented until decisions are made about an ERISA waiver, the design of the UBP, the nature of the premium cap and community rating, and the structure of the HIPCs and CHPs. All other decisions can be deferred.

Work to resolve these issues is now well under way. Options for each key design issue

are now being developed, but how these issues will be resolved is very much undecided. Given the scope of the HSC workplan and the extent of the unresolved issues, this article can only report on some of the difficult questions to be debated, rather than being able to assess why certain decisions were reached and their implications.

ERISA Waiver

Far and away the most critical design issue is the need to obtain an ERISA waiver from Congress. Absent an ERISA waiver, the employer mandate collapses, thus threatening the entire universal coverage structure. The Washington State congressional delegation has introduced legislation that would grant the State an ERISA waiver, but that legislation has not been enacted. Many respondents believe, however, that an ERISA waiver is only likely within the context of national health care reform legislation. This could lead to an ironic result. Depending on how much flexibility is granted to the States in such national legislation, the only way to obtain a waiver may be through legislation that would alter the HSA's framework. This demonstrates the interrelationships between State and national reform efforts. Not surprisingly, business and insurance interests oppose the waiver, and view the failure of the waiver as their best opportunity to scuttle the entire HSA.

In the absence of a waiver, the UBP would remain the only insurance product available, but employers would not be required to participate. As a result, several respondents argued that the absence of an ERISA waiver would be worse than the status quo ante because the HSA depends on universal coverage through the employer mandate. Without the employer mandate, businesses with good risk profiles are likely to self-insure, while businesses with higher risk profiles could opt to participate in the UBP.

The project interviews suggest several possible alternatives if the ERISA waiver is not granted. The most obvious is to revert to the Washington Health Care Commission's majority recommendation of a single payer system. To avoid further ERISA problems, the State might consider a residency-based single-sponsor system. In that case, the employer mandate would be eliminated, providing a stronger argument that the ERISA preemption would not apply (Hopp et al., 1992). It is not clear whether this approach would eliminate the need for an ERISA waiver, but Medicare and Medicaid waivers will still be needed. Another option, suggested by HSA opponents, is to expand the BHP to the 11 percent uninsured, largely through additional State subsidies, while retaining the small group insurance reforms.

A third alternative has emerged in HSC deliberations that would encourage voluntary employer participation absent an employer mandate. To do so, the HSC is considering changes that would provide greater flexibility for employers and wider choice for subscribers. For example, the HSC might permit employers to offer differing cost-sharing levels, and hence lower premiums. Subscribers might be offered more flexible cost-sharing and point-of-service options.

Uniform Benefits Package

A second critical issue is to design the UBP. Although the HSA lists the elements to be included, such as physicians' and other providers' services, hospital care and surgery, prescription drugs, maternity care, and home health care, determining the level of benefits to be provided is

delegated to the HSC. The HSC's responsibility includes setting limits on the scope and duration of benefits. In particular, the HSC must define which benefits are effective and necessary to maintain the health of the citizens of the State, balanced against the need to control costs. Prevention and primary-care services are likely to be emphasized.

From a design perspective, the key is to develop a uniform set of benefits that is both affordable and meets current legislative and employee expectations. To accomplish this balance, the HSC is recommending a minimum set of benefits each CHP must offer. The core set of benefits will exceed the BHP, but will not be a "Cadillac" plan. Beyond the core set of benefits, employers or individuals will be able to purchase additional benefits.

Premium Cap

Two closely related issues are the level of the premium cap to be set and the definition of community rating. For the premium cap, the primary issue is to set the cap at a level that allows CHPs to compete within it, so that the cap becomes a cost-containment device of last resort. Respondents were concerned that the cap not be set at a level that becomes the actual premium cost. Setting the initial premium standard is thus both a political and an actuarial task. The first issue is to determine what the initial standard should be in 1995. Doing so will require private sector actuarial assistance.

One respondent also suggested that the existence of the cap will reduce the ability of providers to raise capital for new technology, but this observation was not shared by others. Another concern is whether caps would be sustainable at tight (i.e., low) levels, given political pressure to expand services, and hence raise the cap. Statutory limits on yearly increases in the cap may also affect sustainability.

Community Rating

Community rating presents a different problem, one that may be further confounded by how the Medicaid population is integrated into the system. In theory, the purpose of community rating is to pool risk so that every subscriber pays a similar rate regardless of health status or risk factors. The fundamental issue is to determine what constitutes the appropriate community—the entire State, each HIPC region (including the State purchasing group), each CHP, or a separate community for the private sector. A secondary issue is to determine how Medicaid recipients and the uninsured will be community-rated. Will they be included only in the State's purchasing group or community-rated across all payers? Neither of these questions has been answered yet, although the current intention is to fold the Medicaid population into the State purchasing cooperative group operated by the HCA. In any event, the Medicaid population would be served by CHPs, and the usual CHPs' provider network premium rates would apply. Details of how the Medicaid population will be incorporated into the State purchasing group will be part of the Medicaid waiver discussion.

Using one statewide community rate would spread the higher costs of providing more extensive benefits to Medicaid recipients than they currently receive across all payers. Depending in part on the level of provider reimbursement, this could result in savings to the State, relative to current expenditures, as the costs of Medicaid would be spread across all payers. But if the State pays private sector

rates to providers, Medicaid expenses could still increase, regardless of how the risk is spread across other payers. If the Medicaid population is community-rated only within the State's HIPC, the State purchasing group would most likely see an increase in premium costs, raising political complaints from State employees. The danger is that the State could become a de facto high-risk pool, especially given the needs of the aged and disabled populations.

Several respondents also noted that a possible irony with community rating is that higher costs might arise from underlying trends once preexisting conditions and other restrictions are removed, as previously excluded individuals with potentially large medical costs are brought into the insurance system. This possibility is supported by the Kessell (1994) analysis. If so, rates could rise for most subscribers after implementation, especially for younger, healthy persons, creating a potential political backlash and an additional public education problem. This discussion is contingent upon the size and composition of the risk pool. For example, adding a young and healthy population to the pool could offset any increased costs from the Medicaid population or result in lower overall costs.

To minimize these effects, the HSC could recommend statutory changes that would further modify community rating to reflect lifestyle choices and to make premiums more affordable for younger subscribers. For example, the HSC could recommend age adjustments for community-rated premiums that would permit higher premium rates for older subscribers, but with a rate band not more than 2 ½ times the premium for younger subscribers, along with rate adjustments to encourage and reflect healthy lifestyles.

CHPs and HIPCs

Developing the standards and working relationships between the CHPs and the HIPCs is another critical design issue. For CHPs, the HSC must determine several important operating issues, including: criteria for becoming a CHP; financial and reporting requirements; how the certification process can be streamlined; network adequacy; and how to define managed care. The HSC must also determine individual and employer enrollment standards and contractual relations between CHPs and providers, such as resolving disputes over any-willing-provider provisions or consumer complaints. Another issue is to determine the relationship between registered employer health plans and CHPs.

According to one analyst, the central question regarding HIPCs is their function in a system with uniform benefits, community rating, and premium caps, where purchasing power is not the primary cost-control mechanism. As another respondent put it: "Why do you need a HIPC if there are similar benefits and prices?" Several other respondents openly questioned the value of HIPCs or their attractiveness to business, and doubted their initial attraction for employers or employees. An insurance industry representative added that what they will really compete on is contractual rights with physicians, selling "I have your doctor." It is entirely possible that the only operating purchasing alliance will be the State purchasing group organized by the HCA, which could functionally resemble a single payer system for the subscribers. Arguing against this interpretation, a State analyst suggested that the HIPCs added value by offering all CHPs in an area, not just the three an employer is required to offer, offering a mechanism for dual-worker families to enroll in the same CHP, facilitating coordination of benefits and

eligibility, evaluating the CHPs' performance for consumers, acting as a source of wellness programs, and possibly facilitating portability of CHPs across employers.

Aside from addressing this conceptual problem, there are a number of technical issues that must be resolved. For instance, a governance structure needs to be defined, and the relationships between HIPCs and CHPs must be clarified. In addition, the Insurance Commissioner's regulatory role needs to be specified, along with HIPCs' data collection and information dissemination roles.

Other Design Issues

Public Education

Somewhat overlooked by the legislature and initially by policymakers, public education emerged in the interviews as a major implementation concern. Most polls indicate that enactment of the HSA was widely supported, but that people are unaware of exactly what the Act means. Recent polls suggest that the level of support has eroded as people learn more details and ask how the program will affect them personally. With the potential for a political backlash as a result of declining public support, our respondents indicated a need to expand public education efforts throughout the implementation process to inform the public about the effects of the planned changes and to retain public support. According to one HSC Commissioner, the "...largest concern is to connect to the people. More important than the deadlines is to bring people along, to warn them about the changes." One problem, however, is that no money was allocated for public education and development of a broad-based community strategy.

In response, the HSC has developed an interesting conceptual strategy to address this deficiency. The HSC plans to conduct public focus-group interviews with residents in selected locations (urban and rural) over time. This would enable the HSC to assess design alternatives based on public perceptions of various cost-benefit tradeoffs and to assess changes in health care delivery once the HSA is implemented.

Public Health

An important goal of the HSA is to improve the public's health and the public health system. Both the legislature and the DOH view improved health status as an important means for cost containment. An important DOH function is to develop an ongoing public health plan that is based on a core set of population-based functions, such as disease prevention and education. In general, the focus will be on developing health promotion and prevention services to target the population's health status rather than personal health care services. As part of this plan, the DOH is required to conduct a needs assessment to develop system capacity improvement standards that are based on communications between State and local health departments, local communities, and CHPs.

According to one respondent, an ancillary goal of the public health provisions is to develop a statewide public health network. The avowed intention is to determine priorities based on an assessment of local needs rather than on an assessment of statewide problems. This would allow each community to focus on areas of greatest value to that locality. In one area, for instance, teen pregnancy may be the top public health priority, while in another the need might be to improve immunization rates. By developing separate community assessments, the DOH's goal is to identify and track community-level interventions.

In this sense, a tie-in with CHP benefits is necessary. If the health prevention focus is to succeed, CHPs will need to emphasize similar benefits in their plans.

In short, this plan will determine public health capacity needs and investment priorities, coordinate public health delivery, and expand community-based public health. This is a good example of the HSA's intent to integrate health care delivery systems—in this case, by developing a public health partnership between the State and local communities.

Data Collection and Analysis

An important long-term set of issues is what data will be collected, what analyses will be conducted, who will own and analyze the data for the Health Services Information System, and who will pay for its development. Protecting data confidentiality is another important issue. Although the DOH has lead responsibility for developing the data systems, the HSC will play an important role in coordinating these decisions through the Health Information Advisory Committee. Most of the issues are still under discussion, but several respondents expressed concern that the legislature anticipates greater data collection than feasible. In theory, however, it appears as though the HSC is thinking very broadly of developing an information system rather than simply collecting data. To accomplish this, the DOH plans to conduct a baseline data survey to be able to document cost savings and cost shifting.

One issue of importance to providers, and likely to spark some dispute, is who owns the data. This is important because the level of data aggregation to be provided is likely to be higher if the State owns the data than if the providers are in control, especially for encounter-level data. (Some sort of partnership appears to be emerging.) It is also important in terms of how the HIPCs and CHPs will use the data in tracking provider behavior and quality of care.

Even though several respondents suggested that Washington State's data capabilities are generally strong, serious deficiencies remain. For example, because there is no State income tax, there are limited data to calculate the income subsidy estimates and how best to target the subsidies to the most deserving firms and individuals. Additional data needs include hospital and physician costs, how much employers currently spend on premiums, and current tracking level data for patient encounters. Another important data issue will be to integrate HMO data (often lacking encounter-level data) with traditional fee-for-service system data.

Risk Adjustment

Risk adjustment is an important issue, given the possibility of adverse selection between CHPs. Because CHPs cannot raise their premiums to reflect their level of patient risk, acceptable risk-adjustment methods need to be developed. This may be more of a problem for CHPs enrolling small groups than for those enrolling larger employer groups, though initial experience in California suggests that fears of adverse selection in the small-group market may not be justified. For the time being, it seems likely that traditional insurance underwriting approaches will be used until a more sophisticated methodology is available.

Phase-In of Coverage

At least two respondents raised a concern about the HSA's decision to phase-in coverage starting with large employers. These respondents suggested that participation

should be uniform. The concern is that during the phase-in period there will be incentives for risk selection that will result in higher premium costs for those in the State's purchasing group required to participate from the beginning, and lower costs in the private sector. As a result, there could be political pressure to revise the HSA.

Annual Employer Subsidies

An issue that received limited attention, but is difficult to resolve, is how to target subsidies to previously uninsured firms. This has an equity dimension, to avoid rewarding profitable firms that simply refused to provide insurance, and an empirical dimension, how to identify the "most deserving" firms. This issue is scheduled to be addressed after July 1995.

General Observations Regarding Implementation

The study interviews suggest four general observations about the implementation process. First, the HSC decisionmaking process is no less political than enacting the HSA was. Developing the HSA's regulatory framework will require both technical and political skills. Nevertheless, delegating the development of rules to an independent agency improves the chances for successful implementation by allowing for input and compromises from stakeholders, greater deliberation, and incremental actions. Second, a major challenge facing the HSC is to implement the program in a manner that facilitates competition and minimizes regulation. Given the regulatory complexity previously described, this will not be an easy task. But many seemed to share the following sentiments expressed by a key person in the implementation process: "If the HSA ends up as a regulatory system, it will be a failure." Third, the interviews suggest that the various stakeholders are satisfied that their views will be represented through the various committees and advisory boards the HSC has established to ensure open lines of communication. Fourth, proponents of the HSA reforms have recognized the need for a major public education campaign as part of the implementation process.

LESSONS LEARNED

Program Replicability

Almost all respondents indicated that the structure of the HSA is technically replicable across States, but reserved final judgment until the HSC completes its work. Many respondents added specific caveats to their responses. For example, several respondents indicated that the market penetration of managed care facilitated the structural changes imposed. Essentially, the HSA "works off of managed care's success," according to one regulator. Some questioned replicability in States with smaller and more rural populations with few providers, especially the lack of HMOs. Others suggested that legislating the framework and delegating details to the regulatory process is an effective way to avoid the need to resolve all contentious issues legislatively.

As previously noted, most respondents suggested that the HSA would not have been enacted absent WSMA support. Physicians remain central to health care delivery. This experience suggests the need for other States to involve the State's medical society throughout the process. However, a State medical society dominated by specialists might not be as cooperative as the WSMA, which was dominated by primary-care physicians during the HSA

debate. In addition, most respondents credited enactment of the HSA to the Governor's active involvement, working closely with strong legislative leadership.

Many respondents also stressed the amount of time it took to develop a consensus, and specifically noted that the formation of the Commission in 1990 resolved many of the structural issues. By including the primary stakeholders on the Commission, many of the most contentious issues were resolved, or at least differences were clarified. The Commission's visibility also helped prepare the public for the changes imposed. The HSA culminated a legislative process begun in 1987 when the BHP was established, but the policy process of building a consensus began in 1981 when the Committee for Affordable Health Care was formed.

Washington State's Uniqueness

The most unique aspect of Washington's political environment that the interviews consistently revealed is the ability of groups to work together. Most respondents described an environment that stresses civility over acrimony among stakeholders and focuses on continuing dialogue to resolve differences. This is not to minimize the inevitable conflicts over major social legislation, but to indicate that the political culture emphasizes collegiality between the public and private sectors. Washington's relatively small population also facilitates consensus and working together.

Some respondents added that residents have a greater level of trust in government in Washington than in other States, though business and insurance respondents certainly disputed this assertion (and the 1994 elections may suggest otherwise as well). Others added that Washington has a progressive outlook that facilitates government involvement in social policy. In health care, the BHP was generally considered to be successful, and the HCA was successful in reducing costs through its purchasing strategies. The agency heads of both the HSC and the HCA have business backgrounds, thus muting, for the time being, business and insurance opposition. At the least, this provides the HSC and HCA with a window of opportunity to demonstrate that they can implement the HSA without burdensome regulations.

Many respondents suggested that the Washington State government possesses high-quality data analytic capabilities, especially at the Office of Financial Management and HCA, but could benefit from additional expertise. In general, State agency and legislative staff appeared to be highly regarded by most respondents.

Program Implementation

Based on the interviews, five main conclusions emerge regarding program implementation. The first, familiar to most observers, is that the regulatory response is every bit as political as enacting the legislation. It follows that the stakeholders need to be a part of the regulatory process, at least through advisory committees. No respondent complained about not being about to communicate directly with the HSC.

The second is that a major public education campaign must be incorporated into any comprehensive health care reform initiative. Implementation requires a complex regulatory structure. Several respondents indicated that they and the legislature underestimated the need to inform the public about the changes the HSA will impose for health care delivery and how those changes will affect each individual.

Indeed, the public education function is an interactive one, with the public

expressing its preferred options. For example, the extensive public hearings held by the HSC led to proposed regulatory changes to provide a greater choice of providers and a wider range of beneficiary options than HSC had originally proposed.

The third conclusion is that implementing comprehensive reform is extremely complex. Many respondents suggested that implementation was more complex and required more resources than anticipated. As a result, close attention must be paid to a State's technical and personnel resources available to resolve the complex issues needed to implement reform successfully. Fourth, as Crittenden (1993) points out, Federal action to implement comprehensive health care reform is needed. Without congressional modifications to ERISA, Medicaid, and Medicare waivers, comprehensive State-level reform may not be feasible.

Fifth, for all the attention the HSA has received, it must be kept in mind that the HSA's managed competition approach remains very much an experiment whose ultimate success is uncertain. Even if the theory of managed competition is accurate, the complexity of the implementation process suggests that it is premature to speculate on the outcome. This case study suggests that in Washington State, managed competition means different things to different people. Business and insurance groups tend to view the HSA as leading to increased regulation ("Canada on the installment plan" according to one opponent), while proponents describe it as being on the competitive end of the regulatory-competition spectrum.

Market Changes and the Legislation

An issue that is beyond the scope of this project is the relationship between legislation and changes in the market. Major changes in the market were already under way when the HSA was enacted. One task facing the HSC, according to several observers, is to regulate in a way that stimulates the competitive forces already altering Washington's health care market. While it is far too soon to determine the HSA's effects on the health care market, certain trends in systems integration and managed care will likely be accelerated. For example, two major HMOs (Group Health Cooperative and Virginia Mason) recently formed an alliance to market a joint insurance product.

Stakeholders

Several stakeholder representatives stressed the need to continue to be involved throughout the process. In particular, the WSMA was severely criticized for its earlier refusal to participate. One observer added bluntly that "Physicians need to accept responsibility for health system reform." This works both ways, however. Several respondents criticized the Clinton Administration's tendency to isolate and attack important stakeholders, such as the American Medical Association.

Insurance and business interests were likewise criticized for not offering an alternative to an Act they opposed. Indeed, two business representatives indicated that business and insurance interests in other States need to do a much better job of organizing and developing a strategy to place a realistic alternative on the table to improve the legislation.

Universal Access and Cost Containment

The consensus view in Washington is that cost containment absent universal access is unlikely, and vice versa. The

reason for this is that the familiar problem of cost-shifting cannot be addressed without universal coverage. Only a few respondents argued that incremental change, such as small group insurance reforms and expansion of the BHP to the uninsured, would achieve adequate cost containment.

CONCLUSION

At this point, Washington State is one of the few States experimenting with comprehensive health care reform. The agenda is ambitious. Given the limited probability for national health care reform, the Washington State experiment is important for learning whether and how States can find solutions to the joint problems of controlling costs while expanding access. The Washington State experience is also important for understanding whether and how managed competition, at least in one form, can be implemented. Finally, the HSA is important for understanding how States can deal with health care reform in the absence of an ERISA waiver.

While the HSC appears to be responding flexibly, both to changes in the policy environment and in response to consumer and business concerns, the process is still at a relatively early stage. A full evaluation of the conceptual approach adopted by the legislature and the design decisions made by the HSC must wait until the Act is implemented.

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