

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



INTRODUCTION

A broad array of businesses, providers, labor unions, consumers, government leaders and health insurers in the United States agree that our health system needs to change to address serious problems with access to care, quality of care, and costs. National and state efforts to address the problems are underway. In Washington State, thousands of people are engaging in a dialogue about how to achieve reform.

The state legislature has identified five different proposals for reform and has commissioned a study of the economic impact of each proposal. As policymakers consider this economic data, it is also vitally important to consider how our state values health care. In this report, we evaluate the proposals using a human rights framework, based on the premise that every human being has the right to health, which includes the right to receive appropriate health care.¹ We believe that this premise should be the starting point for any reform the Legislature considers.

The human right to health is an indispensable component of the right to life, liberty and the pursuit of happiness. Health is fundamental to the welfare of human beings and to our pursuit of fulfilling lives. In the human right to health framework, society has a collective responsibility to protect each person's health. Countries around the world have long recognized this responsibility by ensuring universal access to health care for their people. The United States is one of very few industrialized countries that fail to ensure that all of their people have access to care.

The United States played a leadership role in developing the Universal Declaration of Human Rights, an international declaration adopted in 1948. As a signer, our country has committed to upholding the principles of this Declaration, which include the right to health and health care.² Our health system fails to live up to this obligation, however.

1 Similar analyses of national-level plans have been developed by Anja Rudiger at the National Economic and Social Rights Initiative/National Health Law Program. See http://www.nesri.org/economic_social_rights/right_health.html.

2 Article 25. The right to health and health care has also been recognized in other international agreements, including: International Covenant on Economic, Social, and Cultural Rights (Article 12, signed by the U.S., but not yet ratified); American Declaration on the Rights and Duties of Man (Article 11); Convention on the Elimination of All Forms of Racial Discrimination (Article 5); Convention on the Elimination of All Forms of Discrimination Against Women (Articles 12 & 14); Convention on the Rights of the Child.

WHY USE A HUMAN RIGHTS FRAMEWORK TO ASSESS HEALTH REFORM PROPOSALS?

While many doctors, clinics and hospitals are concerned with preserving and protecting their patients' health, a significant segment of the health care industry is focused on maximizing profit through the provision of health services. Indeed, for-profit private insurers and providers have a legal obligation to their shareholders and investors to make a profit. In this system, health care is a commodity and insurers operate under incentives to reduce care in order to make money. This has grave consequences for health: studies have shown that maximizing profit generally correlates with minimizing care, higher rates of death, unnecessary suffering and loss of health.³

In a health care system based on human rights, the financing and delivery of care prioritizes the protection of health over other factors. Such a system may not restrict care to save costs at the expense of good health, either to gain profit or reduce public expenditures. It increases effectiveness and efficiency by allocating and regulating spending in an equitable way that reduces waste, realigns incentives, and provides timely and appropriate care. Health care is recognized as a public good, not just another consumer product we can choose to buy or forgo.

A human rights approach requires that the development or reform of a health care system must focus on the most vulnerable people while aiming to address the needs of all. Washington's public programs represent our state's effort to lay a foundation for affordable, accessible care for low-income residents who struggle to meet even basic needs of daily living and are unable to pay for health care. Many who do not receive employer-sponsored coverage rely on publicly supported programs. We must ensure that human rights principles are applied to these programs as part of any health reform plan. Reform can be incremental, progressing toward universal availability and access to care, but must not regress and endanger existing access to services.

This paper considers whether and how the human rights principles discussed below are included in the five proposals for health care reform currently being considered in Washington State. We pay particular attention to low-income people and highlight how human rights principles apply to improving their access to health care.

KEY PRINCIPLES IN RECOGNIZING THE RIGHT TO HEALTH CARE

The human rights framework for health care is based on principles that assure health care services are accessible, available, acceptable, and of good quality for everyone, delivered on an equitable basis where and when needed. They also assure that health care is financed and delivered in a non-discriminatory way that enables the participation of individuals and communities, provides access to information, ensures transparency of institutions and

³ Woolhandler and Himmelstein, "When Money is the Mission – The High Costs of Investor-Owned Care," p. 2, *New England Journal of Medicine*, August 5, 1999; Landon, Normand, Lessler, O'Malley, Schmaltz, Loeb and McNeil, "Quality of Care for the Treatment of Acute Medical Conditions in U.S. Hospitals," p. 6, *Archives of Internal Medicine*, Vol. 166, 2511-2517, 2006.

processes, and has effective mechanisms to hold both private sector and government agencies accountable. The goal is a health care system that enables every person to get the care he or she needs.

The key principles are described below. The bullets briefly describe how each principle can be met in a health reform proposal.

RECOGNITION OF RIGHT TO HEALTH CARE

Health care is a right for all individuals and not a privilege or a market commodity.

- The right to health care for everyone is clearly recognized and acknowledged.

ACCESS

Health care services (e.g., primary care, mental health), goods (e.g., drugs, equipment), and facilities (e.g., hospitals, community health clinics) are accessible to everyone.

- Health care is considered a public good, to which everyone has guaranteed access.
- Citizenship status is not a barrier to access.
- Private companies and/or public agencies are held accountable for securing universal access to care.

AFFORDABILITY

Health care is always affordable for everyone, with charges based on the ability to pay, regardless of how health care delivery is financed.

- Health care is either publicly financed (e.g., through taxes) or market financing is publicly controlled and public subsidies are provided equitably.
- Revenues are spent on health services, with a minimal amount on administration and profits.
- In an insurance system, risk pools are as broad as possible.

EQUITY & NON-DISCRIMINATION

Health care facilities, goods and services are distributed equitably, with resources allocated and accessed according to needs and health risks. Health care is provided and accessible without discrimination (in intent or effect) based on health status, race, ethnicity, age, gender, marital status, sexual orientation, gender identity or expression, disability, language, religion, national origin, income, or social status.

- Disparities in health care outcomes are eliminated.
- Health care institutions and providers are required to provide culturally appropriate care. They must respect dignity and medical ethics and protect patient confidentiality and privacy rights.
- Monitoring, reporting, and compliance procedures eliminate direct and indirect discrimination by insurers, providers, and public entities.

COMPREHENSIVENESS

Health care includes all screening, treatments, therapies, drugs, equipment and supplies needed to protect and restore health.

- All private and public health plans meet a standard set of benefits or a minimum level of coverage, including preventive care, mental health, reproductive health, dental, and vision care.
- Incentives for comprehensive care replace market incentives for limiting care.

AVAILABILITY

Adequate health care infrastructure (e.g. hospitals, community health facilities, trained health care professionals), goods (e.g. drugs, equipment) and services (e.g. primary care, mental health) are available in all geographical areas and to all communities.

- Sufficient health care professionals are recruited and retained in underserved areas and understaffed fields.

QUALITY

All health care is medically appropriate, of good quality and provided in a timely, safe, and patient-centered manner.

- Uniform, enforceable quality standards and independent quality control are in place for all insurers and providers.
- Incentives reward quality, coordinated, safe, patient-oriented and timely care.
- Everyone may choose a primary health care provider; continuity of care is assured by avoiding disruptions due to changes in coverage.

INFORMATION & TRANSPARENCY

Health information is easily accessible for everyone, enabling people to protect their health and receive quality services. Institutions that organize, finance, or deliver health care operate in a transparent way.

- All patients receive comprehensive information on treatments, services, facilities, costs, and rights in user-friendly formats.
- Communication between patients and providers is encouraged and facilitated.

ACCOUNTABILITY

Private companies, public agencies, providers, and employers are accountable directly to patients for meeting human rights principles through enforceable standards, regulations, and independent compliance monitoring.

PARTICIPATION

Individuals and communities can take an active role in decisions that affect their health, including in the organization and implementation of health care services.

- Patients can choose among providers and be actively involved in decisions regarding their health.
- Patients and communities can participate meaningfully in health system decision-making and are included in insurer and provider governance and oversight structures.

PUBLIC HEALTH

Public health systems are maintained and improved to protect and promote optimal population health.

- Appropriate resources are allocated to public health systems to prevent disease, promote health, ensure clean and healthy water, air, food, and protect other environmental resources.
- Health impact assessments are conducted whenever proposed policies may have health consequences.

PUBLIC PROGRAMS - PROTECTING LOW-INCOME PEOPLE

While the human right to health care requires that everyone receives the care they need, it also calls for a focus on those who are most vulnerable. In Washington, many of these people are currently served by Department of Social and Health Services (DSHS) health care programs, such as Medicaid and Basic Health.

Principles key to protecting low-income people are:⁴

Do not cut existing public programs. Maintain and expand them to address unmet needs. (Affordability, Comprehensiveness, Access, Equity)

- Eliminate benefit gaps and inequitable restrictions on eligibility.
- Eliminate or reduce premiums, deductibles, copayments and coinsurance.
- Expand financial eligibility using affordable sliding scales based on family budgets and reasonable cost of living measures.
- Exempt public program clients from payroll tax increases.

Eliminate barriers that keep eligible persons from qualifying for and maintaining coverage through public programs. (Access, Information and Transparency, Accountability)

- Discontinue burdensome procedures that deny benefits to eligible individuals⁵.

4 Each low-income principle is followed by the general health reform principle(s) (in parentheses) to which it is linked.

5 For example, income documentation procedures that require people to produce information that is hard for them to obtain, and systems for paying premiums that lack convenient payment options (e.g., those that require money orders from people who do not have checking accounts).

Ensure that beneficiaries of public programs receive the language access and transportation services they need to obtain quality health care. (Access, Availability, Nondiscrimination and Equity)

- Provide interpretation and translation for individuals whose language abilities pose a barrier to receiving quality care.
- Offer transportation to low-income people when needed to access health care.

Guarantee that beneficiaries have appropriate and accessible health providers. (Access, Availability, Non-Discrimination and Equity)

APPLYING THE PRINCIPLES TO WASHINGTON'S HEALTH REFORM PROPOSALS

Using the above framework, we offer an analysis of the five proposals described in Senate Bill 6333, which the Washington Legislature passed in 2008. The legislation established a citizens' work group on health reform to assess these approaches to health reform.⁶

The five proposals are:

- a Connector Plan modeled on the current Massachusetts reform plan;⁷
- a Standardized Universal Plan named "Washington Health Partnership";⁸
- a Universal Single Payer Plan;⁹
- Small Employer and Young Adult Proposals;¹⁰ and
- a "Guaranteed Health Benefit" plan prepared by the Office of the Insurance Commissioner.¹¹

In preparation for the work group's analysis in 2009, the legislature has contracted with an independent consultant, Mathematica Policy Research, Inc., to analyze the expected economic impact of implementing each proposal.¹² Many of the legislative proposals were skeletal and lacking in detail, so Mathematica has worked with legislative staff to develop more detailed descriptions of each proposal. NoHLA's analysis is based on the descriptions in the legislation, well as tables prepared by Mathematica, provided to us in August 2008.

6 The bill provides brief descriptions of each of the five proposals, and can be found at <http://apps.leg.wa.gov/documents/billdocs/2007-08/Pdf/Bills/Session%20Law%202008/6333-S.SL.pdf>

7 Based on the original version of House Bill 1569 (2007).

8 Based on Senate Bill 6221 (2008).

9 Based on a Canadian-style model; the state government is the sole purchaser of health services. The legislature did not reference a specific bill in connection with the Universal Single Payer Plan.

10 Based on Proposed Second Substitute Senate Bill 6030 (2008).

11 Based on Senate Bill 6603. This plan would provide catastrophic insurance and would also include a preventive health benefit.

12 Mathematica's analysis will address the following factors for each health reform proposal: (a) The number of Washingtonians covered and the number remaining uninsured; (b) The scope of coverage available to persons covered under the proposal; (c) The impact on affordability of health care to individuals, businesses, and government; (d) The redistribution of amounts currently spent by individuals, businesses, and government on health, as well as any savings; (e) The cost of health care as experienced throughout the state by individuals and families, employees of small and large businesses, businesses of all sizes, associations, local governments, public health districts, and by the state; (f) The impact on employment; (g) The impact on consumer choice; (h) Administrative efficiencies and resulting savings; (i) The impact on hospital charity care; and (j) The extent to which each proposal promotes: (i) Improved health outcomes; (ii) Prevention and early intervention; (iii) Chronic care management; (iv) Services based on empirical evidence; (v) Incentives to use effective and necessary services; (vi) Disincentives to discourage use of marginally effective or inappropriate services; and (vii) A medical home.

QUICK LOOK:

Human Rights Assessment of Washington's Health Reform Proposals

	Small Employer and Young Adult Proposals	Massachusetts Model	OIC's Plan: Catastrophic + Preventive	Washington Health Partnership	Universal Single Payer Plan
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HUMAN RIGHTS PRINCIPLES

Recognition of Right to Health Care					
Access					
Affordability					
Equity & Non-Discrimination					
Comprehensiveness					
Availability					
Quality					*
Information and Transparency					
Accountability					*
Participation					*
Public Health Promotion					*

PRINCIPLES FOR PROTECTING LOW-INCOME PEOPLE

Maintain and expand public programs					
Eliminate barriers to qualifying for & maintaining coverage in public programs					
Ensure language access & transportation services in public programs					*
Guarantee accessible & appropriate providers in public programs					

KEY:	Clearly meets principles	Partially meets principles	Fails to meet principles	* While in concept a single payer plan is likely to comply with many human rights principles, we were unable to fully assess this plan due to the absence of information on plan design. Therefore, our ratings may under-represent the strengths of this reform proposal.
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ANALYSIS OF THE FIVE WASHINGTON HEALTH REFORM PROPOSALS

BACKGROUND: The Current System

When evaluating the pending proposals, it is necessary to understand how the state's health care market currently operates. This brief summary provides an overview.

Washington's health care market is dominated by private insurance companies. In the private market, insurance is available through employers, business association plans, and the individual insurance market. The benefits available are largely unregulated. For example, in the individual insurance market companies may impose pre-existing condition waiting periods up to nine months, and they may reject people with costly health profiles and refer them to the Washington State Health Insurance Pool (WSHIP). WSHIP offers comprehensive, though costly, insurance to any individual who qualifies and can afford to pay the premiums. Insurers must follow certain minimum requirements imposed by state and federal law.¹³

The state is also an important purchaser of health care. The state covers public employees and offers a number of public programs, primarily for low-income residents: Medicaid, Apple Health for Kids (the umbrella for all children's programs, including the State Children's Health Insurance Program, SCHIP), Medical Care Services (MCS), and Basic Health (BH). Medicaid, the joint federal-state program, is largely limited to indigent families, children, pregnant women, seniors and individuals with disabilities. Individuals must have incomes well below the federal poverty level to qualify, except for children and pregnant women. Apple Health is scheduled to include children whose families have incomes up to 300% of federal poverty in January 2009; they pay sliding-scale premiums above 200%. MCS is the medical coverage accompanying state-funded cash benefits for incapacitated indigent individuals. BH, established in 1987, is a state-subsidized insurance program for residents with incomes below 200% of federal poverty. Current BH enrollment of 105,000 is being reduced, through attrition, to 97,300 enrollees. Over 900,000 (14%) of Washington's residents are enrolled in Medicaid, Apple Health, MCS and BH. Almost 900,000 Washington residents receive Medicare, federal health insurance for seniors and people with disabilities.

Over 725,000 Washington residents (11%) are currently uninsured.¹⁴ Over half of the uninsured have incomes below 125% of federal poverty. Nonprofit community clinics and free clinics provide care on a sliding scale, but there is still much unmet need. Some local governments offer public health clinics providing services to individuals, although these do not exist in the vast majority of counties due to extremely limited funding. A state "charity care" law requires hospitals to provide free or reduced-cost care to very low-income residents.

In the past few years, the Legislature has taken steps toward expanding insurance options. It has expanded children's coverage through the Apple Health program, as noted above. It also established a Health Insurance Partnership to offer subsidies to small employers and their low-income employees, but this program was cancelled in late 2008 due to the state budget

¹³ For example, mental health benefits must be provided on a par with other medical benefits offered by the insurance plan.

¹⁴ 2008 Washington State Population Survey.

shortfall. In 2007, the Legislature passed omnibus legislation to develop a number of pilot programs, initiatives and incremental changes dealing with various aspects of the health care system. However, no broad health system reform bill has passed to date.¹⁵

THE FIVE PROPOSALS

We have rated each of the five health reform proposals currently being considered in Washington using the above human rights principles. A full circle indicates that the proposal fully meets the human rights principles, a half-full circle indicates that it partially meets the principles and an empty circle indicates that it fails to meet the principles.

Several of these proposals leave in place federally funded health care programs, such as Medicaid, Medicare, SCHIP, the Federal Employee Benefit Plan and military health plans. The purpose of these “carve-outs” is to maintain existing programs that provide access to care within the constraints of federal law and maintain federal funding. While this approach may be the only way for the state to leverage federal funding, the resulting patchwork of health care programs for Washingtonians does not meet the equity principle under the human rights framework.

Small Employer & Young Adult Proposals

The Small Employer and Young Adult (SEYA) proposals allow less comprehensive health plans to be offered to specific groups that currently have low rates of coverage: employees of small businesses, and young adults, 19 to 34 years of age. They do so by modifying state insurance regulations. Under SEYA, these special health plans would be allowed to exclude certain benefits that state law currently requires. Insurers would be allowed to adjust health plan premiums to reflect the health status and experience of members of each specific group, and would be allowed to pool the health risks of young adults separately from other enrollees. The proposals would promote the use of high deductible health plans in conjunction with health savings accounts.

Recognition of Right to Health Care for Everyone



The SEYA proposals do not recognize the right to health care for everyone.

Access



The SEYA proposals do not recognize healthcare as a public good, nor do they guarantee access for all. In fact, by proposing to sell pared-down insurance products to small employer groups and young adults, the proposals stipulate that those groups do not require access to comprehensive health care. The proposals deregulate the insurance market and thus reduce the accountability of insurance companies for providing access to appropriate care.

¹⁵ A 1993 health insurance reform law did pass the Legislature but was largely repealed in 1995.

Affordability



The SEYA proposals do not make health care affordable for everyone. The proposals attempt to make health care affordable for small employer groups and young adults who currently cannot afford it; however, the high deductible plans and health savings accounts the SEYA proposals promote can actually result in unaffordable health care costs. They have been shown to benefit mainly the wealthy, and create additional cost barriers for those with greater health care needs.¹⁶ By creating a separate pool for youth, and by encouraging high-deductible plans, these proposals incentivize young and healthy people to pull out of broader risk pools, potentially resulting in higher costs for those remaining in these risk pools.

Equity & Non-Discrimination



The SEYA proposals are not equitable because they offer less comprehensive health plans to small employer groups and young adults. They do not meet the goal of non-discrimination because they allow for inferior health plans targeting specific groups, based on age, health status, income and other factors. The SEYA proposals do not include regulations or incentives to assure that the private sector provides culturally appropriate services that meet patients' diverse needs.

Comprehensiveness



The SEYA proposals do not meet the goal of comprehensive health care as their main purpose is to offer less comprehensive health plans to small employer groups and young adults.

Availability



The SEYA proposals do not address the issue of availability. To the extent that they include no regulations or incentives for the private sector in this area, the goal of availability in all geographic areas and to all communities is unlikely to be met.

Quality



The SEYA proposals do not address the issue of quality. Since they effectively encourage policyholders to avoid the regular use of health care, policyholders are likely not to have a medical home.

Information and Transparency



The SEYA proposals do not address the issue of information and transparency.

16 "National Survey of Enrollees in Consumer Directed Health Plans," p. 5-6, The Kaiser Family Foundation, November 2006 (available at: www.kff.org/kaiserpolls/upload/7594.pdf); "Consumer-Directed Health Plans, Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans, p. 5-6, 26-30, United States Government Accountability Office, August 2006 (available at: www.gao.gov/new.items/d06798.pdf); "Stop Bad Ideas: A Series Examining Proposals That Could Move Private Insurance in the Wrong Direction," p. 1, 3-4, Families USA (available at: www.familiesusa.org/assets/pdfs/medicare-privatization-dec.pdf).

Accountability



The SEYA proposals would allow insurance companies to offer health plans that do not provide benefits currently mandated by the state. Although the proposals require regulation and oversight of these plans by the State Office of the Insurance Commissioner, they also strip that Office of its regulatory power regarding benefit requirements and thus reduce accountability mechanisms.

Participation



The SEYA proposals do not address the issue of participation.

Public Health



The SEYA proposals do not address public health services or infrastructure.

Principles Related to Low-income Populations¹⁷



The SEYA proposals would not alter existing public programs.

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, 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. The Massachusetts Model would be administered by the Health Care Authority.

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.

¹⁷ This is a combined rating for all the low-income principles. For a breakout of individual ratings, see “Quick Look” chart earlier in this paper.

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.

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 where needed.

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



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.¹⁸

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 unlikely that people remaining on DSHS medical programs are will continue to have problems accessing providers.

Office of the Insurance Commissioner's Guaranteed Health Benefit Plan

The Office of the Insurance Commissioner's (OIC) proposed Guaranteed Health Benefit (GHB) plan is designed to assure coverage for catastrophic and preventive health care for all Washington residents. Under this plan, the state would negotiate and pay a capitated rate for private insurers to cover "medically necessary care" over \$10,000 per person per year and to cover basic preventive care including immunizations, cancer screenings, annual exams, and annual dental exams. All insurance companies in Washington that offer "routine coverage" (health coverage below the \$10,000 per year threshold) would be required to offer GHB coverage to everyone in their designated areas who meets the minimum residency requirement, with the following exceptions: people new to the state, who would be excluded from the plan for six months and subjected to a pre-existing condition waiting period upon enrollment; and people who receive health coverage through DSHS medical programs or Medicare; federal employees; military, and institutionalized persons. The funding mechanism for this plan has not yet been determined.

Recognition of Right to Health Care for Everyone



The GHB plan does not explicitly recognize the right to health care, but does recognize that all those residing in Washington for more than six months are entitled to coverage for catastrophic care and some preventive services.

Access



Access to catastrophic and limited preventive insurance coverage would be guaranteed for everyone except excluded groups under this plan, but access to "routine coverage" is not guaranteed. Those new to the state do not have access to GHB coverage. Those who have routine coverage would be automatically enrolled with the same carrier for GHB coverage, helping to maintain access. Insurance companies could not reject individuals in their area who meet the eligibility requirements; catastrophic and preventive care – but not overall health care – would be treated as public goods. Carriers would be paid risk-adjusted, capitated rates to provide services, suggesting there could be a profit motive to restrict services provided to enrollees above the \$10,000 level.

Affordability



Insurance coverage may be more affordable for some and less affordable for others under this proposal, as compared to the current system. The GHB should reduce the cost of routine coverage to an individual or employer because that coverage would be limited to \$10,000 in expenses annually, and because universal catastrophic coverage will reduce the costs that are shifted from uninsured to insured individuals. The Insurance Commissioner estimates this will result in a 35-40% drop in the price of routine coverage. It is not yet clear, however, how the financing of this plan will affect affordability for individuals, and whether individual contributions to the financing will offset savings on routine care. Basic Health subsidized coverage would be expanded from 200% to 300% of the federal poverty level, but there is not enough detail in the plan to determine the impact this will have on affordability.

Equity & Non-Discrimination



The GHB promotes equity in the routine insurance market by eliminating any risk over \$10,000. It does not require that disparities in access to care be eliminated, nor does it implement procedures for addressing cultural competency or monitoring discrimination.

Comprehensiveness



Coverage under the GHB would be comprehensive for “medically necessary care” (as defined by HCA) only after \$10,000 of expenses are incurred in one year. Basic preventive health measures would be covered, including cancer screenings, immunizations, annual exams, and annual dental exams, with the Board determining the exact schedule of benefits. For those moving to Washington after the effective date of implementation, there would be a pre-existing conditions exclusion for GHB coverage. For all others, there would be no pre-existing conditions exclusion.

Availability



The proposal does not address making health care available where it is needed.

Quality



The state would contract with participating carriers to reward health outcomes, encourage care that has proven value, and encourage use of evidence-based standards. The GHB does not address the issue of medical homes; for those without routine care it will be hard to maintain medical homes, keep the same providers or assure coordination and continuity of care.

Information and Transparency



The proposal does not address whether the program will ensure that health information is available and easily accessible for everyone. Nothing in the plan suggests that it would facilitate communication between providers and patients. Further, the proposal does not yet address how a patient with multiple providers would determine when they reach the \$10,000 limit.

Accountability



Rates charged by carriers must be negotiated by the Health Care Authority and approved by the board. The HCA would oversee the carriers’ plans to ensure that they meet state and federal requirements. The State Auditor would examine records of the program every second year. These requirements may not ensure full accountability, however, especially in assuring that carriers pay for all necessary catastrophic services.

Participation



The proposal does not address the issues of participation in the organization and implementation of health care services, individual involvement in decision-making, or choice of providers. It does require that GHB board meetings be open to the public.

Public Health



Immunizations and other basic prevention services would be covered, making these services more available to individuals who are currently uninsured or those whose insurance does not cover prevention, such as many high-deductible plans. The proposal does not mention any plan to improve or maintain existing public health infrastructure.

Principles Related to Low-income Populations



The expansion of BH eligibility to 300% of FPL would have a sliding scale that is as yet unknown. The plan would not otherwise affect eligibility, benefits or costs of public programs. It is unclear if beneficiaries of public programs who are employed would need to contribute to the program. If so, this would be an extra cost that could offset the benefit of expanded BH eligibility and create additional costs for public program clients.

This plan would not address current eligibility barriers for public programs. However, those not enrolled in public programs would be eligible for this plan and automatically enrolled if they have resided in Washington for 6 months; presumably this means no documentation barriers would exist. This plan does not address the provision of interpretation, translation, or transportation services needed to obtain medical care, including whether these services would count toward the \$10,000 cap or be covered above that cap.

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.¹⁹ 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.

¹⁹ 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>.

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.²⁰ 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 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.

²⁰ 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: Cost and Coverage Impacts," p. 18, The Lewin Group, Inc., September 2003 (available at: www.lewin.com/content/publications/2769.pdf).

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 Populations



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.²¹ 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.

Universal Single-Payer Plan

The single payer option proposed by the legislature would be based on the Canadian health system and modified for Washington State. When identifying the plan, the legislature simply mentioned it without specifying many details, making it difficult to evaluate on some of our criteria. As a state-administered system, it would provide health insurance for everyone in Washington, except undocumented immigrants and those covered by Medicare, the Federal Employee Benefit Plan (including retirees) and military health plans (including retirees). Existing state public health insurance programs (Medicaid, Basic Health, etc.) would be discontinued and beneficiaries would transfer into the single payer plan. Eligible individuals would be enrolled automatically, and there would be no premiums, deductibles or point-of-service

cost-sharing associated with the single payer plan. This plan would be funded through general revenues, but the source of these revenues has not yet been determined.

*Please note that while in concept a single payer plan is likely to comply with many human rights principles, we were unable to fully assess this plan because of the absence of information on plan design. Principles for which insufficient information exists are given a * rating.*

Recognition of Right to Health Care for Everyone



The single payer plan recognizes the right to health care for most Washingtonians. However, undocumented immigrants do not have a right to care under this plan.

Access



The single payer plan would provide access to care for most Washingtonians, including many who cannot currently access care. However, it would exclude undocumented immigrants. For those now in state health programs, the single payer plan could potentially improve their access to health care providers. The single payer plan would not affect access to care for those who have federal insurance through Medicare, the Federal Employee Benefit Program or the military.

21 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>).

Affordability



In a single payer plan, health care is publicly financed. A single payer plan also has one combined risk pool. One of the main characteristics of a single payer plan is that it reduces health care expenses by eliminating the administrative and marketing costs, and profits, of insurance carriers. The affordability of the plan for individuals would depend on how it is financed. It is likely that taxes would be increased to generate revenue for this plan, but no specific funding mechanism has been proposed.

Equity & Non-Discrimination



Another characteristic of a single payer plan is equitable distribution of resources. We do not have sufficient information about this plan to determine its ability to eliminate health disparities or its approach to culturally competent health care. Since the health care available under the single payer plan would be the same for all enrollees, many discriminating factors in the current health system – age, gender and income among them – would be eliminated; instead there would be a single community-rated risk pool and a common set of benefits.

Comprehensiveness



As currently envisioned, the single payer plan would offer a health plan modeled on the existing state employees' benefit plan. This plan covers most services, but does not include dental coverage.

Availability



We expect that a single payer plan serving the majority of state residents would attempt to make health care infrastructure, goods and services available in all geographic areas and to all communities, although the mechanism for doing this has not yet been described. Presumably, the governing authority would perform needs assessments and provide incentives to attract providers to rural and underserved areas, but more information is needed.

Quality



Since the single payer plan would cover a large percentage of Washington residents, data related to quality would presumably be more available and quality measures could be more easily instituted. None of this has yet been discussed in detail, however.

Information and Transparency



A single payer plan in which individuals are automatically enrolled and one benefit plan is available to everyone would go a long way toward making health coverage and benefits more transparent. More details are needed regarding how information for individuals, and communication between patient and provider, are handled in the single payer system.

Accountability

Accountability measures for providers and the government are not addressed. We expect that, like other single payer plans, this proposal will be developed to include guidance for the governing authority and the public that addresses the human rights principle of accountability.

Participation

The single payer plan, as developed to date, does not address participation.

Public Health

The single payer plan, as developed to date, does not address public health services or infrastructure.

Principles Related to Low-income Populations

Low-income individuals and families who currently receive health care through state public programs would switch to the single payer plan. The analysis prepared by Mathematica assumes that Medicaid and SCHIP would provide wrap-around coverage for mandatory populations up to 150% of the federal poverty level, assuring that individuals in this income category would not experience a reduction in services. There is no information on whether wraparound coverage would also be available to other populations the state currently serves under Medicaid and SCHIP, including children between 150% and 300% of federal poverty, pregnant women between 150% and 185% of federal poverty, and the Medically Needy. For low-income people ineligible for these programs who now have no or limited coverage, automatic enrollment in the single payer plan should improve access to health care. Provider access may also improve for public program clients once access to care is no longer based on source of payment (i.e. there is one payer), although there could still be barriers to getting subsidies or wraparound services. It is also not yet clear how the single payer plan would address language access services or transportation services.

CONCLUSION

The human rights framework is a powerful tool for assessing health reform proposals. It assures that health care services are accessible, available, acceptable, of good quality and delivered to everyone on an equitable basis, where and when needed.

There are four plans for which there is sufficient information to rate all of the human rights principles. Of these, the Washington Health Partnership comes closest to meeting the principles. The Massachusetts Model and the OIC's Guaranteed Health Benefit Plan do not meet many of the principles, and the Small Employer and Young Adult proposals do not meet any of them. Significantly, none of the plans comes close to meeting the low-income principles. There are few assurances that low-income people will benefit from these proposals in their current forms, and some may be disadvantaged.

We did not have enough information to fully rate the Single Payer Plan. Based on its consistency with the human rights principles we were able to rate, we expect that as further details emerge it will also meet or approach the remaining principles.

We call on policy makers, advocates and all Washingtonians to adopt human rights principles as the basis for making decisions regarding health care reform in Washington. The five reform proposals under review must be refined and improved to meet these principles. Only by doing so can we address the underlying problems of the health system and assure that people will get the care they need.

About Northwest Health Law Advocates

Northwest Health Law Advocates (NoHLA) is a nonprofit organization that works to improve access to health care for all Washington residents, in particular those who have limited resources and depend on public health insurance programs. We work on behalf of health care consumers in administrative, legislative and legal forums, and provide consultation and training to community advocates.

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