Fordham Urban Law Journal

Volume 35 | Number 3 Article 7

2008

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THE HEALTHY WASHINGTON INITIATIVE: BLUE-RIBBON PROCESS, RED-HERRING RESULT

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"Quality, affordable health care is a right, not a privilege, and the Healthy Washington Initiative will make changes that bring us another step closer to serving all Washingtonians."[1]

INTRODUCTION

In 2006, empowered by the perceived public support for change in the state,[2] the Washington State Legislature established the Blue Ribbon Commission on Health Care Costs and Access (the "Commission").[3] The Commission was charged with delivering a five-year plan for substantially improving access to affordable health care for all Washingtonians.[4] After performing an extensive examination of the problems of access and affordability of health care in Washington, the Commission issued its final report to the Washington State Legislature in January 2007.[5] Unfortunately, rather than taking the opportunity to move Washington boldly into the forefront of innovation in health-care access and affordability for all citizens, the Commission recommended relatively conservative,

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1. David Ammons, *Health Coverage 'a Right,'* SPOKANE SPOKESMAN-REVIEW, Feb. 7, 2007, (quoting Christine Gregoire, Governor of Washington), *available at* http://www.spokesmanreview.com/tools/story_pf.asp?ID=173082.

2. *See* Charles Barrilleaux & Paul Brace, *Notes from the Laboratories of Democracy: State Government Enactments of Market- and State-Based Health Insurance Reforms in the 1990s*, 32 J. HEALTH POL. POL'Y & L. 656, 666 (Aug. 2007) (identifying Washington as highly amenable to both state- and market-based health-insurance reforms)

3. The Commission consisted of fifteen state officials and employees, including Governor Christine Gregoire, the Senate Majority Leader, the Speaker of the House of Representatives, the Insurance Commissioner, and the administrative officials charged with administering the state's public health insurance programs. *See* BLUE RIBBON COMM'N ON HEALTH CARE COSTS & ACCESS, WASH. STATE, FINAL REPORT (2007) [hereinafter FINAL REPORT], *available at* http://www.insurance.wa.gov/consumers/documents/Final%20Report.pdf.

4. *Id.* at 1.

5. *See id.*

non-controversial, and generally ineffective policies. These policies included enrolling state health-program beneficiaries in disease-management programs, instituting pay-for-performance systems in state health programs, organizing the private-insurance market to be more accessible to consumers, and making the system Washington uses to insure its highest-risk citizens only slightly more affordable.[6] The Commission's recommendations noticeably lacked initiatives designed to change the behavior of individuals or private insurers to increase access and coverage.

One month after the Commission issued its final report, legislation to implement many of the Commission's recommendations was introduced in both houses of the state legislature.[7] The legislative committees made only one significant revision to the initial legislation, removing a potentially controversial provision. This provision would allow exceptions to state coverage mandates for health carriers offering health plans to individuals, small businesses, and young adults.[8] The revised legislation sailed through the legislature, and was signed into law with much fanfare by Governor Christine Gregoire shortly thereafter.[9] Unfortunately, rather than representing a victory for advocates of meaningful health-care reform for the uninsured and underinsured, the legislation authorized mostly palliative policies that will have little effect on many currently uninsured and underinsured Washingtonians. It will have even less effect on those whose risk of becoming uninsured grows at the fastest rate, young adults. At best, the legislation implemented will nibble away at the access and affordability problems for poor and middle-income Washington citizens. It will not make significant strides towards solving the problems of the state's uninsured and underinsured. Despite all of its promise and promotion, the Healthy Washington Initiative squanders a rare opportunity of public and political will coalescing in favor of effecting real change.

Part I of this Article explores the process that gave rise to the Healthy Washington Initiative and analyzes the key provisions of the initiative that are directed towards the problems of limited ac-

6. *See id.* at 5, 6, 9, 12. This Article will not further discuss the proposals regarding improving the efficiency and quality of the already existing state health plans.

7. *See* Engrossed Second Substitute, S.B. 5930, 60th Leg., 2007 Sess. (Wash. 2007) [hereinafter S.B. 5930].

8. *See id.*

9. *See* Ammons, *supra* note 1. Governor Gregoire did veto two sections of the legislation, but they were of little consequence. One vetoed section was duplicative of earlier legislation, and the other mandated an early effective date for part of the legislation. *See* Certificate of Enrollment, S.B. 5930.

cess to, and excessive costs of, health-care coverage in Washington. It then suggests that the Healthy Washington Initiative will fail to increase coverage for the key demographic of uninsured young adults. Part II describes what an effective Healthy Washington Initiative should look like. It argues that the legislature could better expend the current resources devoted to the Healthy Washington Initiative. Finally, Part II suggests that the legislature change the manner in which health-care coverage is delivered to reflect the changing role of work and employment in our society, particularly among young adults, who are at an increasingly great risk of being uninsured.

I. THE HEALTHY WASHINGTON INITIATIVE

A. The Blue Ribbon Commission

1. *Process*

The Commission's process for soliciting input and gathering data was thorough, thoughtful, and inclusive. The Commission formally met eight times throughout 2006.[10] Most of the meetings lasted full days.[11] The agendas from the meetings indicate that the Commission considered a large amount of varied data to develop its five-year plan to substantially improve access to affordable health care.[12] The Commission solicited input from a wide variety of stakeholders, including health care consumers, health care providers, special interest groups, public and private health insurers, and Washington businesses.[13] The Request for Proposals specifically asked for stakeholder input on six topics, ranging from aspirational questions about the Commission's appropriate goals, to concrete questions about the proposals.[14] The stakeholders submitted seventy-three proposals, totaling over 700 pages.[15] The proposals ranged from encouraging the continuation of the current employer-based system of health insurance through additional tax

10. *See* Washington State Blue Ribbon Commission on Health Care Costs and Access, 2006 Meeting Agendas, http://www.leg.wa.gov/Joint/Committees/HCCA (last visited Mar. 3, 2008).

11. *See id.*

12. *See id.*

13. *See* Washington State Blue Ribbon Commission on Health Care Costs and Access, Request for Proposals, http://www.leg.wa.gov/documents/joint/HCCA/BRC%20RFP_3_web.pdf (last visited Mar. 3, 2008).

14. *See id.*

15. *See* Washington State Blue Ribbon Commission on Health Care Costs and Access, Proposals Submitted by Stakeholders (Sept. 5, 2006), http://www.leg.wa.gov/documents/joint/HCCA/FinalproposalWeb.pdf.

credits for employers and rolling back coverage mandates to facilitate the development of more affordable health insurance plans for small employers and their employees, to establishing a universal health coverage system for all Washingtonians, de-linked from employment.[16] Many of the proposals aimed to expand coverage for specific consumer groups, such as children and senior citizens.[17] A few of the proposals were self-serving and specific, for example the Institute for Healthcare Advancement's proposal to have the State of Washington purchase a series of books it publishes called "*What to Do for Health*," and distribute them through various health-care providers in Washington.[18] Other proposals adopted more community-oriented and broad-based approaches, such as the proposal from Group Health Cooperative, the largest non-profit, integrated health-care system in Washington. Group Health suggested reforms that would mandate medical homes for low-income children, improve the insurance marketplace for small employers and individuals, and focus on promoting effective care and healthy lifestyles, among other things.[19]

The Commission had a large variety of data and proposals at its disposal throughout the six-month period during which it met regularly to formulate its final report and recommendations. The Commission also examined other organizations' and states' health-care vision statements, and surveyed health-care reform efforts throughout the nation.[20] It viewed presentations by a wide variety of interested persons, including former Oregon Governor John Kitzhaber, representatives of the Robert Wood Johnson Foundation, the Washington Office of Insurance Commissioner, and various other providers and employers.[21] The Commission also viewed

16. *See* Washington State Blue Ribbon Commission on Health Care Cost and Access, Summary of Proposals (Sept. 7, 2006), http://www.leg.wa.gov/documents/joint/HCCA/ProposalsSummary.pdf.

17. *See id.*

18. *Id.* at 5.

19. *Id.* at 3.

20. *See id.* The Commission reviewed the health-care reform plans of Florida, Maine, Maryland, Massachusetts, Vermont, and West Virginia. *See* Washington State Blue Ribbon Commission on Health Care Costs and Access, Working Notes: What's Going on Around the Nation (June 16, 2006), http://www.leg.wa.gov/documents/joint/HCCA/WorkNotesonStatePrograms.pdf. The Maryland plan, known as "Fair Share," was struck down by the federal courts as violating the federal Employee Retirement Income Security Act of 1974 ("ERISA"). *See* Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180 (4th Cir. 2007).

21. *See* Washington State Blue Ribbon Commission on Health Care Costs and Access, September 11, 2006 Meeting Agenda, http://www.leg.wa.gov/documents/joint/HCCA/agenda9-11-06.pdf.

a presentation on the history of health insurance and current trends in coverage.[22] It received data from other government-sponsored sources on the identity and characteristics of the uninsured in Washington.[23]

2. *Goals, Strategies, & Recommendations*

In January 2007, the Commission issued its final report on health care costs and access.[24] Noting that there are approximately 593,000 Washingtonians without health care coverage, including 73,000 children, the Commission set forth five goals that it had adopted early in its deliberations in 2006: (1) all Washingtonians will have access to health coverage that provides effective care by 2012, with all children having such coverage by 2010; (2) Washington will be one of the top ten healthiest states in the nation; (3) population health indicators will be consistent across race, gender, and income levels throughout the state; (4) increased use of evidence-based care brings better health outcomes and satisfaction to consumers; and (5) the rate of increase in total health-care spending will be no more than the growth in personal income.[25]

To implement these goals, the Commission identified four strategies: (1) build a high-quality, high-performing health-care system; (2) provide affordable health-insurance options for individuals and small businesses; (3) ensure the health of the next generation; and (4) promote prevention and health-lifestyles.[26]

To further these strategies, the Commission made sixteen recommendations, each of which directs the state to take certain actions.[27] The recommendations can generally be divided into three groups: (1) those directed towards state payors, such as Medicaid; (2) those directed towards the private insurance market; (3) and those directed towards providing tools and information to consum-

22. Greg Scandlen, Presentation to the Blue Ribbon Commission on Health Care Costs and Access: The Origins of CD Health (Oct. 3, 2006), http://www.leg.wa.gov/documents/joint/HCCA/ScandlenCHCC.pdf.

23. *See* Vicki Wilson, Dir., Presentation to the Blue Ribbon Commission on Health Care Costs and Access: Washington State Planning Grant Access to Health Insurance Project (Oct. 27, 2006), http://www.leg.wa.gov/documents/joint/HCCA/Uninsured%2010-27%20Wilson%20OFM.pdf; Press Release, Mike Kreidler, Wash. Ins. Comm'r, New Report Reveals that the Cost of the Uninsured Rises to More than $550 Million (Sept. 7, 2006), http://www.insurance.wa.gov/news/dynamic/newsrelease detail.asp?rcdNum=514.

24. *See* FINAL REPORT, *supra* note 3, at 3.

25. *Id.* at 3.

26. *Id.* at 4.

27. *See id.* at 5-16.

ers.[28] A number of the recommended actions required other state administrative agencies, such as the Washington Office of the Insurance Commissioner ("OIC"), to provide further reports to the governor and legislature.[29] A few recommended actions directed state health purchasing agencies to act.[30] Others specifically charged the governor and the legislature to introduce and pass legislation to improve the health of the population.[31] The Commission specifically noted that its work was only a "starting point," and that the Commission was not expected to include all the ideas that the governor or legislature might consider to address Washington's health-care challenges.[32]

3. *Pre-Legislation Reports*

The Commission's final report tasked the OIC with providing three reports to the governor and legislature to help implement legislation designed to effectuate the Commission's recommendations.[33] One report responded to the Commission's Recommendation #8: "Give individuals and families more choice in selecting private insurance plans that work for them."[34] The Commission directed the OIC to provide a report identifying the impacts and likely tradeoffs in terms of cost and coverage if state laws were modified to provide health carriers more freedom from extensive benefit mandates in order to target insurance products to small businesses, individuals, and young adults and/or children, by February 1, 2007.[35]

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28. *See id.* This Article will not discuss further the recommendations that are directed towards providing additional tools and information to consumers.

29. *See id.* at 5, 8-9, 12.

30. *See id.* at 6, 7.

31. *See id.* at 10-11, 13, 17.

32. *Id.* at 17.

33. One of the mandated reports was to respond to Recommendation #6: "Reduce health care administrative costs." *Id.* at 8. The OIC was directed to provide another report to the governor and the legislature identifying the key contributors to health care administrative costs and evaluating opportunities to address them, by September 2007. This due date was extended to December 1, 2007. Telephone Interview with Mary Clogston, Legislative Liaison to the Ins. Comm'r, in Spokane, Wash. (Nov. 6, 2007). The report was issued on November 26, 2007.

34. *See* FINAL REPORT, *supra* note 3, at 9.

35. *See id.* Nationwide, the number of uninsured young adults (19-26) stands at 33.2%. *See* Sara Rosenbaum, *SCHIP Reconsidered*, HEALTH AFF., Aug. 14, 2007, at w608, w614, http://content.healthaffairs.org/cgi/reprint/hlthaff.26.5.w608v1. In Washington, adults ages 19-25 constituted 29.8% of the uninsured in 2006, and adults ages 26-34 constituted 21% of the uninsured. *See* Wilson, *supra* note 23, at 11.

The OIC contracted with Milliman, Inc., a private consulting and actuarial firm in Seattle, Washington, to assist in the preparation of the required report.[36] The OIC requested that insurance carriers provide Milliman with at least one example of an insurance product design that meets the Commission's criteria, the estimated premiums for such a plan under the current Washington ratings statutes,[37] and the estimated premiums for such plan designs under carrier-proposed changes to current rating requirements.[38] In addition, the OIC requested that the carriers provide Milliman with their views of the plan designs and proposed rating changes' impacts and likely tradeoffs.[39] In order to encourage carrier participation, specificity, and candor, Milliman gave the carrier-provided responses to the OIC without attributing the responses to specific carriers.[40] The OIC also hosted meetings with carriers and other interested groups, such as consumers, small business organizations, state health-purchasing agencies, and providers, to solicit their views on mandates and rating requirements.[41]

Seven health plans provided Milliman with written comments, and several provided proposed benefit packages with comparative pricing for products with and without changes to the state's rating laws.[42] Despite this promising process, the tight timeline for completing the report prevented the OIC from providing the governor

36. *See* OFFICE OF THE INS. COMM'R, WASH. STATE, REPORT TO THE GOVERNOR AND THE LEGISLATURE IN RESPONSE TO RECOMMENDATION #8 OF THE BLUE RIBBON COMMISSION FINAL REPORT 2 (2007), http://www.insurance.wa.gov/consumers/documents/BRCmemo.pdf [hereinafter OIC RECOMMENDATION #8 REPORT].

37. Washington currently employs an adjusted community ratings approach. *See id.* at Attachment 5 ("Comments Regarding NAIC Model Rating Requirements and Washington State Rating Requirements"). Washington allows only very limited differentiation in the rates offered to small groups. Currently, permissible rating adjustment factors are: the design of the plan; the geographic area covered by the plan; the family size; beneficiary age; and participation in wellness activities. *Id.* Age brackets may be no smaller than five years beginning at age twenty and ending at age sixty-five. *Id.* In addition, the rates for the most expensive coverage offered cannot exceed 375% of the rates offered for the lowest-priced coverage offered. The medical experience of all small groups must be pooled and annual rate adjustments may vary by plus or minus 4% from the overall adjustment of the carrier's entire small group pool. *Id.* The Commissioner must approve the overall adjustment, and there must be actuarial justification for the adjustment. *Id.*

38. *Id.* at 2.

39. *Id.*

40. *See id.*

41. *See id.*

42. *See* MILLIMAN, INC., REPORT TO OFFICE OF THE INSURANCE COMMISSIONER BLUE RIBBON COMMISSION ON MARKETPLACE REACTION TO POTENTIAL CHANGES IN BENEFIT MANDATE AND RATE REGULATIONS (2007), http://www.insurance.wa.gov/consumers/documents/BRCreport.pdf.

and the legislature with any truly meaningful information.[43] They were unable to provide detailed comments on the public-policy issues engendered by eliminating specific benefit mandates. Nor did the OIC undertake a review of the proposed changes' public-policy implications.[44]

The data that the OIC was able to gather showed a consensus among the carriers that relaxing the current 375% maximum permitted variation between high and low rates would lower the premium rates for young adults in the individual and small-group markets.[45] Unfortunately, for all of the specific sample insurance products proposed, the lower premiums for young adults came at the expense of higher premiums for older adults.[46] One carrier provided estimated small-group benefit plan premiums for two products, one with a high-deductible and one with a low-deductible, with the proposed rate-band range change from 375% to 425%. For both products, the lowest premiums charged (presumably for covering healthy young adults) decreased 4%, while the highest charged (presumably for the oldest covered adults) increased by more than double that amount, 8.8%.[47]

The carriers also submitted plan designs with limited benefits, excluding many of the benefits Washington law currently mandates.[48] Limited benefit plans proposed included one designed for individuals of all ages with a relaxed age slope, one designed for children, and one designed specifically for young adults.[49] Premium prices for these plans ranged from 84% of current premium for young adults under twenty-four, to 95% of current premium for those sixty and over.[50] Not surprisingly, the plan designs that carried the most significant savings over current benefit plans available in Washington were those with very low annual maximum coverage amounts ($50,000 and $20,000), high deductibles ($1500), and limited benefits.[51] Several carriers that do not currently par-

43. *See* OIC RECOMMENDATION #8 REPORT, *supra* note 36, at 3.

44. *See id.*

45. *See id.*

46. *See id.* at 2-3. Three carriers submitted sample product pricing with relaxed maximum variations in premium rates. Two of the samples were for individual products, and one was for two small group products, one with a $200 deductible, and one with a $1000 deductible. *Id.*

47. *Id.* at 3.

48. *See id.* at 4-6.

49. *See id.*

50. *See id.*

51. *See id.* at 5-7. Generally, the more comprehensive plans excluded coverage for maternity, mental health, chemical dependency, vision, skilled nursing facility, home

ticipate in the Washington insurance market expressed a desire to market limited-benefit plans in Washington, structured with a schedule of benefits.[52] These plans are typically marketed towards part-time, seasonal, or hourly employees that do not qualify for an employer's traditional comprehensive medical plan.[53]

Other concepts carriers put forward included a plan that would reward healthy lifestyle behaviors by charging lower individual premiums to those who maintain appropriate body weight, refrain from high-risk behaviors (such as smoking), and appropriately manage certain chronic diseases, such as asthma and diabetes.[54] Still others were designed to be attractive to young adults by coupling services that were most likely to be used by young adults, such as maternity and pharmacy benefits, with high-deductible catastrophic plans.[55]

The Commission's Recommendation #11 addressed the affordability of coverage for high-cost individuals.[56] The Washington Legislature charged the OIC with providing a report to the governor and legislature evaluating options for restructuring and improving the Washington State Health Insurance Pool ("WSHIP") by March 1, 2007.[57] Specifically, the OIC was directed to consider improvements and changes in chronic-care management, reimbursement rates and plan designs, and eligibility and subsidy criteria.[58]

The WSHIP is a statutorily mandated public-private partnership that provides health insurance coverage for anyone with severe and chronic illness who has been denied health insurance in the individual market.[59] WSHIP has been in operation since 1988.[60] It offers

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health, hospice, health education, community wellness, nicotine dependency, and alternative medicine. The most restrictive plans focused solely on care in facilities, eliminating coverage of most professional services. *Id.* at 5-6.

52. *See id.* at 7.

53. *See id.*

54. *See id.* at 9.

55. *See id.*

56. *See* FINAL REPORT, *supra* note 3, at 12. "Five percent of the people in our health care system account for fifty percent of the costs of the system." OFFICE OF THE INS. COMM'R, WASH. STATE, ADDRESSING THE AFFORDABILITY OF COVERAGE FOR HIGH-COST INDIVIDUALS 1 (2007), http://www.insurance.wa.gov/publications/health/210_Report_WSHIP.pdf [hereinafter ADDRESSING AFFORDABILITY].

57. *See* FINAL REPORT, *supra* note 3, at 12.

58. *Id.*

59. *See* ADDRESSING AFFORDABILITY, *supra* note 56, at 1. Insurers offering individual coverage in Washington use the Standard Health Questionnaire ("SHQ") to determine whether to insure an applicant. Any individual who scores over a prespecified amount is automatically denied coverage and referred to WSHIP.

three health plans: a standard indemnity plan, which currently has 600 enrollees, a preferred-provider plan with 1700 enrollees, and three Medicare "wrap-around" plans with 900 Medicare-eligible enrollees.[61] In 2005, more than 6000 applicants for individual health plans were referred to WSHIP, but only 972 (one in six) enrolled.[62] Nearly 800 people disenrolled from WSHIP during that same time period.[63] This low enrollment in WSHIP indicates that reforms are needed if WSHIP is to have any effect on managing health care costs for high-cost individuals.[64]

In addition to the specific mandates from the Commission to consider improvements in chronic-care management, changing reimbursement rates and plan designs, and changing eligibility and subsidy criteria, the OIC also considered broadening the sources of funding for WSHIP.[65] WSHIP is currently funded by enrollee premiums and carrier assessments.[66] To immediately broaden WSHIP's funding base, the OIC recommended that the legislature appropriate $5 million for the current biennium, and convene a task force to recommend equitable, stable, long-term funding options for WSHIP.[67] The OIC noted that the state's Uniform Medical Plan's WSHIP assessments against stop-loss carriers are based on only one-in-ten of its covered lives, while direct carriers in the private health insurance market are assessed based on their direct percentage of covered lives in the market.[68] Self-funded plans do not pay any assessment at all,[69] which tends to increase the cost of private health-insurance plans relative to self-funded health plans, and acts as an incentive for an increasing number of employers to self-fund their health benefits and remove themselves from the pool of WSHIP funders.[70] The thirty-three other high-risk pools in use in other states use more varied financing mechanisms to subsidize the inevitable losses between premiums and claim expenses.[71]

60. *See* DEBORAH CHOLLET, OFFICE OF THE INS. COMM'R, WASH. STATE, THE AFFORDABILITY OF COVERAGE FOR HIGH-COST INDIVIDUALS: OPTIONS FOR WASHINGTON STATE 1 (2007), http://www.insurance.wa.gov/publications/health/2118-Report_Reinsurance5.pdf.

61. ADDRESSING AFFORDABILITY, *supra* note 55, at 1.

62. *Id.*

63. *Id.*

64. *Id.*

65. *See id.* at 4.

66. *Id.*

67. The task force would require additional funding. *Id.* at 2.

68. *Id.* at 4-5.

69. *Id.* at 5.

70. *Id.*

71. *Id.*

WSHIP also has extraordinarily high average claim expenses compared to other high-risk pools around the nation.[72] This results in a spiral of escalating costs related to WSHIP for private health insurers, which is inevitably passed on to their subscribers and employer-sponsors of these plans.[73] The OIC-recommended task force would have the formidable role of formulating recommendations regarding long-term funding sources for WSHIP.[74]

WSHIP provides chronic-care management services for a number of diseases.[75] The OIC recommended that the legislature make participation in care-management services mandatory to providers, and provide monetary incentives to those who effectively perform care-management services.[76] It also recommended that WSHIP explore the effectiveness of paying for medical services provided by e-mail, group visits, or other cost-effective methods of delivering quality health-care services.[77]

Although disease-management programs may be worthwhile for reasons unrelated to cost savings, such as improved patient satisfaction and enhanced patient-provider interaction, the OIC's recommendations regarding the disease-management programs ignore the growing body of evidence that such programs do not generally reduce overall health spending.[78] In fact, there is some evidence that these programs, when applied to a very sick patient population, cost the insurer more money than comparable care de-

72. The average annual cost per enrollee in WSHIP is $1418 per month. The average annual cost per enrollee in other pools around the country is about $631. *Id.*

73. *Id.*

74. *Id.* at 7.

75. Chronic-care management services are available for depression, HIV, asthma, diabetes, coronary artery disease, congestive heart failure, breast cancer, and stem cell/bone marrow transplants. *Id.*

76. *Id.* at 8.

77. *Id.* at 9.

78. *See, e.g.*, CONG. BUDGET OFFICE, AN ANALYSIS OF THE LITERATURE ON DISEASE MANAGEMENT PROGRAM (2004), *http://www.cbo.gov/ftpdocs/59xx/doc5909/10-13-DiseaseMngmnt.pdf*; Laura B. Benko, *Disease Management Strikes Out; PacifiCare Ends Program Early, CMS Cites Rising Costs*, MODERN HEALTHCARE, Jan. 23, 2006, at 9; Matthew DoBias, *Big Deposit, No Return?*, MODERN HEALTHCARE, July 15, 2007, at 8; Melanie Evans, *Minn.'s Hatch Blats Blues Deal; Says Expensive Disease-management Deal Not Working*, MODERN HEALTHCARE, May 1, 2006, at 12; Joanne Wojcik, *Are Disease Management's Claims Unfounded? Vendors' Assertions that Programs Reduce Health Spending Scrutinized*, BUS. INS., Apr. 17, 2006, at 13. *But see Independence Blue Cross' Disease Management Program Reduces Medical Cost Trends By 1.5-2%*, MANAGED CARE WKLY. DIG., May 26, 2006, at 36; *McKesson Reports Disease Management Program Saved New Hampshire $1.3 Million in a Year*, MED. DEVICES & SURGICAL TECH. WK., Oct. 22, 2006, at 117; Robert L. Whiddon, *Battle Weary: Disease Management Continues to Hold Promise for Advisers Wrestling with Escalating Medical Costs*, EMP. BENEFIT ADVISOR, Aug. 1, 2007.

livered to a population not enrolled in a disease-management program.[79] Therefore, recommending mandatory participation in such programs for a very sick population, such as the WSHIP population, and recommending that disease-management programs for this population be expanded, seems at odds with the Commission's and the OIC's mandate to create more affordable health insurance for high-cost individuals.

The OIC also focused attention on WSHIP's reimbursement rates and plan design, in accordance with the Commission's directive. The OIC recommended statutory changes to WSHIP to provide more "benefit design flexibility."[80] Usually, "benefit design flexibility" allows insurers to have some freedom from rigid benefit mandates, so they can offer less inclusive, and presumably cheaper, insurance products. In line with the mainstream understanding of "benefit design flexibility," the OIC recommends permitting WSHIP to offer non-comprehensive benefit plans to subscribers in order to bring down the costs of premiums.[81] Nevertheless, the OIC's recommendation for WSHIP also proposes turning what are currently statutorily mandated maximum benefit amounts into minimum levels of benefits that WSHIP must offer its subscribers under the rubric of "benefit design flexibility."[82] There is no analysis of the likely effects on premiums of these seemingly competing mandates included in the OIC report. It is entirely possible that the requirement that current maximum benefit amounts become minimum benefit amounts will result in premium increases used by insurers to fund the higher amounts of benefits that they must now offer. These premium increases may completely offset any premium decreases that would otherwise flow from a pared-down version of WSHIP's health plans.

Prior to the Commission's work and the OIC's recommendations, WSHIP guaranteed renewal of existing policies until the subscriber becomes eligible for Medicare.[83] This inhibited WSHIP's

79. *See* DoBias, *supra* note 78.

80. ADDRESSING AFFORDABILITY, *supra* note 56, at 9.

81. The cost of the premiums is cited by two-thirds of high-risk citizens referred to WSHIP as a barrier to enrollment. *Id.* at 12-13. Nevertheless, even if WSHIP offers policies that are not comprehensive, WSHIP would be required to continue to offer comprehensive policies as an option for its enrollees. *Id.* at 11.

82. The OIC's recommendation would require current maximum time limits on inpatient hospital care per year, inpatient mental health and chemical addiction services, and skilled nursing services to be set as minimums, and increase the lifetime maximum benefit level from $1 million to a limit comparable to the majority of Washington individual health plans, which is currently $2 million. *Id.* at 9-10.

83. *See* WASH. REV. CODE § 48.41.160 (2006).

ability to change any terms of insurance offered to any existing WSHIP subscriber, even when the policy was up for renewal.[84] WSHIP's only option to change or phase out a plan that was not cost-effective, or that suffered from other flaws, was to close it to new enrollees.[85] The OIC WSHIP Revisions Work Group recommended that WSHIP's guaranteed-issue requirements be replaced with a requirement that enrollees be guaranteed that they could continue their general scope of coverage, but not necessarily every specific provision of their current policy.[86] The intent of this recommendation is to provide WSHIP with more flexibility to design and offer new plans to respond to changing needs and circumstances.[87]

Currently, when an applicant for individual insurance in the private health insurance market is identified as one of the eight percent of persons who would be most costly to treat under individual coverage, the applicant is referred to WSHIP.[88] This threshold was established in 2000 to bring health insurance carriers back into the individual market in Washington.[89] Nevertheless, four out of every seven persons referred to WSHIP remain uninsured because they cannot afford WSHIP or private health insurance premiums. One possible strategy to make WSHIP premiums more affordable is to lower the WSHIP eligibility threshold so that less sick individuals will be placed in WSHIP, which will presumably lower the per-enrollee expenditures incurred by WSHIP.[90]

In order to keep health insurance premiums and health insurance carriers' retained-income levels reasonable, Washington law requires a health insurance carrier to pay into WSHIP when its loss ratio in the individual market is less than seventy-two percent.[91]

84. *See* ADDRESSING AFFORDABILITY, *supra* note 56, at 11.

85. *See id.*

86. *See id.* In January 2007, the OIC convened an eight-person work group to develop its recommendations. *Id.* at 1. The OIC stated that it could not adopt this proposal because it believed that the Washington State Constitution's prohibition against impairment of the obligations of the contract prohibits eliminating the guaranteed renewability of WSHIP policies for current enrollees. *Id.* at 12.

87. *See id.* at 11.

88. Washington is the only state to use standardized underwriting to refer applicants to the high-risk pool. The state uses a Standard Health Questionnaire to standardize underwriting for individual health plans. When an applicant scores over 324 points on the questionnaire, the applicant is referred to WSHIP. *Id.* at 14.

89. *See id.* at 15.

90. *See id.*

91. *Id.* at 16. An insurer's loss ratio consists of incurred losses (the amount it has paid out as claims) plus any loss adjustment expenses, divided by its earned premiums. *See* Rupp's Insurance and Risk Management Glossary, Loss Ratio, http://insur-

Adjusting this figure has the potential to lower premiums in the individual market, which would theoretically produce lower premiums for WSHIP enrollees.[92] Because of the quick timeframe the Commission gave the OIC to complete its work, the OIC was unable to evaluate the impact on premiums of adjusting the eight percent WSHIP eligibility threshold and the seventy-two percent individual-plan loss ratio. The OIC recommended that the legislature provide funding for the OIC to perform this evaluation by September 1, 2008.[93]

The OIC did not confine its exploration of methods to make health insurance coverage more affordable to the existing WSHIP. The OIC commissioned a report ("Chollet Report") exploring alternative options for making coverage for high-cost individuals more affordable.[94] The Chollet Report specifically examined the possible uses of reinsurance, high-risk pools, expanding the primary insurance market to cover more high-risk individuals, and risk-adjustment strategies.[95] The majority of the report explains the concept of reinsurance, and analyzes its possible use as a state-sponsored market-support strategy to make individual insurance more available and affordable.[96] Because reinsurance limits the

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ance.cch.com/rupps/loss-ratio.htm (last visited Mar. 3, 2008). Under Washington law, there is little incentive for a health insurance carrier to pay out insufficient amounts in claims payments, and/or maintain extremely high premiums, because either or both of these circumstances will result in a loss ratio higher than seventy-two percent, which will trigger the payment of the excess to WSHIP. A reasonable insurer would spend those funds to lower premiums and/or pay additional claims to engender customer goodwill, rather than pay it to the state with no reciprocal benefit. *See, e.g.*, Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 197-98 (4th Cir. 2007) (emphasizing that a reasonable employer would put money into enhancing employee benefits to attract and retain quality employees, rather than pay the same amount of money to the state, where its payment will buy no such ancillary benefit).

92. ADDRESSING AFFORDABILITY, *supra* note 56, at 16.

93. *See id.* at 15.

94. CHOLLET, *supra* note 60. The Chollet Report states that a high-risk pool, such as WSHIP, is "potentially the least effective means in helping individuals find and retain adequate coverage." *Id.* at 13.

95. *See id.* "Reinsurance" is best described as insurance for insurers. Insurers purchase reinsurance to protect themselves from the risk of large losses. The principal goal of reinsurance is to spread risk incurred by insurers from a small proportion of high-cost individuals who account for a significant percentage of the total medical cost of the pool. *Id.* at 2-3 (noting that the highest-cost one percent of the population accounts for at least twenty-five percent of total health-care expenditures). "Risk adjustment" is a process of measuring the health expenditures of groups or individuals enrolled in competing insurance plans and adjusting payment to the plans to account for the differences in their risks of health-care expenditures. *Id.* at 11. Risk adjustment acts as a equalizer of insurers, so that insurers have less incentive to engage in "cherry-picking"—insuring only the populations with the lowest risks.

96. *See id.* at 2.

downside exposure of enrolling new individuals, conventional, unsubsidized reinsurance generally either reduces the primary insurer's need for very high reserves, thereby (theoretically) reducing premiums, or removes the incentive for primary insurers to rate and design their benefits to avoid risk, thereby (theoretically) improving access to adequate coverage for small groups and individuals with health problems.[97]

State-subsidized reinsurance is intended to directly reduce primary-insurance premiums, and to support insurers that are obligated by law to offer insurance to high-risk groups and individuals.[98] States that operate reinsurance plans generally follow one of two models: (1) those that permit primary insurers to obtain reinsurance when the policyholder renews coverage, even if the primary insurer did not purchase reinsurance when the applicant first enrolled; and (2) those that permit primary insurers to reinsure only when an applicant first enrolls.[99] In addition, states that operate reinsurance plans follow several different benefit design models.[100] States must decide the appropriate attachment point for reinsurance, the covered services and cost-sharing obligations that are counted towards the attachment point and are subject to reinsurance after the attachment point is reached, and whether the program will be limited to primary insurance products that are considered "standard" with regard to the benefits offered.[101] The plan's benefit design has implications for the administrative cost of the reinsurance program and the amount of reserves the program must maintain to properly anticipate risk.[102]

States must also decide how they will finance their subsidized reinsurance plan. All states require primary insurers to pay a premium for the subsidized reinsurance.[103] Some states cap their premiums, thereby ensuring that the state will levy assessments against all insurers, even those who do not use the reinsurance pool in addition to the premiums to fund the reinsurance pool.[104] Other states do not cap their premiums, or have a very high cap, thereby

97. *Id.* at 3.

98. *Id.* Studies suggest that removing the medical costs of the highest-cost three percent of insured lives via public financing could reduce average premiums by one-third. *Id.*

99. *Id.* at 5.

100. *Id.* at 6.

101. *Id.* at 6-7 (citing the examples of reinsurance programs maintained by Arizona, Connecticut, Idaho, New Mexico, and New York).

102. *See id.* at 7.

103. *Id.* at 8.

104. *Id.*

making assessments against primary insurers less likely.[105] Generally, programs with capped premiums encourage broader participation in the reinsurance pool by primary insurers. In contrast, programs with uncapped premiums encourage fewer insurers to use the pool, and therefore limit the program's effect on the access costs in the primary market.[106] Currently, no state has financed a reinsurance program in whole or in part by using general tax revenues.[107]

The Chollet Report compares the advantages and disadvantages of reinsurance, risk adjustment, and high-risk pools such as WSHIP on making small group and individual insurance more affordable, accessible, and effective.[108] The Chollet Report concludes that either a properly structured reinsurance or risk-adjustment program performs better than the WSHIP high-risk pool.[109] The report recommends that Washington undertake further study and gather quantitative data to explore the options of reinsurance or risk adjustment as alternatives to WSHIP.[110]

B. Legislation Directed Towards Reforming the Small Group & Individual Insurance Markets

The Blue Ribbon Commission's short time frame for input from the Insurance Commissioner on ways to make insurance products more affordable and accessible to small businesses, individuals, and young adults and/or children inhibited the Commissioner's ability to gather complete and meaningful data from the private insurance market to aid it in making recommendations in this regard. Nevertheless, the legislature and governor have continued this project. They created a Health Insurance Partnership Board (the "Board") and charged it with developing policies to connect employees of small businesses with health plans that qualify for premium-subsidy payments.[111] Subsidies will be based on gross family income, family size, and the ages of eligible family members.[112] The entire sub-

105. *Id.*
106. *Id.*
107. *Id.* at 10.
108. *See id.* at 21-24.
109. *Id.* at 23.
110. *Id.* at 25.
111. *See* Engrossed Second Substitute, H.B. 1569, 60th Leg., 2007 Sess. §§ 4-5 (Wash. 2007) [hereinafter H.B. 1569]. The Board must include at least four health-benefit plans, with multiple deductible and point-of-service cost-sharing options. *Id.* § 5(b). The plans must offer coverage ranging from catastrophic to comprehensive, and must include one high-deductible health plan. *Id.*
112. S.B. 5930 § 58(2)(g).

sidy will be applied to the employee's premium obligation; therefore, the small business employer would not get any subsidy for his or her contribution.[113] Enrollment in the partnership is not an entitlement; if the funding appropriated for the partnership fails to cover expenditures, the Health Care Authority Administrator may freeze new enrollment in the program and establish a waiting list.[114] Administrative expenses will be paid for through a surcharge on all health-benefit plans offered through the partnership.[115] The surcharge, however, must be included in the premium for each health-benefit plan, thereby passing this cost on to the employer and employee.[116]

The employer remains free to determine the criteria for eligibility and enrollment in its benefit plan, and the terms and amounts of the employer's contributions to that plan, subject to a minimum employer premium contribution level the Board established.[117] Nevertheless, in order to participate, a small employer must establish a cafeteria plan under section 125 of the Federal Internal Revenue Code that will enable employees to use pre-tax dollars to pay their share of the premiums.[118] Small employers must also comply with the open-enrollment requirements of the Health Insurance Portability and Accountability Act ("HIPAA") and must act as a plan sponsor or administrator in accordance with federal law.[119] The Board is charged with developing appropriate rating methodologies, but they must be based on the already-existing adjusted community rating criteria for small groups.[120] The legislation did not authorize the rate-band change from 375% to 425% that had been suggested by the private insurers who participated in the Insurance Commissioner's data-gathering exercise to prepare the report requested by the Blue Ribbon Commission.[121] Nor did it change the age brackets an insurer is permitted to use for adjusted community rating, as the private insurers suggested.[122]

H.B. 1569 requires the partnership to begin accepting applications from participants eligible to receive premiums by September

113. *Id.*
114. H.B. 1569 § 12.
115. S.B. 5930 § 58(2)(f).
116. *Id.*
117. H.B. 1569 § 5(a).
118. S.B. 5930 § 58(2)(a).
119. *Id.* § 58(2)(b).
120. S.B. 1569 § 5(e).
121. *See id.* § 7(3)(d).
122. *See id.* § 7(3)(b).

1, 2008.[123] The Board must submit a preliminary report to the governor and the legislature that includes an implementation plan to incorporate the individual and small-group markets into the partnership on or before December 1, 2008.[124] The Board must submit a report and recommendations to the governor and legislature by September 1, 2009, regarding the possibility of having additional markets participate in the partnership, including public employees, public school employees, and persons enrolled in Washington's Basic Health Plan.[125]

C. Legislation Directed Towards Reforming the High-risk Insurance Market

Following the recommendations of the Chollet Report, the legislature and the governor statutorily authorized the Insurance Commissioner to evaluate options and design a state-supported reinsurance program.[126] An interim report from the Commission on this process was due to the governor and legislature by December 1, 2007, and a final report, including implementing legislation and financing options, is due by September 1, 2008. The legislation directs the Commissioner to prepare a very detailed report, including an analysis of the costs and benefits of state-sponsored reinsurance, and more importantly, directs the Commissioner to evaluate and quantify, where possible, the behavioral responses of insurers to the program (i.e., whether insurers will actually reduce premiums in response to the availability of subsidized reinsurance, and make coverage for high-cost individuals more affordable and available).[127] It also directs the Commissioner to use a specified reinsurance corridor in designing the plan.[128]

Although the legislation contemplates transitioning from the WSHIP to a new subsidized reinsurance plan, it also implements the Insurance Commissioner's major recommendations to reform the WSHIP in the near-term.[129] It allows the WSHIP to offer ben-

123. *Id.* § 6.

124. *Id.* § 10.

125. *Id.* § 11. The Basic Health Plan is a subsidized health plan sponsored by the state, available to individuals that fall below a certain level of income but are not eligible for Medicaid.

126. *See* S.B. 5930 § 25.

127. *Id.* § 25(1).

128. The reinsurance corridor (the amount of loss at which the reinsurance payment is triggered) specified by the legislature is $10,000 to $90,000. *Id.* § 25(1)(b).

129. *See id.* § 25(1)(e)(g) (contemplating that there will be a transition from the "status quo" to reinsurance).

efit plans that are not comprehensive, although it requires WSHIP to include at least one comprehensive plan.[130] For the comprehensive plan, S.B. 5930 changes certain benefit maximums to benefit minimums.[131] It also mandates that WSHIP contract with proven disease-management providers and requires WSHIP to "encourage" enrollees who are eligible for care-management services to participate.[132]

The legislature and the governor also appear to have rejected the Commissioner's understanding of the Washington State Constitution's "impairment of contracts" clause.[133] The new legislation replaces WSHIP's "guaranteed renewability" language with a more flexible "continued coverage" guarantee.[134] Rather than requiring WSHIP to continue offering the same plan to enrollees from year-to-year, as did the prior WSHIP legislation, the new legislation requires only that WSHIP make a replacement plan, which includes all of the services covered under the enrollees' current plan, and is available to all individuals in the plan being replaced.[135] The new plan must not "significantly" limit access to the kind of services covered under the replacement plan through "unreasonable" cost-sharing requirements or otherwise.[136] Individuals enrolled in WSHIP must be permitted to transfer to a plan that is fully comparable to the plan it replaces.[137] The legislation, however, does not define what constitutes a "significant" limit on access or an "unreasonable" cost-sharing requirement. Additionally, it has specific notice requirements for enrollees whose WSHIP plans are discontinued, and requires WSHIP to evaluate the impact on WSHIP enrollees prior to discontinuing a plan.[138]

130. *See id.* § 26(4).

131. *See id.* § 26(4)(a) (inpatient hospital days and inpatient mental and chemical dependency treatment); *id.* § 26(4)(e) (skilled nursing facilities).

132. *See id.* § 26(10).

133. In order for Washington to violate the State Constitution's "impairment of contracts" clause, a court would have to find that the impairment was substantial and did not serve a legitimate public purpose. *See* Tyrpak v. Daniels, 874 P.2d 1374 (Wash. 1994). Alternatively, if the impairment was minimal, it could violate the impairment of contracts clause if it was not a legitimate exercise of the state's police power. *Id.* Given the current problems with WSHIP, it seems likely that if the change from "guaranteed renewability" to a guarantee of "continued coverage" was challenged under this clause, the change would be found both to serve a legitimate public purpose and to be a proper exercise of the state's police power. *See id.*

134. *See* S.B. 5930 § 27(1).

135. *See id.* § 27(4)(a).

136. *See id.*

137. *See id.*

138. *See id.* § 27(4)(b).

II. WHAT AN EFFECTIVE HEALTHY WASHINGTON INITIATIVE SHOULD LOOK LIKE

The Blue Ribbon Commission performed a thorough study, and its efforts to explore the possibilities for meaningful health care reform in Washington are laudable. Nevertheless, the Commission's and the legislature's efforts will be unsuccessful if the state fails to consider not only who is uninsured, but why they are uninsured. Both nationally and in Washington, recent efforts to extend health insurance coverage to uninsured populations have focused on children and young adolescents under age twenty-one. Nevertheless, recent statistics show that this is not the population at the greatest risk of being uninsured.[139] Federal statistics show that more than ten million young adults are uninsured—a 33.2% uninsurance rate.[140] Washington is no exception to this national trend. The percentage of adults ages 19-25 covered by employer-sponsored health insurance dropped from 63.4% in 2000 to 53.1% in 2006.[141] During the same time period, the percentage of young adults covered by public programs and individual insurance has remained virtually flat, while the percentage of young adults without any health insurance rose from 18.4% in 2000 to 29% in 2006.[142] Of the total uninsured population in Washington, 50.7% are adults ages 19-34, and 29.8% are adults ages 19-25.[143] In addition, the risk of being uninsured is growing far faster for this age group than for any other age group in the population.[144]

Financially, most of Washington's uninsured are near or below the poverty line.[145] They also have the fastest growing risk of being uninsured of any income level group.[146] Despite the fact that most of the uninsured have incomes under 200% of the poverty level, the overwhelming majority of them are in families where there is at

139. *See* Rosenbaum, *supra* note 35.

140. *Id.*

141. *See* WASH. STATE HEALTH CARE AUTH., HEALTH INSURANCE PARTNERSHIP BOARD ORIENTATION § 3, http://www.hip.hca.wa.gov/doc/pre-meeting-materials-092407.pdf [hereinafter HIP BOARD ORIENTATION] (discussing HIP Board Overview on Washington State Insurance Trends).

142. *See id.*

143. *See id.* § 2, at 7.

144. *See id.* The reason for this may be that this demographic includes many adolescents who age out of the state safety-net systems that have provided them with health insurance throughout their childhood, such as child welfare programs, foster-care placements, and special education programs. *See* Rosenbaum, *supra* note 35, at w614.

145. *See id.* § 2, at 8.

146. *See id.*

least one worker.[147] Slightly over half of the uninsured are adults without children, and again, in Washington, this is the group with the fastest growing risk of being uninsured out of all demographic groups.[148] In Washington, of the uninsured who are themselves working, 32.9% are self-employed.[149] This is more than the percentages of uninsured that small and very small employers employ.[150] Of those who are uninsured, 28.6% are not in the work force, either voluntarily or through involuntary unemployment.[151]

The assumptions that most of the uninsured young adults are employed by small businesses, and that access to health insurance for all but the elderly and the "deserving" poor should be tied to employment, have spurred states to take more aggressive action to reform their health insurance markets to make coverage for those employed by small businesses more affordable.[152] Numerous state reforms are centered on small businesses and their employees, and they range from programs very similar to the Healthy Washington Initiative's Health Insurance Partnership, designed to make it easier and more affordable for small businesses to offer health insurance to employees, to mandates requiring individuals, employers, and/or insurers to participate in the health insurance market.[153] Health care reform policies that focus on increasing accessibility of insurance through the workplace have been shown to encourage the development of new health insurance markets, but do not increase the overall levels of insurance coverage.[154] Nevertheless, the Washington statistics show that the majority of uninsured young adults in the state are self-employed or not employed at all. Therefore, "solutions" to the problem of the uninsured that continue to link accessibility of health insurance to traditional employment, or focus on only the "deserving" poor and the relatively small percentage of people who fall into the high-risk category, may increase the number and accessibility of such products in

147. *See id.* § 2, at 9; *see also* Barrilleaux & Brace, *supra* note 2, at 658 (stating that the working poor make up a large part of the uninsured population).

148. *See* HIP BOARD ORIENTATION, *supra* note 141, § 2, at 10.

149. *See id.* § 2, at 12.

150. *See id.*

151. *See id.*

152. *See* Rosenbaum, *supra* note 35, at w614.

153. *See* Washington State Blue Ribbon Commission on Health Care Costs and Access, *supra* note 19.

154. *See* Mark A. Hall, *The Impact of Health Insurance Market Reforms on Market Competition*, 6 AM. J. MANAGED CARE 57 (2000), *available at* http://www.ajmc.com/files/articlefiles/AJMC2000JanHallp57_67.pdf.

Washington, but they are not comprehensive solutions to the problem of the uninsured in the state.

Malcolm Gladwell, in his best-selling book *The Tipping Point: How Little Things Can Make a Big Difference*, describes the "tipping point" as the point at which something that was once considered outside of the norm becomes the norm, and therefore, fundamental change occurs.[155] There is currently a vigorous debate amongst researchers as to whether we have reached the tipping point where employers will stop offering health insurance benefits as part of their employment packages.[156] Even if we have not yet reached the "tipping point" that will spur fundamental change in the employment-based health insurance system from the employers' point of view, there is evidence that from the perspective of health care consumers, we are at or very close to a tipping point. The model of work for those under age thirty-five continues to evolve from full-time, permanent employment to longer periods of schooling continuing into adulthood, and more self, temporary, and part-time employment.[157] As this trend continues, and perhaps accelerates, it is likely that an increasing number of people will no longer be in a position to benefit from traditional employment-based health insurance. Therefore, any reform that continues to link availability of health insurance to employment will merely nibble away at increasingly smaller pieces of the problem.

Furthermore, as it covers declining segments of the population, employment-based health insurance will become increasingly inefficient and expensive to maintain. In Washington, the OIC conservatively estimates that thirty cents of every health care dollar received by health care providers is spent on administrative ex-

155. MALCOLM GLADWELL, THE TIPPING POINT: HOW LITTLE THINGS CAN MAKE A BIG DIFFERENCE (2003).

156. *Compare* Paul Fronstin, *The Future of Employment-Based Health Benefits: Have Employers Reached a Tipping Point?*, EMP. BENEFIT RES. INST. (EBRI), (Issue Brief No. 312 Dec. 2007) (arguing that employers have not yet reached the tipping point) *with* COMM. FOR ECON. DEV. (CED), QUALITY, AFFORDABLE HEALTH CARE FOR ALL: MOVING BEYOND THE EMPLOYER-BASED HEALTH-INSURANCE SYSTEM REPORT (2007), *available at* http://www.ced.org/docs/report/report_healthcare200710.pdf (urging replacement of the employment-based health benefits system).

157. *See, e.g.*, Ashley Smith, *What Generation Y Wants in a Job*, TELEGRAPH (Nashua, N.H.), Nov. 26, 2007 (reporting that Generation Y (those born between 1979 and 1999) wants to spend less time "paying their dues" in entry-level positions, values flex-time, plans to switch careers more often and expect to spend more time in school than previous generations. This indicates that they are more likely to be employed part-time, be periodically unemployed, or be full-time students than prior generations, and therefore more likely to be ineligible for health insurance offered through an employer).

penses for health plans and providers. Before a health-care dollar even gets to a provider, approximately fourteen cents of the insurance premium has been consumed by health plan administration.[158] The inefficiencies of this system, although noticeable in the aggregate, will become even more noticeable to those who bear them when they are spread amongst a decreasing percentage of the adult population, specifically those with traditional full-time employment. When enough people with political (i.e., voting) power are not served by an increasingly expensive and inefficient system, and the shrinking pool of workers who are served by the system (albeit badly) notice that they are shouldering an increasingly greater individual share of the financial burden of maintaining an inefficient system, the system will be forced to change.

The employment-based health insurance system is merely a vestige of sixty-five-year-old World War II-era wage controls and high corporate taxes during the war period, and not the "sacred cow" that most American politicians view it as.[159] Given the current trends in employment (or unemployment) for those under age thirty-five, only reforms that de-link health insurance from employment will reach young adults, the fastest-growing segment of the uninsured population.

Maintaining an individual, virtually unregulated health insurance market that operates in parallel with an employment-based market that serves an increasingly older and sicker population results in untenable individual and employment-based insurance rates. Eight years ago, Washington passed legislation designed to stimulate the individual health insurance market by removing persons likely to be the most costly individuals to insure from the market, and stripping the OIC of its authority to regulate individual health

158. OFFICE OF THE INS. COMM'R, WASH. STATE, HEALTH CARE ADMINISTRATIVE EXPENSE ANALYSIS, BLUE RIBBON COMMISSION RECOMMENDATION #6, FINAL REPORT 3 (2007), http://www.insurance.wa.gov/consumers/documents/BRC_Efficiencies_Report.pdf.

159. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 333-34 (1982); Randall K. Abbott, *Will Employer-provided Health Benefits Disappear by 2010?*, 21 J. COMPENSATION & BENEFITS 8, (May/June 2005); Leon Applebaum, *The Development of Voluntary Health Insurance in the United States,* 28 J. INSURANCE 28-33 (Sept. 1961); Carolyn V. Juarez, *Liberty, Justice, and Insurance for All: Re-Imagining the Employment-Based Health Insurance System,* 37 U. MICH. J.L. REFORM 881, 885 (Spring 2004). *But see* Frank R. Dobbin, *The Origins of Private Social Insurance: Public Policy and Fringe Benefits in America, 1920-1950*, 97 AM. J. SOC. 1416, 1437-38 (stating that war-time price and wage controls took effect after employers had already started offering fringe benefits such as health insurance to retain workers).

insurance rates.[160] Despite these efforts to maintain an affordable individual health-insurance market, which could cover those who are not eligible for employment-based insurance, rates for individual health-care coverage have increased an average of sixteen percent since the legislation was enacted.[161] Recently, the second-largest individual health insurance plan in the state has filed a rate increase of 22.5% for 2008.[162] Clearly, this growth rate is untenable and only further increases the number of uninsured in the state by placing individual insurance coverage out of reach for a greater number of young adults.

In order to efficiently integrate these two markets, without instituting a politically unpalatable and possibly equally inefficient single-payor government-run system, the state should start by giving the tax benefits currently given to employers who pay all or part of their employees' health insurance premiums directly to those who purchase health insurance.[163] The state should require insurance companies to community-rate their products for an entire geographic area, and to insure everybody who applies for their insurance product within that area. To guarantee that insurers fairly share the risk of high-cost claims, the state should establish fund pools that compare the risks of insurers in various parts of the state. Insurers with below-average demographic factors would draw money from the pools to compensate for taking on these increased risks that are unavoidable in a community-rating system. Insurers with above-average demographic factors would pay money into the pools, to ensure that there are not innumerable choices of insurance for citizens living in areas with favorable demographics and virtually no choices of insurance for those living in areas with unfavorable demographics.[164] This would also discourage insurers from selling their products only in markets with the healthiest populations.

In order to encourage private-insurer participation in this reformed health insurance market, the state should institute a "risk-

160. *See* WASH. STATE OFFICE OF THE INS. COMM'R, FACT SHEET: RESTORING AUTHORITY IN THE INDIVIDUAL HEALTH MARKET, http://www.insurance.wa.gov/oic files/rules/proposed/ESB5261FactSheet.pdf.

161. *Id.*

162. *Id.*

163. Recent anecdotal evidence suggests that eliminating the employer tax deduction for health benefits would bring about the "tipping point" for employers to stop offering health-insurance benefits to employees. *See* Fronstin, *supra* note 155, at 14.

164. *See* Colonial Life Ins. Co. of Am. v. Curiale, 617 N.Y.S.2d 377 (App. Div. 1994) (describing a similar system).

corridor" strategy, similar to the strategy employed by the federal government to encourage private-plan participation in Medicare Part D, the prescription drug benefit for senior citizens.[165] Under this strategy, private plans would set their premiums for a geographic area based on a target cost figure the state calculates. The target cost figure would be the anticipated average yearly cost of care for an enrollee in the plan. If the plan spent less than the targeted cost per enrollee, the insurer would keep a small percentage of the savings, and be required to reinvest the remainder of the savings in the plan by enriching the benefit package or lowering plan premiums. If the plan exceeds the targeted cost per enrollee, the state will pay a percentage of the excess costs to the plan as reinsurance. This will remove some of the uncertainty and the risk of large losses, provide an incentive for the insurer to deliver cost-effective, quality care and to encourage healthy lifestyles for enrollees, and encourage insurer participation in the market.

The legislature and the governor should also rethink their decision not to allow insurers to provide benefit packages to specific groups that do not contain all of the benefits that are currently mandated by Washington law. Because uninsured young adults are typically willing to accept a certain amount of risk, are not in their years of peak earning potential, and are generally healthy, they are a particularly attractive market for pared-down benefits packages tailored to their most likely health-care needs. It would be worthwhile to explore whether pared-down benefits packages are necessary to lower premiums to levels where young adults could afford coverage for their basic, catastrophic, and preventative medical needs, thus allowing them to save for any possible future medical needs that the pared-down plans do not cover.

Even a health insurance system that is completely independent from employment will be useless if people do not access it. Young adults without children or other dependents tend to consider themselves "invincible," and are far less likely to purchase health insurance for themselves than older adults or adults with children.[166] Any effective effort to reform the private insurance market to

165. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003).

166. *See* Gene Meyer, *'Boomerang' Generation Comes Back to Empty Nest,* KAN. CITY STAR, Aug. 6, 2007 (quoting an insurance provider who recognizes that young adults who are recently out of college and return home to live are likely to age out of their parents health care insurance, and that young adults "don't think about being uninsured, and most don't know how much health care can cost you if you go uninsured.")

reach the uninsured in Washington must mandate that all who can afford it must purchase health insurance.[167] Nevertheless, experience reveals that compliance with government mandates is highest when the mandated action is affordable; therefore, there must be an affordable private health insurance market for an individual coverage mandate to be effective.[168] The requirements of geographic community-rating, risk-pool adjustments, and limited government reinsurance through "risk corridors" should result in the emergence of an affordable private insurance market.

If the penalty for noncompliance with an individual health insurance mandate is insignificant, then noncompliance likely becomes financially attractive.[169] Furthermore, individuals subject to the mandate must believe that penalties for noncompliance are likely to be enforced against them for the mandate to be effective.[170] In order to enforce an individual health insurance mandate, those who choose not to purchase insurance could be tracked through multiple data sources, such as comparing voter registration and driver's license records, with the records of insurers who cover the geographic area under review.[171] Financial penalties for noncompliance, however, have proven to be of limited utility in other contexts, such as mandated automobile liability insurance and minimum-wage laws.[172] More effective are penalties for non-compliance that prevent the individual from participating in important aspects of life, such as exclusion from school or day care for failure to comply with required childhood immunizations.[173] Possible exclusions that might be effective with a majority of the young adult population are the inability to obtain a driver's license, enroll in an institute of higher education or vocational school, or be employed without showing the employer proof of health insurance. Financial penalties for failure to purchase health insurance are likely to be ineffective among a large number of the uninsured, particularly young, relatively healthy adults, who are willing to take their

167. *See* Barilleaux & Brace, *supra* note 2, at 675.

168. *See* Sherry A. Glied, Jacob Hartz, & Genessa Giorgi, *Consider it Done? The Likely Efficacy of Mandates for Health Insurance*, 26 HEALTH AFFAIRS 1612, 1618 (2007).

169. *See id.* If the penalty is too high, however, people simply will not pay it. *Id.*

170. *See id.* at 1618-19.

171. *See id.* at 1619.

172. *See id.* at 1616-17.

173. *See id.* at 1616.

chances and deal with the costs of receiving care when they need it.[174]

Finally, for those who truly cannot afford the cost of private health insurance, we should lay to rest the notion of the "deserving" poor, and provide government-subsidized insurance to all who meet income and resource eligibility guidelines, regardless of why they meet those guidelines.[175] The lives and health of young adults without children are just as worth preserving as the lives of young adults with children.[176] Today's "slackers" may be tomorrow's engines of innovation, but if they are derailed by bad health and the inability to access quality health care, their contributions will be lost to society.[177]

CONCLUSION

Washingtonians have demonstrated their desire and willingness to try both state-based and market-based health-care reform policies to address the problem of the uninsured.[178] Governor Gregoire's statement that health care is a right, and the creation of, and the extensive work done by, the Blue Ribbon Commission and

174. *See, e.g.*, Hanns Kuttner & Matthew S. Rutledge, *Higher Income and Uninsured: Common or Rare?*, 26 HEALTH AFFAIRS 1745, 1752 (2007).

175. *See* Sandra Tanenbaum, *Medicaid Eligibility Policy in the 1980s: Medical Utilitarianism and the "Deserving" Poor*, 20 J. HEALTH POL. POL'Y & L. 933 (1995).

176. Indeed, this category includes many of our college and graduate students, many of whom will make extensive contributions to our economy in the coming years. Because so many of them are unemployed or are employed in part-time jobs that are low-paying and do not offer insurance, they remain ineligible for Medicaid and unable to afford private insurance.

177. As of this Article, two bills have been introduced into the Washington Legislature to establish a state-wide catastrophic and preventative health insurance program that would be available to virtually all residents of Washington. The program would be funded by a payroll tax levied on employers and employees, and would be administered by private health insurers who competitively bid for the contracts. All benefits mandated by state law must be included in the program's coverage, and persons who are eligible for coverage under the program but who do not register with an insurance carrier participating in the program will be assigned to a carrier. Premium rates will be based on a single community-rated risk pool. *See* H.B. 2640, 60th Leg., 2008 Sess. (Wash. 2008); S.B. 6603, 60th Leg., 2008 Sess. (Wash. 2008). Although these bills have some promising elements, their continued reliance on an employer- and employee-financed system to cover all Washingtonians, including those who do not work, makes them financially vulnerable and somewhat inequitable. In addition, they do not mandate any penalties or disincentives for failure to enroll, and it is unclear how persons who fail to enroll will be identified and assigned to a carrier. Both bills have been referred to the respective chambers' Committees on Health.

178. *See* Barilleaux & Brace, *supra* note 2, at 666 (listing Washington as a state that has embraced a high number of state-based health insurance reform policies and a high number of market-based health insurance reform policies to address the problem of the uninsured).

the administrative and executive agencies working to carry out its mandates, also demonstrate that Washington has the political will to make major changes to its health insurance system that would have a real impact on those who are currently uninsured and those who are most likely to constitute the uninsured in the future. Many of these people are young, childless adults. Washington is moving in the right direction by considering a mixture of market-based and state-based policies, and by introducing legislation that would make catastrophic and primary care available for all. But without the political will to institute and enforce a properly tailored individual mandate, and to divorce health insurance from the employment system, these efforts will not have the desired effect of making Washington one of the healthiest states in the nation. If health care is truly a right, then it should not disappear when one is unemployed, self-employed, or in school. We need to match our legislation to our vision, if we are truly to become a Healthy Washington.