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Implementation of the Washington State Basic Health Plan

Thomas L. Kobler

The Washington State Basic Health Plan can be characterized as a demonstration project. We have the ability to serve up to 30,000 of the estimated 410,000 people who are eligible for this program under the current legislation; expansion of the program will require legislative approval. The Plan provides basic health services and is funded primarily by two sources: the general state fund, and premiums charged to our customers. Premiums are set on a sliding scale basis depending on family income. The Plan is run by an independent state agency that is required by law to use managed health care systems to provide the medical services. There was a great deal of effort to keep this program completely separate from Medicaid because of concerns about our association with the stigma that is attached to Medicaid. We negotiate individual agreements with each of the managed health care systems with which we contract, such as Group Health Cooperative of Puget Sound.

While there were many issues that we had to deal with early on, the three most problematic areas involved 1) defining basic health care, 2) expectations, and 3) unresolved challenges.

Defining Basic Health Care

In an attempt to define basic health care benefits, we used four categories of criteria to determine which benefits would be included or excluded in the package: 1) emphasis on prevention, such as prenatal care, well-baby care, and child immunizations; 2) cost, or affordability, for both the state and our members; 3) noncompetitive with the private sector, i.e., the state will not compete with the insurance industry; and 4) compatibility with managed care concepts, i.e., examination of each benefit to determine whether or not it fits within the managed care perspective. For example, mental health benefits typically are controlled by either a number of visits, copayments, or dollars, which is not necessarily consistent with a managed care perspective.

The benefit package essentially includes primary care services, physician and hospital, both inpatient and outpatient. We want people to use preventive services and thus waived any copayments for them. There are also no copayments for maternity, laboratory and x-ray, and ambulance services. However, copayments are critical to any benefit package. What has been missing in health care for so long is the patient's own financial involvement in the medical services utilized. With copayments set at $5 per primary care physician visit, $50 per inpatient admission, and $25 per emergency room visit, we are attempting to include patients in the overall financial picture.

More notable than what we include is what we exclude and what we limit. Our preexisting condition clause is not like the typical insurance preexisting clause. Essentially, if members enter the program with a preexisting condition, medical services for that condition will not be covered for the first 12 months but will become fully covered after that time if the service is included as a regular benefit. That clause was a way to protect risk for the managed health care systems, since we knew very little about the population in terms of actual utilization or historical data.

Another concern was how to keep people from moving in and out of the plan only when they needed health care services. We are selling this product to individuals and families, not to employers. We do not have the ability, as an employer does, to restrict people to one program for 12 months and to allow them the opportunity to change programs once a year. While we looked at that option, we decided against it because we would likely be stuck with a fair amount of obligation to the managed health care systems as well as a lot of bad debt if members could not afford to pay their monthly premiums. Thus, we have what is referred to as the 12-month lockout. If a member leaves the program, he or she is not eligible to rejoin for up to 12 months, subject to availability of slots. This provides the right incentive for people to think twice about dropping the program. There is one exception: people who leave Basic Health due to accessibility of health care coverage from another source (i.e., Medicaid or employer) can reenter without waiting 12 months subject to availability of slots.

Regarding exclusions, we are much like an insurance company. We don't cover voluntary plastic surgery, for instance. We would like to be able to include outpatient prescription drugs as a benefit, but the issues of cost and management are problematic. In most health maintenance organizations (HMOs) and other managed care systems, pharmacy benefits are growing two to three times faster in terms of cost as compared to the other benefits.

Expectations

Another problematic issue, in terms of legislative inheritance, was meeting or redefining expectations. After the bill was

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had been trimmed away by 1989, and thus provider discounts by limiting this program to a pilot project, we had additional $85 or $90 per member, which is divided between the state and All of this brought our budgeted cost in the early stages to about much of what was termed "fat" in the health care system in 1986 increases the potential enrollment and therefore adds some risk. Taking this program from a statewide to a pilot project de­ tended primarily because the monthly fee did not account for the two and a half years (contractual center dates were July 1989) of medical inflation (about 15% per year). Also, by limiting this program to a pilot project, we had additional risks. Taking this program from a statewide to a pilot project decreases the potential enrollment and therefore adds some risk regarding the type of people who may join the program. Also, much of what was termed "fat" in the health care system in 1986 had been trimmed away by 1989, and thus provider discounts were not as significant as had been planned on two years earlier. All of this brought our budgeted cost in the early stages to about $85 or $90 per member, which is divided between the state and the enrollee. Our total budget for the 1989-1991 period, increasing our current enrollment to 25,000 people, is about $47 million.

Insurance versus entitlement is another issue which has been a real balancing act. Most state programs are entitlement pro­ grams; taxpayers get the program for free. However, the Basic Health Plan is essentially an insurance company within the state government, which allows us to stretch our funding over a much broader base by using many of the insurance principles of en­ rolling the healthy as well as the ill into the program.

Additionally, there were many myths that we had to confront. Many people thought that the model envisioned for managed care was Group Health (a staff model HMO), which frightened a lot of people, and thus a fair amount of education was necessary to make the managed care model more palatable. Another fear was that the working poor population was a utilization time bomb, but we were able to dispel that myth. There was also the fear that this population would mirror the high utilization rates of Medicaid and would have a higher incidence of liability. It is a common misconception that people on Medicaid sue their providers more often than anyone else. We have worked through and dispelled most of these fears, but some of them still linger. Over time, as we collect our utilization data, we hope to dispel all of these myths.

Unresolved Challenges

What is the role of the Basic Health Plan in relation to the contracting providers? I like to envision us as partners. A critical premise is to work with managed health care systems in the pri­ vate sector to make the plan work. In dividing responsibilities between the Basic Health Plan and managed health care sys­ tems, we took responsibility for eligibility and enrollment func­ tions, collecting the premiums, and paying the managed health care systems. The managed health care systems are responsible for providing the medical services delivery, claims processing, and utilization control and management. We share the responsi­ bility of marketing.

Determining a sliding scale premium without creating barri­ ers to access is a tough issue. How do you know when you have arrived? How can you tell if you are maximizing member contrib­ utions? We developed a schedule which seems to be working, but those questions continue to haunt us.

The single most difficult issue for us on a daily basis is defining income. Although we follow the Internal Revenue Service definition, we have seen more variations of what is not income or what we would like to include as income and the enrollee does not. As our ceiling is 200% of the federal poverty level, measuring income is critical for determining not only eligibility but also how much of a premium should be paid by our cus­ tomer, since that varies based on family income as it relates to the federal poverty level.

We work hard to maintain flexibility in our operation, as well as with the plans with which we contract. If we make a mistake, we need to have the ability to implement the change immedi­ately and not wait until the end of the year or when it's time to renew the contract.
Experience to Date

We had three initial plans that we went operational with in January and February 1989. Group Health Northwest in Spokane reached its initial 1,000 enrollee limit within the first three months. Group Health Cooperative of Puget Sound reached its initial 3,000 enrollee limit in four months. The Pierce County/Tacoma area, which has a limit of 5,000 enrollees, has had consistent growth, with approximately 3,000 enrollees as of November 1989. In the two counties where we closed enrollment early on, we have 3,500 people on a waiting list.

As of November 1989, we had over 7,000 people enrolled in the program. We have added additional contractors and have another 1,300 people who have been determined eligible for the program but who must make their payment before they can receive medical services. In my opinion, the program has been very successful in that regard.

The average age of our enrolled population is 24 years—a very young population. Half of our enrollees are children. We have about 2,700 families enrolled in the program, many of which are single parent families. The largest segment of the population eligible for the program are young, single males, but they have not been our largest enrollment.

When surveyed, approximately 19% of our enrollees admitted to having health insurance available to them at the time of enrollment. We were surprised by this high percentage and will need to investigate this later. However, we are aware, for instance, of one six-member family that had been paying one-third of their income for an individual policy; obviously, when our program became available, they rightly switched policies.

Final Recommendations

If other states are to address the problem of the uninsured working poor, they must start now. Seek out your legislators and the legislative staff as soon as possible. You need to work with them and educate them. Also seek out business. They have much to be concerned about in terms of cost shifting and additional taxes. Set up coalitions: bring together the purchasers, the providers, the insurers; work out the differences and form a solid base before confronting the legislature. It is difficult to keep the politics from driving the process of developing and implementing a program such as ours, but it is vital to keep your expectations realistic. You will not only have less grief when you can’t meet your time frames or your goals but also a much better chance at success.