Oncology Issues

Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

States Go Full-Speed Ahead with Health Care Reform

Jamie Young

To cite this article: Jamie Young (1994) States Go Full-Speed Ahead with Health Care Reform, Oncology Issues, 9:1, 8-9, DOI: 10.1080/10463356.1994.11904444

To link to this article: https://doi.org/10.1080/10463356.1994.11904444

Published online: 18 Oct 2017.

States Go Full-Speed Ahead With Health Care Reform

by Jamie Young

You have read about *it* in *Oncology Issues* and been bombarded by national news and newspaper accounts, not to mention just about anywhere else you can imagine. *It*, as you might have guessed, is federal health care reform. Something will pass or it won't...maybe. However, as this column has noted before, the states continue with their own agendas.

The newly formed Washington State Medical Oncology Society, led by Dr. Robert Burdick of Seattle, has already recognized and made a priority its need to get a seat at the table in that state's health care reform movement. That reform effort has it roots in the 1990 legislative session when House Concurrent Resolution 4443 was passed, creating the Washington Health Care Cost Control and Access Commission. This group was charged to recommend changes to health financing, payment, and legal systems necessary to contain health care costs, change medical malpractice and liability practices, and ensure universal access to health services for all Washington residents.

The commission's final report was issued on November 30, 1992. It found that state residents with adequate insurance receive some of the most technologically advanced medical care in the world. Yet, the commission also found that the health system is in trouble. Costs are rising at two to three times the general inflation rate. At the same time, 550,000 to 680,000 Washington residents (11 to 14 percent of the state's population) do not have health insurance. Therefore, the commission determined that the goal of the state's health system should be to maintain or improve the health of all residents at a reasonable cost.

To achieve this goal, the commission recommended comprehensive and fundamental reform. The reformed system should encourage healthy behaviors, enhance the efficient delivery of health services, promote prudent use of services by consumers, and equitably distribute the costs. The commission believed that a substantial majority of the state's population should receive health services through managed health care systems and integrated delivery systems that manage care and that assume financial risk for providing appropriate health benefits cost-effectively.

These findings were the basis for the Washington legislature's action to pass the Washington Health Services Act of 1993. It has been described by the *Wall Street Journal* as a "managed competition" plan that could be the first test of the Clinton Administration's approach to health care reform. The new law attempts to provide basic coverage for the uninsured, contain costs by imposing ceilings on health insurance premiums, and through the use of health insurance cooperatives increase the purchasing power of individuals and small businesses.

Perhaps the key component to the entire law, and certainly the focal point from the Washington State Medical Oncology Society's viewpoint, is the five member Health Services Commission that has been appointed to oversee these changes. This commission will ultimately establish a health benefits package (called the Uniform Benefits Package or UBP) and set a maximum premium that will be allowed for that package. This minimum level of coverage must be offered by insurers by 1995, and all state residents must have the minimum coverage by 1999. The Commission will also design optional supplemental benefits packages.

Under the law, the uniform benefits package must cover at least:

- visits to the doctor
- hospital care and surgery
- prescription drugs
- maternity, reproductive, and wellness services
- home health and hospice care
- alcohol/drug treatment and mental health services
- short-term skilled nursing
- preventive dental care for children.

Another key element of reform in the state of Washington is the increase in taxes necessary to expand the Basic Health Plan and Medicaid, as well as fund other measures. Almost 60,000 adults and more than 135,000 children will receive health care coverage by 1995 as a result of this expansion.

To fully implement its reform plan, Washington State must seek amendments to the Employee Retirement Income Security Act (ERISA), which limits the state's ability to regulate businesses that self-insure their workers health benefits, as well as applicable waivers from Medicare and Medicaid laws.

Cost controls will be reached, according to the commission, by premium caps and inflation limits on the uniform benefits package. The flow of funds into the health care system would be limited, forcing providers to be more efficient in the production of health care—somewhat like a global budget. In addition, practice indicators will be developed to increase the efficiency of clinical decision making and therefore reduce costs. Medical malpractice reform has also been thrown into the mix.

Also established under this commission is a five-member health ser-

Jamie Young is ACCC Director of Public Policy.

vices effectiveness committee, whose members possess a breadth of experience and knowledge in the treatment, research, and public and private funding of health care services. Members will advise the commission on:

- health services that may be determined by the commission to be appropriate and effective
- use of technology and practice indicators
- the uniform benefits package
- rules that insurers and certified health plans must use to determine whether a procedure, treatment, drug, or the health service is no longer experimental or investigative.

The potential influence and impact this group will have on the delivery of cancer care will be far-reaching! In fact, there is talk of Washington State applying for model state status under the federal health care plan. What this means is that this reform effort is not only important to Dr. Burdick and the 60 members of his state society, but also for everyone in the country. The same can be said for reform efforts in Florida, Oregon, and Tennessee.

TRENTON

Another example that highlights both the need to stay attuned to developments at the state level and the difficulty in doing so is what has been occurring in New Jersey. The New Jersey Small Employer Health Benefits Program Board of Directors proposed rules last July in the *New Jersey Register* to implement a recently passed law creating a small employer health benefits program. The board's interim administrator is the Prudential Insurance Company of America. In accordance with this new law, insurance companies, hospital service corporations, medical service corporations, HMOs, and multiple employer arrangements offering health benefits plans for small employers must offer, as a condition of transacting business in New Jersey, health benefit plans promulgated by the aforementioned board. The board is charged with establishing five health benefits plans and policies, optional riders, and claim forms.

The rules proposed detailed a lengthy and specific definition of "experimental or investigational." Comments were received on these proposed rules, which many viewed as inconsistent and highly subjective. Another hearing was held more recently where amendments to the original rules were considered.

ACCC provided written comments, in addition to those of the New Jersey Oncology Society and others. Included among the amendments was language to alter the criteria used to determine whether to consider covering charges for prescription drugs used for purposes other than that for which they were approved by the FDA, i.e., off-label uses. The ACCC model language, which is incorporated in legislation pending in New Jersey, was suggested for inclusion.

However, while the three compendia concept was included in the amendments, the rules also stated that the use of the peer-reviewed literature will be appropriate if it is supported by "the preponderance of the evidence that exists in clinical studies" that are reported in the literature. ACCC and others opposed this language because of the "preponderance of evidence" test that would be applied to the literature. This legal concept is incompatible with good science and clinical trials and is inconsistent with the pending New Jersey legislation as well as other state and federal legislation. Yet, despite our efforts, the rules were adopted with the amendments proposed by the board. On December 13, the New Jersey Assembly passed the off-label bill, Senate Bill 1631, and sent it on to the governor for signature. On December 23, the governor signed the bill, as expected, and it takes effect in 180 days. These rules will have to be rewritten to be consistent with the new state law.

The lesson to be learned is the importance of working with organized state oncology societies, as well as national associations such as ACCC and other members of the medical and pharmaceutical industry, to stay on top of the minutiae that occur at the state and local levels, not just on Capitol Hill.

COLUMBUS AND PROVIDENCE

Work continues in various states on off-label drug legislation. In Ohio, hearings have been held by the House Insurance Committee. Negotiations with the insurance industry have removed any remaining opposition to the bill so that chances of passage in early 1994 appear good. Negotiations have also been ongoing in Rhode Island where the legislature earlier this year adjourned without final passage of House Bill 6642, thus killing the bill. The ACCC has been meeting with legislators, the Society of Rhode Island Clinical Oncologists, the American Cancer Society, the state department of health, the Pharmaceutical Manufacturers Association, Rhode Island Blue Cross/Blue Shield, and the Health Insurance Association of America. The intent is to arrive at an agreed-to bill for re-introduction in 1994. ■