Special Report

Washington Research Council *March 22, 1999*

Health Insurance Still Suffers From 1993 Reforms

Six years ago, Washington adopted the nation's most sweeping health-care reform law.

Heralded at the time as presaging reforms Congress would soon pass, Washington's Health Services Act radically altered the health-insurance market here by replacing a market system with one designed by the Legislature.

The new system was justified as a necessary cure for perceived market failure. Reform advocates cited rising costs and the growing number of uninsured people as evidence of the market's supposed inability to get things right.

In a matter of months, though, the national fever for reform subsided. Congress declined to adopt massive health-care reform. And over the next few years, the central elements of Washington's health-care reform were repealed.

Briefly

It's clear by now that the market for individual health insurance in Washington is in serious trouble. Only three health insurers remain in that market. In 17 of the state's 39 counties, insurers refuse to accept new applicants for coverage.

Something is wrong with the market's regulatory structure. While no one has produced a comprehensive demonstration that the regulatory reforms implemented in 1994 have caused the problems, an analysis of the incentives inherent in these reforms shows that individuals acting in their own rational self-interest would reduce the market to its present state.

The legislature should take the steps necessary to draw insurers back into the market. It should repeal the reforms or modify them to change their incentives. At the same time, lawmakers should support programs assisting individuals who cannot afford coverage or who are turned away by private insurers.

However, the state retained several popular insurance reforms, which had been designed to work within the context of the original reform law.

Reforms aside, the market's supposed failure to control rising costs was shortly corrected by market forces. Managed-care systems, already on their way to market dominance in the pre-reform early 1990s, exerted a strong check on health-care inflation.

Moreover, reforms did not noticeably change the number of uninsured. The share of the population without health insurance has been remarkably stable, regardless of policy changes. More than anything else, the strength of the economy seems to have had the most effect on the uninsured population.

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Market failure, however, can be induced by public policies. And this has been the case in Washington's health insurance market — particularly in the troubled individual market.

Objective indicators of individual-market distress are clear. Some insurers have left the state. Those remaining have lost millions of dollars on individual policyholders. For their part, policyholders have suffered stiff rate increases. Washington's largest health insurers, dominating more than 80 percent of the market, in many or all counties have stopped accepting new applicants.

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The unintended consequence of reform, in short, has been that individuals are increasingly unable to buy insurance.

Some may argue that the appropriate response to these policy-induced market troubles is another round of regulation.

But the state's policy goal should be to restore conditions enabling the health-insurance marketplace to operate efficiently. A competitive health-insurance market can, and does, provide access to health care for most Americans at affordable prices.

The changes required in Washington are relatively few — mainly fixing those regulations that depart dramatically from the national norm.

Regulations in need of change include those prescribing preexisting condition limits, guaranteed issue and portability.

The Individual Market

In 1997, the Governor vetoed most of a bill the Legislature had passed in hopes of resolving the problems afflicting the commercial market for individual health insurance.

In his veto message, the Governor declared, "There is no objective data to support the claim that the 'lack of incentives' to purchase health care in a timely manner is contributing significantly to the costs of health insurance."

It is clear today, however, that changes had been occurring in the individual insurance market then and have continued since.

Yearly, nearly all insurance companies in that market have been losing millions of dollars on individual insurance. The number of companies selling individual insurance has been declining, whether through withdrawal or merger. The price of individual coverage has been rising. And the number of individual policyholders has been dropping.

Between 1994 and 1997, the state's six largest health insurers collectively lost more than $116 million on individual coverage.

Today, it's almost impossible for people who have no insurance to buy an individual policy from a private insurer in Eastern Washington. Regence Blue Shield accepts new applicants only in Yakima and Walla Walla counties.

In 17 of the state's 39 counties, carriers have closed the door to new applicants.

Two health insurers now dominate the commercial individual market. Premera Blue Cross serves about 60 percent of the market, and Regence Blue Shield about 20 percent. Group Health Cooperative and several smaller Blue Shield insurers serve most of the rest.

In 1993, the year before insurance reforms took hold, 19 insurers sold individual policies. Today, only four do.

Last year, Premera Blue Cross stopped accepting new applicants for individual insurance. Premera currently has about 119,000 individual policyholders, who by law the insurer must continue to serve.

In a prepared statement, Premera Blue Cross said, "The individual market in Washington state has become increasingly unstable in recent years, as evidenced by decreasing enrollment, financial losses and decline of plans available to individual subscribers."

BOX 1

Enrollments of Individuals at the Largest Insurers

Firm	1993	1994	1995	1996	1997	1998
Premera*	133,254	187,113	199,396	171,811	144,609	118,814
Regence**	40,191	47,133	50,836	51,265	54,230	58,390
Group Health	26,777	26,168	24,596	22,236	20,388	20,839
Total	200,222	260,414	274,828	245,312	219,227	198,043

*Enrollments for 1993-97 include those of Blue Cross of Washington and Alaska and Medical Services Corp. of Eastern Washington. The two insurers merged in 1998 to form Premera Blue Cross.

**Enrollments for 1993-96 include members of Pierce County Medical Bureau, which merged with Regence in 1997.

The same problems besetting the commercial individual market have been afflicting the state's Basic Health Plan (BHP). Expanded six years ago into a full-blown state health insurance program for Washington residents, the BHP provides subsidized coverage for residents ineligible for Medicaid but earning too little to afford private health insurance.

Any and all other residents, however, may buy BHP coverage if they are willing to pay the full premium. And it's the unsubsidized portion of the BHP — which is part of the individual market — that is in real trouble.

This year, rates for unsubsidized members jumped an average of nearly 50 percent. At the same time, unsubsidized BHP enrollment plummeted by more than half, to 8,422.

As recently as two years ago, 18 health insurers were contracting to serve BHP members. Last year, the number dropped to 14. This year, only 10 are left, although most of the shrinkage resulted from mergers.

Last summer, Sisters of Providence Health System's insurance unit, Providence Health Care, decided it could no longer contract with the BHP, having lost millions of dollars from covering medical care for the working

BOX 2

Rate Increases by the Largest Insurers

Firm	1995	1996	1997	1998
Premera	19.0	14.0	11.4	18.7
PCMB*	34.2	0.0	19.0	0.0
Regence	14.4	0.0	13.0	12.0
Group Health	9.8	3.0	3.6	7.3

*Pierce County Medical Bureau (PCMB) merged into Regence BlueShield in April 1997.

poor and expecting to lose still more if it renewed its contract for 1999. Ironically, Sisters of Providence's main mission is to serve the poor.

In Clallam, Jefferson and Kittitas counties, only a single insurer now serves BHP members. And BHP officials say they are no longer confident that, in the future, there will be at least one insurer in each of the state's 39 counties.

Despite these changes, the state Insurance Commissioner has questioned the seriousness of problems in the individual market. That market serves only 5 percent of state residents, the Commissioner said in a 1999 white paper, adding that a 1997 University of Washington study "shows consumers do not wait until they are sick to buy coverage." The study, "Individual Insurance Reform and Open Enrollment," was done by Dr. Robert Crittenden and Susan Casey, at the UW's Department of Health Services and Department of Family Medicine.

"Nevertheless, incentives matter. And an examination of the incentives produced by the reforms shows that insurance buyers acting out of rational self-interest would produce the very market changes that have come about."

Incentives Matter

During the past few years, the reasons for the ills besetting the individual market have been hotly debated. At the center of the controversy lie Washington's health-insurance reforms, which became effective in 1994.

The reforms include the right of residents to buy insurance at any time no matter how sick they may be (guaranteed issue); the prohibition against insurers withholding coverage of pre-existing health conditions for more than 90 days; and the right of residents to switch from one insurance plan to another without any waiting period whatever for coverage of pre-existing conditions (portability).

Critics have pointed at the reforms as the main reasons for the problems in the individual market. Some evidence suggests this is the case; however, no one has done a comprehensive policyholder analysis.

Two years ago, the Governor stated there was no objective data supporting the claim that a lack of incentives to buy health insurance before needing major medical care was "contributing significantly to the costs of health insurance."

Nevertheless, incentives matter. And an examination of the incentives produced by the reforms shows that insurance buyers acting out of rational self-interest would produce the very market changes that have come about.

Consider rate increases. As rates rise, buyers weigh the added cost of coverage against their perceived need for insurance. Their need will vary with income, age and health. Poorer, younger and healthier people may well choose to bet they will not need major medical services and therefore opt to forego insurance.

But what if they lose their bets? They need not greatly worry, because insurers must accept their applications for coverage, and the longest period insurers may force them to wait before coverage begins is three months.

Rate increases beget more rate increases. As rates rise during any given year, individuals who had decided it was just barely worth it to buy insurance will choose to give it up the following year. People who need medical treatment will stick with coverage, so on average those who stay insured will be sicker, and carriers will have to raise rates to pay their claims. This process is likely to continue, in what insurers refer to as "a death spiral."

As rates rise, it also increasingly makes sense to buy and retain insurance only as long as it's needed.

Last year, for instance, 80 percent of the new enrollees over age 18 in Premera Blue Cross's health plan that mirrors the state Basic Health Plan were women. This plan includes maternity benefits.

Of the women in Premera Blue Cross's BHP look-alike, about 60 percent had babies within seven months of enrolling, and 80 percent within nine months.

Of the women who enrolled in the plan during the year ending September 1997 and had babies, 73 percent canceled coverage within the first eight months.

Of those who canceled, 15 percent did so the same month they delivered, and nearly 60 percent dropped coverage within three months after delivery.

As rates rise, it increasingly makes sense to exploit the state's guarantee of portability as well. This guarantee enables people who have had any one insurance plan to switch to any other plan. It also precludes any waiting period for coverage of health conditions.

Given portability, it makes sense for people to buy plans with higher deductibles and fewer benefits while they are healthy, and then switch to benefit-richer plans, which are more expensive, only after falling sick.

Is it the fault of consumers that the individual market is in trouble? No, said Premera Blue Cross senior vice president Trae Anderson at a legislative hearing last September. "They are making reasonable and appropriate personal choices which are available to them. The fault lies with the system we've set up, not with the people who are participating in it."

Possible evidence against a death spiral would be that while the number of individuals with health insurance declines, the overall number of people insured rises as more people are employed and are covered by insurance sponsored by their employers.

A 1998 study by The Heritage Foundation indicates this is not the case. Heritage compared the group of 16 states that have adopted the most aggressive insurance reforms with the other 34. Aggressive reforms include requirements to sell coverage to all applicants, however sick; to refrain from refusing to cover preexisting health problems; and to charge community rates.

Among the 16 states are Washington, Oregon and Idaho. Of the 16, Heritage notes, Washington is "at the forefront of comprehensive state insurance market regulation."

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State Individual Market Insurance Reforms[1]

	Guaranteed Issue		Preexisting Condition Exclusions		
	Selected Products	All Products	Limit Exclusion Periods (months)	Credit Exclusion Periods	Creditable Coverage Gap (days)
AL					
AK					
AZ					
AR					
CA			12-Dec	X	30
CO					
CT			12-Dec	X	63
DE					
FL			12-Jun	X	63
GA			(not specified) /24	---	---
HI					
ID	X		12-Jun	X	63
IL					
IN			12-Dec	X[2]	30
IA	X		12-Dec	X	63
KS					
KY		X	12-Dec	X	60
LA			12-Dec	X	60
ME		X	12-Dec	X	90
MD			12-Jun	X	63
MA	X[3]		6/6[4]	X	30
MI			12/6[5] or 6/6	---	---
MN			12-Jun	X	60
MS			12-Dec	---	---
MO					
MT			36/12	X	30
NE					
NV					
NH		X[6]	9-Mar	X	63
NJ	X[7]		12-Jun	X	31
NM			6-Jun	X	31
NY		X	12-Jun	X	63
NC					
ND			12-Jun	X	63
OH		X[8]	12-Jun	X	30
OK					
OR			6-Jun	X[2]	60
PA					
RI			No preexisting condition exclusion period allowed		
SC					
SD		X[8]	12-Dec	X	63
TN					
TX					
UT		X[8]	12-Jun	X	62
VT		X	12-Dec	X	63
VA			12-Dec	X	30
WA		X	3-Mar	X	90
WV					
WI					
WY			12-Jun	X	90

[1]These individual market reform provisions do not apply to HIPAA-eligibles except in those states utilizing existing individuals market reforms as the alternative mechanism to satisfy HIPAA's group-to-individual portability requirement.

[2]Only exclusion periods satisfied under group coverage can be credited.

[3]Health plans required to offer an annual open enrollment period of 30 days for the three guaranteed issue products.

[4]Preexisting condition exclusion periods cannot be applied to guaranteed issue products.

[5]Commercial insurers: 12/6, BCBSMI and HMOs: 6/6

[6]Health plans required to offer an annual open enrollment period of 60 days for all products.

[7]Health plans required to guarantee issue five standardized products and five rider products.

[8]Health plans required to offer coverage on a guaranteed issue basis until they reach an enrollment cap.

Source: The Blue Cross Blue Shield Association, December 1998

BOX 3

Heritage drew this overall conclusion: "Although the primary intention of insurance reforms is to make insurance coverage more affordable and available, thereby increasing the number of people covered by private health insurance, the 16 states that implemented the most comprehensive reforms have had the exact opposite experience. The result: More citizens uninsured. Fewer citizens covered by private insurance. Fewer citizens covered by individual insurance."

According to the Heritage study, Washington has the most aggressive combination of insurance reforms nationwide.

Information supplied by the Blue Cross Blue Shield Association shows that Washington is one of only nine states requiring insurers to accept any and all applicants (guaranteed issue). Of the other eight, three require guaranteed issue only until an enrollment cap is reached. And one limits guaranteed issue to an annual 60-day open-enrollment period.

Excepting Rhode Island, Washington has the shortest preexisting-condition limit. But Rhode Island does not force insurers to accept anyone who applies for coverage. All but one other state requiring guaranteed issue allows insurers to impose a 12-month wait on new policyholders with health problems. New Hampshire allows a nine-month period.

Washington also has the shortest "look-back" period – three months. Insurers may hold off paying for medical care of a preexisting condition of a new policyholder (who had no prior coverage) for three months only if the policyholder had or should have had treatment for the condition within the three months before buying coverage.

History of Washington Reform

Health-care reform in Washington grew out of legislative concerns about the number of residents lacking health insurance and the rapidly rising costs of medical care.

In 1992, the Washington Health Care Commission report to the Governor and the Legislature declared the state's health system was in trouble: "Costs are rising out of control; spending for health services is increasing at two to three times the general inflation rate. At the same time, an estimated 550,000 to 680,000 Washington residents do not have health insurance." That amounted to 11 to 14 percent of the population. (See Box 4.)

Among other things, the commission urged that a reformed health-care system "should include strong incentives and techniques to control total health system costs." And it recommended universal access, by which was meant that residents should "receive a comprehensive, uniform and affordable set of confidential, appropriate and effective health services."

In 1993, the Legislature radically reformed health care in this state through adoption of the Health Services Act, which was to take effect in 1995. Underpinning the act was the idea of "managed competition." State-certified health plans would compete within a framework of rules dictated by the government.

Certified health insurers would market policies that must include a "uniform benefits package," as determined by the newly created Health Services Commission, whose five members were appointed by the Governor and confirmed by the Senate.

Critics argued that the proposed basic package was far from basic. Even the smallest of suggested packages included an impressive list of benefits. Everybody would have access to care ranging from preventive to catastrophic medical services. Common to all three proposed packages were preventive services (such as checkups, immunizations and prenatal care), primary care, specialist care, inpatient and outpatient hospital services, emergency services, prescription drugs, and reproductive and maternity care.

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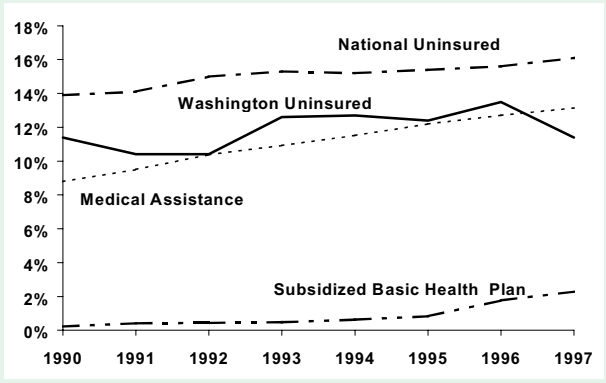
BOX 4

As the graph shows, the uninsured portion of the population was actually closer to 10 percent in 1992, rising in the early 1990s and declining in recent years, as unemployment dropped. Throughout the 1990s, Washington has had a lower share of its population uninsured than has the nation as a whole.



Source: Census Bureau, Office of Financial Management, Caseload Forecast Council, Washington Research Council calculations

From 1990 to 1997 enrollment in the state's Medical Assistance programs, including Medicaid, rose from 9 percent to 13 percent of the population. Additionally, enrollment in the subsidized Basic Health Plan grew to 2 percent of state population by 1997. In spite of this expansion in publicly provided insurance, the uninsured percentage of the population in 1997 was no lower than in 1990.

For this benefit package health plans would be required to charge a "community rate" that varied only by geography or family size. Rates could not vary, for example, by age and health. Each health plan would create its own community-rating structure for its policyholders. The Health Services Commission would set the maximum premium that health plans could charge.

"In early 1994, the commissioner announced new rules. They stipulated that insurers must accept anyone applying for coverage, regardless of age, sex, occupation, medical history or current health condition. "

A uniform benefits package and an insurance premium cap were supposed to control the rise of health-care costs. A uniform benefits package, it was said, would enable consumers to compare prices, thereby promoting price competition. A cap would posit the premium that an optimally run insurer would charge and then compel real-life insurers to match or better it.

Other provisions in the Health Services Act aimed at controlling costs were community rating and managed care. Community rating, proponents said, would "prevent big purchasers from shifting costs to small business and individuals."

The act required insurers to market the uniform benefits package within a framework of managed care, as defined in the law.

In what was called the "employer mandate," the Health Services Act required employers to sponsor health insurance for their employees; to offer a choice of at least three plans (each featuring a state-prescribed basic benefit package); and to pay at least half the cost of the lowest-priced health plan marketed in their areas by insurers.

Under the act, employers would buy coverage directly from one or another health plan or they would join a state-authorized health insurance purchasing cooperative. These cooperatives would replace insurance agents, brokers and consultants.

Slated to take effect July 1, 1995, the act required the state Insurance Commissioner to promulgate interim insurance reforms. In early 1994, the Commissioner announced new rules. They stipulated that insurers must accept anyone applying for coverage, regardless of age, sex, occupation, medical history or current health condition. Only for lack of premium payment could insurers cancel or refuse to renew policies.

The rules also barred insurers from excluding or denying coverage because of a preexisting condition – defined as any health condition, illness or injury someone had before applying for coverage. Exclusions in existing policies were nullified.

Although the act did not require it, the Insurance Commissioner decreed that for a three-month period, beginning July 1 of that year, residents lacking insurance would be permitted to buy coverage that began right away, regardless of how sick they may have been. After that, insurers were barred from making anyone wait longer than 90 days before they had to begin paying medical bills.

Privately, insurance companies voiced concerns about the new rules. Their main fear was that a three-month waiting period was too short.

Though the Health Services Act required all residents to have health insurance by mid-1999, until then people who had opted to go without insurance could hold off buying coverage, thus escaping their part of the social cost. There was no incentive for them to buy insurance any earlier than 1999. If they fell sick or became pregnant, they would have to wait only three months for insurance to kick in. And they could drop coverage upon receiving the care they needed.

Insurers also noted that the new rules did not apply to employers electing to self-insure, as big corporations typically did. That would allow them to avoid the costs of insurance reform, too.

Finally, insurers worried that the new rules would attract sickly, uninsured people from other states.

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Critics pointed out that for the state to force employers to sponsor employee health insurance, it would have to win a Congressional exemption from the federal Employee Retirement Income Security Act, which precluded states from regulating employee benefits, including health care. It was widely believed that gaining an exemption was unlikely.

Critics also predicted that when the Health Services Act went into effect the following year, many employers that had been sponsoring employee health insurance would quit doing so. They would quit if the uniform benefits package was the only policy they could buy and if it cost more than what they had been paying for insurance.

In the 1994 elections, the Republicans regained control of the House. Health Care Committee chairman Phil Dyer indicated he would work toward eliminating the employer mandate and the insurance premium cap. He also wanted to replace the uniform benefits package with a so-called standard package based on the health benefits in the Basic Health Plan, the state program that subsidized coverage for low-income workers.

In 1995, the Legislature acted to undo the governmental controls in the Health Services Act by passing ESHB 1046, the Health Care Simplification Act, whose prime sponsor was Rep. Dyer. The changes resulted largely from Republican control of the House and failure of the state to gain an exemption from the Employee Retirement Income Security Act.

Senate Democrats had warned that Dyer's bill "would do away with all the cost-control mechanisms in the Act, which are critical to stopping the reoccurrence of runaway health care inflation." But the House approved reform of the 1993 reform law by a 77-19 vote after 16 Senate Democrats had joined all 24 Republican senators in voting for the measure.

Stripped from the Health Services Act were the employer mandate, the premium cap, health insurance purchasing cooperatives, the requirement for insurers to be certified by the state and the provision requiring all state residents to acquire health insurance by July 1999. The new law also

relaxed community rating, which was retained for individuals and small groups, by allowing premiums to vary age and participation in employer wellness programs as well as by family size and region. And it replaced the Health Services Commission with a nine-member Health Care Policy Board, which lacked rule-making authority.

But the new statute put into law the insurance-reforms previously issued by the Insurance Commissioner. It also stated that insurers must market a policy with benefits mirroring those in the state's Basic Health Plan.

At the end of 1996, for the second year in a row, insurers reported losses in the millions of dollars on individual policyholders. Early in the 1997 legislative session, Rep. Dyer introduced the Individual Market Stabilization Act. The bill said that the lack of incentives for individuals to buy and keep health insurance had "contributed to the soaring cost" of medical claims on local insurance companies.

"When the regulations governing the individual market allow insurers to operate profitably and responsibly, the state will see a return to a competitive marketplace, one in which health insurers will eagerly enter and compete for business."

To motivate healthy individuals to buy health insurance, Dyer proposed a yearly two-month open-enrollment period for uninsured people to buy coverage. During the other 10 months, insurers could turn away applicants or grant only partial coverage.

To make his bill politically acceptable, Dyer included a way for people to buy insurance if they skipped the open-enrollment period. At any time, they could apply for insurance from the Washington State Health Insurance Pool, commonly called the "High-Risk Pool." The bill would set a new maximum premium the pool could charge. As before, the excess of claims over premiums would be distributed over all the insurers in the individual market.

The Legislature adopted the bill, but the Governor vetoed most of it.

Policy Recommendations

To enable the health-insurance marketplace to operate efficiently, a series of policy changes should be implemented.

Public policy should incorporate incentives that will encourage individuals to buy insurance before they need major medical care and to retain it after the necessary care has been received. In short, a successful insurance market requires broad participation, allowing risk to be shared across a large pool of policyholders. When some are allowed to enter after finding they need medical care, then the market is unsustainable. People are no longer insuring against risks, they are collecting against realities.

When the regulations governing the individual market allow insurers to operate profitably and responsibly, the state will see a return to a competitive marketplace, one in which health insurers will eagerly enter and compete for business.

How can these conditions be restored? Several possibilities are open to lawmakers and regulators.

One option is to complete the business of repealing the 1993 insurance reforms. This is less radical than it might appear. The reforms were originally intended to operate within a highly state-controlled system of universal health care. (For example, the Health Services Act required everyone to have insurance by this year.)

That system was never implemented. But in anticipation of full reform, some insurance regulations were adopted and retained even as sweeping reform was repealed. Standing alone, those remaining reforms, particularly as they apply to the individual market, embody perverse incentives.

Repeal would not leave the uninsured or medically needy without remedy. Medicaid provides coverage for those with very low or no income. And the subsidized Basic Health Plan is available for the working poor.

As well as these two insurance mechanisms, the state also has a way for residents with health conditions to buy private coverage even if they initially have been turned away by insurers. In 1987 the Legislature created the Washington State Health Insurance Pool. The Pool provides access to health insurance for all state residents meeting any one of the following four conditions:

1. Their application for coverage has been denied by at least one insurer for medical reasons,
2. They pay more for coverage than a standard-risk person of the same age and gender,
3. They face a preexisting-condition limitation on coverage, or
4. They have had coverage involuntarily terminated for any reason other than failing to pay the premium.

The maximum premium the Pool may charge is 150 percent of the average group standard rate charged by the five largest health insurers for groups with up to 10 members for policies with benefits comparable to those offered by the Pool.

"Short of repealing the balance of the 1993 Act, the state should address those regulations that depart substantially from the national marketplace."

Short of repealing the balance of the 1993 Act, the state should address those regulations that depart substantially from the national marketplace. As noted above, only eight other states require insurers to accept any and all applicants (guaranteed issue). None of the others has such a far-reaching guarantee.

Three provide for an enrollment cap and one limits guaranteed issue to an annual 60-day open-enrollment period. Either approach would be preferable to Washington's current policy.

Washington has the shortest preexisting-condition limit, excepting Rhode Island, which does not require guaranteed issue. Adopting the more typical twelve-month limit would help restore market stability.

These modest recommendations would bring Washington's health insurance rules and regulations closer to alignment with the federal 1996 Health Insurance Portability and Accountability Act.

Under HIPPA, preexisting-condition limitations must relate to a condition for which medical advice was recommended or received during the six-month period prior to an individual's enrollment date. The exclusion may not last more than twelve months after the enrollment date, and it must be reduced by the number of days an individual had prior coverage without a break in coverage of 63 days or more. Changing Washington's regulation to align with the federal law would be appropriate.

Washington residents are best served by a strong, competitive health insurance market, supplemented by a small, effective safety net. The goal is achievable.

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