1 **6089 AMS PELZ S4386.4**

2 **SB 6089** - S AMD TO WM COMM AMD (S-4141.1/92)
3 By Senator Pelz

4 WITHDRAWN 3/5/92

5 Beginning on page 6, line 21 of the amendment, strike all material
6 through page 13, line 26, and insert the following:

7 "**Sec. 5.** RCW 70.47.060 and 1991 sp.s. c 4 s 2 and 1991 c 3 s 339
8 are each reenacted and amended to read as follows:
9 The administrator has the following powers and duties:
10 (1) To design and from time to time revise a schedule of covered
11 basic health care services, including physician services, inpatient and
12 outpatient hospital services, and other services that may be necessary
13 for basic health care, which enrollees in any participating managed
14 health care system under the Washington basic health plan shall be
15 entitled to receive in return for premium payments to the plan. The
16 schedule of services shall emphasize proven preventive and primary
17 health care, shall include all services necessary for prenatal,
18 postnatal, and well-child care, and shall include a separate schedule
19 of basic health care services for children, eighteen years of age and
20 younger, for those enrollees who choose to secure basic coverage
21 through the plan only for their dependent children. In designing and
22 revising the schedule of services, the administrator shall consider the
23 guidelines for assessing health services under the mandated benefits
24 act of 1984, RCW 48.42.080, and such other factors as the administrator
25 deems appropriate.
26 (2) To design and implement a structure of periodic premiums due
27 the administrator from enrollees that is based upon gross family
28 income, giving appropriate consideration to family size as well as the

ages of all family members. The enrollment of children shall not require the enrollment of their parent or parents who are eligible for the plan.

(a) An employer or other financial sponsor may, with the approval of the administrator, pay the premium on behalf of any enrollee, by arrangement with the enrollee and through a mechanism acceptable to the administrator, but in no case shall the payment made on behalf of the enrollee exceed eighty percent of total premiums due from the enrollee.

(b) Premiums due from nonsubsidized enrollees, who are not otherwise eligible to be enrollees, shall be in an amount equal to the cost charged by the managed health care system provider to the state for the plan plus the administrative cost of providing the plan to those enrollees.

(3) To design and implement a structure of nominal copayments due a managed health care system from enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(4) To design and implement, in concert with a sufficient number of potential providers in a discrete area, an enrollee financial participation structure, separate from that otherwise established under this chapter, that has the following characteristics:

(a) Nominal premiums that are based upon ability to pay, but not set at a level that would discourage enrollment;

(b) A modified fee-for-services payment schedule for providers;

(c) Coinsurance rates that are established based on specific service and procedure costs and the enrollee's ability to pay for the care. However, coinsurance rates for families with incomes below one hundred twenty percent of the federal poverty level shall be nominal. No coinsurance shall be required for specific proven prevention

programs, such as prenatal care. The coinsurance rate levels shall not have a measurable negative effect upon the enrollee's health status; and

(d) A case management system that fosters a provider-enrollee relationship whereby, in an effort to control cost, maintain or improve the health status of the enrollee, and maximize patient involvement in her or his health care decision-making process, every effort is made by the provider to inform the enrollee of the cost of the specific services and procedures and related health benefits.

The potential financial liability of the plan to any such providers shall not exceed in the aggregate an amount greater than that which might otherwise have been incurred by the plan on the basis of the number of enrollees multiplied by the average of the prepaid capitated rates negotiated with participating managed health care systems under RCW 70.47.100 and reduced by any sums charged enrollees on the basis of the coinsurance rates that are established under this subsection.

(5) To limit enrollment of persons who qualify for subsidies so as to prevent an overexpenditure of appropriations for such purposes. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment until the administrator finds the danger no longer exists.

(6)(a) To limit the payment of a subsidy to an enrollee, as defined in RCW 70.47.020, whose gross family income at the time of enrollment does not exceed twice the federal poverty level, subject to the provisions of subsection (11) of this section, adjusted for family size and determined annually by the federal department of health and human services.

(b) Except as provided for in subsection (11)(b) of this section, to limit participation of nonsubsidized enrollees in the plan to those whose family incomes at the time of enrollment does not exceed three

times the federal poverty level, subject to the provisions of subsection (11) of this section, adjusted for family size and determined annually by the federal department of health and human services.

(7) To adopt a schedule for the orderly development of the delivery of services and availability of the plan to residents of the state, subject to the limitations contained in RCW 70.47.080.

In the selection of any area of the state for the initial operation of the plan, the administrator shall take into account the levels and rates of unemployment in different areas of the state, the need to provide basic health care coverage to a population reasonably representative of the portion of the state's population that lacks such coverage, and the need for geographic, demographic, and economic diversity.

((~~Before July 1, 1988, the administrator shall endeavor to secure participation contracts with managed health care systems in discrete geographic areas within at least five congressional districts.~~

~~(7)~~)) (8) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state.

((~~(8)~~)) (9) To receive periodic premiums from enrollees, deposit them in the basic health plan operating account, keep records of

enrollee status, and authorize periodic payments to managed health care systems on the basis of the number of enrollees participating in the respective managed health care systems.

((~~(9)~~)) (10) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and at least annually thereafter, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. An enrollee who remains current in payment of the sliding-scale premium, as determined under subsection (2) of this section, and whose gross family income has risen above ((~~twice~~)) three times the federal poverty level, may continue enrollment unless and until the enrollee's gross family income has remained above ((~~twice~~)) three times the poverty level for ((~~six~~)) eighteen consecutive months, by making payment at the unsubsidized rate required for the managed health care system in which he or she may be enrolled plus the administrative cost of providing the plan to that enrollee. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to re-enroll in the plan.

((~~(10)~~)) (11) To accept applications from small business owners on behalf of themselves and their employees, spouses, and dependent children who reside in an area served by the plan. The administrator may require all or the substantial majority of the eligible employees

of such businesses to enroll in the plan and establish those procedures necessary to facilitate the orderly enrollment of groups in the plan and into a managed health care system. For the purposes of this subsection, an employee means an individual who regularly works for the employer for at least twenty hours per week. Such businesses shall have less than one hundred employees and nonsubsidized enrollment shall be limited to those not otherwise eligible for medicare, whose gross family income at the time of enrollment does not exceed three times the federal poverty level as adjusted for family size and determined by the federal department of health and human services, who wish to enroll in the plan at no cost to the state and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. The administrator shall adjust the amount determined to be due on behalf of or from all such enrollees whenever the amount negotiated by the administrator with the participating managed health care system or systems is modified or the administrative cost of providing the plan to such enrollees changes. No nonsubsidized enrollee of a small business group shall be eligible for any subsidy from the plan and at no time shall the administrator allow the credit of the state or funds from the trust account to be used or extended on their behalf. If a small business otherwise eligible under this subsection enrolls all of its eligible nonsubsidized enrollees in the plan, those employees of the business not eligible as nonsubsidized enrollees whose gross family income at the time of enrollment is below two times the federal poverty level as adjusted for family size and determined by the federal department of health and human services, shall be enrolled in the plan as regular subsidized enrollees.

(12) To accept applications from individuals residing in areas serviced by the plan, on behalf of themselves and their spouses and dependent children, under sixty-five years of age and not otherwise

1 eligible for medicare, whose gross family income at the time of
2 enrollment does not exceed three times the federal poverty level as
3 adjusted for family size and determined by the federal department of
4 health and human services, who wish to enroll in the plan at no cost to
5 the state and choose to obtain the basic health care coverage and
6 services from a managed care system participating in the plan. Any
7 such nonsubsidized enrollees must pay the amount negotiated by the
8 administrator with the participating managed health care system and the
9 administrative cost of providing the plan to such nonsubsidized
10 enrollees and shall not be eligible for any subsidy from the plan.

11 (13) To determine the rate to be paid to each participating managed
12 health care system in return for the provision of covered basic health
13 care services to enrollees in the system. Although the schedule of
14 covered basic health care services will be the same for similar
15 enrollees, the rates negotiated with participating managed health care
16 systems may vary among the systems. In negotiating rates with
17 participating systems, the administrator shall consider the
18 characteristics of the populations served by the respective systems,
19 economic circumstances of the local area, the need to conserve the
20 resources of the basic health plan trust account, and other factors the
21 administrator finds relevant. In determining the rate to be paid to a
22 contractor, the administrator shall strive to assure that the rate does
23 not result in adverse cost shifting to other private payers of health
24 care.

25 ((~~(11)~~)) (14) To monitor the provision of covered services to
26 enrollees by participating managed health care systems in order to
27 assure enrollee access to good quality basic health care, to require
28 periodic data reports concerning the utilization of health care
29 services rendered to enrollees in order to provide adequate information
30 for evaluation, and to inspect the books and records of participating

managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed health care systems and to the administrator. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

((~~(12)~~)) (15) To monitor the access that state residents have to adequate and necessary health care services, determine the extent of any unmet needs for such services or lack of access that may exist from time to time, and make such reports and recommendations to the legislature as the administrator deems appropriate.

((~~(13)~~)) (16) To evaluate the effects this chapter has on private employer-based health care coverage and to take appropriate measures consistent with state and federal statutes that will discourage the reduction of such coverage in the state.

((~~(14)~~)) (17) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

((~~(15)~~)) (18) To provide, consistent with available resources, technical assistance for rural health activities that endeavor to develop needed health care services in rural parts of the state."

Correct internal references accordingly.

SB 6089 - S AMD TO WM COMM AMD (S-4141.1/92)
By Senator

On page 15, after line 28 of the amendment, insert the following:

1 "NEW SECTION. **Sec. 9.** The sum of six million dollars, or as
2 much thereof as may be necessary, is appropriated for the biennium
3 ending June 30, 1993, from the general fund to the basic health plan
4 for the purposes of subsidizing small business enrollees under RCW
5 70.47.060(11)."

6 "NEW SECTION. **Sec. 10.** If specific funding for the purposes of
7 section 9 of this act, referencing section 9 of this act by bill and
8 section number, is not provided by June 30, 1992, in the omnibus
9 appropriations act, section 9 of this act shall be null and void."

10 Renumber the remaining sections consecutively and correct internal
11 references accordingly.

12 **SB 6089** - S AMD TO WM COMM AMD (S-4141.1/92)
13 By Senator Pelz

14 WITHDRAWN 3/5/92

15 On page 66, line 16 of the title amendment, after "penalties;"
16 insert "making an appropriation;"