S-3191.3

SENATE BILL 6035

State of Washington 52nd Legislature 1992 Regular Session

By Senators West, Anderson, Johnson and Bailey

Read first time 01/13/92. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to the basic health plan; amending RCW 70.47.010, 70.47.020, 70.47.040, 70.47.050, 70.47.080, 70.47.090, 70.47.100, 70.47.110, 70.47.120, and 70.47.150; reenacting and amending RCW 70.47.030 and 70.47.060; adding a new section to chapter 70.47 RCW; creating new sections; and repealing RCW 43.131.355 and 43.131.356.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** A new section is added to chapter 70.47 RCW to read as follows:

The powers, duties, and functions of the Washington basic health plan are hereby transferred to the Washington state health care authority. All references to the administrator of the Washington basic health plan in the Revised Code of Washington shall be construed to mean the director of the basic health plan under the Washington state health care authority.

NEW SECTION. **Sec. 2.** All reports, documents, surveys, books, records, files, papers, or written material in the possession of the Washington basic health plan shall be delivered to the custody of the Washington state health care authority. All cabinets, furniture, office equipment, motor vehicles, and other tangible property used by the Washington basic health plan shall be made available to the Washington state health care authority. All funds, credits, or other assets held by the Washington basic health plan shall be assigned to the Washington state health care authority.

Any appropriations made to the Washington basic health plan shall, on the effective date of this section, be transferred and credited to the Washington state health care authority. At no time may those funds in the basic health plan trust account, any funds appropriated for the subsidy of any enrollees or any premium payments or other sums made or received on behalf of any enrollees in the basic health plan be commingled with any appropriated funds designated or intended for the purposes of providing health care coverage to any state or other public employees.

Whenever any question arises as to the transfer of any personnel, funds, books, documents, records, papers, files, equipment, or other tangible property used or held in the exercise of the powers and the performance of the duties and functions transferred, the director of financial management shall make a determination as to the proper allocation and certify the same to the state agencies concerned.

NEW SECTION. **Sec. 3.** All employees of the Washington basic health plan are transferred to the jurisdiction of the Washington state health care authority. All employees classified under chapter 41.06 RCW, the state civil service law, are assigned to the Washington state health care authority to perform their usual duties upon the same terms

as formerly, without any loss of rights, subject to any action that may be appropriate thereafter in accordance with the laws and rules governing state civil service.

NEW SECTION. **Sec. 4.** All rules and all pending business before the Washington basic health plan shall be continued and acted upon by the Washington state health care authority. All existing contracts and obligations shall remain in full force and shall be performed by the Washington state health care authority.

NEW SECTION. **Sec. 5.** The transfer of the powers, duties, functions, and personnel of the Washington basic health plan shall not affect the validity of any act performed prior to the effective date of this section.

NEW SECTION. **Sec. 6.** If apportionments of budgeted funds are required because of the transfers directed by sections 2 through 5 of this act, the director of financial management shall certify the apportionments to the agencies affected, the state auditor, and the state treasurer. Each of these shall make the appropriate transfer and adjustments in funds and appropriation accounts and equipment records in accordance with the certification.

NEW SECTION. **Sec. 7.** Nothing contained in sections 1 through 6 of this act may be construed to alter any existing collective bargaining unit or the provisions of any existing collective bargaining agreement until the agreement has expired or until the bargaining unit has been modified by action of the personnel board as provided by law.

Sec. 8. RCW 70.47.010 and 1987 1st ex.s. c 5 s 3 are each amended to read as follows:

(1) The legislature finds that:

(a) A significant percentage of the population of this state does not have reasonably available insurance or other coverage of the costs of necessary basic health care services;

(b) This lack of basic health care coverage is detrimental to the health of the individuals lacking coverage and to the public welfare, and results in substantial expenditures for emergency and remedial health care, often at the expense of health care providers, health care facilities, and all purchasers of health care, including the state; and

(c) The use of managed health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state generally, and by low-income pregnant women who are an especially vulnerable population, along with their children, and who need greater access to managed health care.

(2) The purpose of this chapter is to provide necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization of necessary health care services. To that end, this chapter establishes a program to be made available to those residents under sixty-five years of age not otherwise eligible for medicare with gross family income at or below two hundred percent of the federal poverty guidelines who share in the cost of receiving basic health care services from a managed health care system.

(3) It is not the intent of this chapter to provide health care services for those persons who are presently covered through private employer-based health plans, nor to replace employer-based health plans. Further, it is the intent of the legislature to expand,

wherever possible, the availability of private health care coverage and to discourage the decline of employer-based coverage.

(4) ((~~The program authorized under this chapter is strictly limited in respect to the total number of individuals who may be allowed to participate and the specific areas within the state where it may be established. All such restrictions or limitations shall remain in full force and effect until quantifiable evidence based upon the actual operation of the program, including detailed cost benefit analysis, has been presented to the legislature and the legislature, by specific act at that time, may then modify such limitations~~))

(a) It is the purpose of this chapter to acknowledge the initial success of this program that has (i) assisted thousands of families in their search for affordable health care; (ii) demonstrated that low-income uninsured families are willing to pay for their own health care coverage to the extent of their ability to pay; and (iii) proved that local health care providers are willing to enter into a public/private partnership as they configure their own professional and business relationships into a managed care system.

(b) As a consequence, the legislature intends to extend the option to enroll to certain citizens between two hundred and three hundred percent of federal poverty guidelines within the state who reside in communities where the plan is operational and who collectively or individually wish to exercise the opportunity to purchase health care coverage through the program if it is done at no cost to the state.

Sec. 9. RCW 70.47.020 and 1987 1st ex.s. c 5 s 4 are each amended to read as follows:

As used in this chapter:

(1) "Washington basic health plan" or "plan" means the system of enrollment and payment on a prepaid capitated basis for basic health

care services, administered by the plan ((~~administrator~~)) director through participating managed health care systems, created by this chapter.

(2) "Director" means the Washington basic health plan director.

(3) "Administrator" means the ((~~Washington basic health plan~~)) administrator of the state health care authority.

((~~(3)~~)) (4) "Managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the ((~~administrator~~)) director and rendered by duly licensed providers, on a prepaid capitated basis to a defined patient population enrolled in the plan and in the managed health care system.

((~~(4)~~)) (5) "Enrollee" means an individual, or an individual plus the individual's spouse and/or dependent children, all under the age of sixty-five and not otherwise eligible for medicare, who resides in an area of the state served by a managed health care system participating in the plan, whose gross family income at the time of enrollment does not exceed twice the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services, who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan.

((~~(5)~~)) Nonsubsidized enrollees shall be considered enrollees unless otherwise specified.

(6) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse and/or dependent children not otherwise eligible for medicare, who reside in an area of the state served by a managed health care system participating in the plan, 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 choose to obtain basic health care coverage from a particular managed care system in return for periodic payments to the plan. "Nonsubsidized enrollee" also includes any enrollee who originally enrolled subject to the income limitations specified in subsection (5) of this section, but who subsequently pays the full unsubsidized premium as set forth in RCW 70.47.060(9).

(7) "Subsidy" means the difference between the amount of periodic payment the ((~~administrator~~)) director makes, from funds appropriated from the basic health plan trust account, to a managed health care system on behalf of an enrollee plus the administrative cost to the plan of providing the plan to that enrollee, and the amount determined to be the enrollee's responsibility under RCW 70.47.060(2).

((~~(6)~~)) (8) "Premium" means a periodic payment, based upon gross family income and determined under RCW 70.47.060(2), which an enrollee makes to the plan as consideration for enrollment in the plan.

((~~(7)~~)) (9) "Rate" means the per capita amount, negotiated by the ((~~administrator~~)) director with and paid to a participating managed health care system, that is based upon the enrollment of enrollees in the plan and in that system.

Sec. 10. RCW 70.47.030 and 1991 sp.s. c 13 s 68 and 1991 sp.s. c 4 s 1 are each reenacted and amended to read as follows:

(1) The basic health plan trust account is hereby established in the state treasury. ((~~All~~)) Any nongeneral fund-state funds collected for this program shall be deposited in the basic health plan trust account and may be expended without further appropriation. Moneys in the account shall be used exclusively for the purposes of this chapter,

including payments to participating managed health care systems on behalf of enrollees in the plan and payment of costs of administering the plan. After July 1, 1991, the ((~~administrator~~)) director shall not expend or encumber for an ensuing fiscal period amounts exceeding ninety-five percent of the amount anticipated to be spent for purchased services during the fiscal year.

(2) The basic health plan subscription account is created in the custody of the state treasurer. All receipts from amounts due under RCW 70.47.060(10) and (11) shall be deposited into the account. Funds in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of enrollees in the plan and payment of costs of administrating the plan. The account is subject to allotment procedures under chapter 43.88 RCW, but no appropriation is required for expenditures.

(3) The director shall take every precaution to see that none of the funds in the separate accounts created in this section or that any premiums paid either by subsidized or nonsubsidized enrollees are commingled in any way, except that the director may combine funds designated for administration of the plan into a single administrative account.

Sec. 11. RCW 70.47.040 and 1987 1st ex.s. c 5 s 6 are each amended to read as follows:

(1) The Washington basic health plan is created as an independent ((~~agency of the state~~)) program within the Washington state health care authority. The administrative head and appointing authority of the plan shall be the ((~~administrator~~)) director who shall be appointed by the ((~~governor, with the consent of the senate~~)) administrator, and shall serve at the administrator's pleasure ((~~of the governor. The~~

~~salary for this office shall be set by the governor pursuant to RCW 43.03.040~~)). The administrator shall appoint a medical director. The ((~~administrator~~)) director, medical director, and up to five other employees shall be exempt from the civil service law, chapter 41.06 RCW.

(2) The ((~~administrator~~)) director shall employ such other staff as are necessary to fulfill the responsibilities and duties of the ((~~administrator~~)) director, such staff to be subject to the civil service law, chapter 41.06 RCW. In addition, the ((~~administrator~~)) director may contract with third parties for services necessary to carry out its activities where this will promote economy, avoid duplication of effort, and make best use of available expertise. Any such contractor or consultant shall be prohibited from releasing, publishing, or otherwise using any information made available to it under its contractual responsibility without specific permission of the plan. The ((~~administrator~~)) director may call upon other agencies of the state to provide available information as necessary to assist the ((~~administrator~~)) director in meeting its responsibilities under this chapter, which information shall be supplied as promptly as circumstances permit.

(3) The ((~~administrator~~)) director may appoint such technical or advisory committees as he or she deems necessary. The ((~~administrator~~)) director shall appoint a standing technical advisory committee that is representative of health care professionals, health care providers, and those directly involved in the purchase, provision, or delivery of health care services, as well as consumers and those knowledgeable of the ethical issues involved with health care public policy. Individuals appointed to any technical or other advisory committee shall serve without compensation for their services as

members, but may be reimbursed for their travel expenses pursuant to RCW 43.03.050 and 43.03.060.

(4) The ((~~administrator~~)) director may apply for, receive, and accept grants, gifts, and other payments, including property and service, from any governmental or other public or private entity or person, and may make arrangements as to the use of these receipts, including the undertaking of special studies and other projects relating to health care costs and access to health care.

(5) In the design, organization, and administration of the plan under this chapter, the ((~~administrator~~)) director shall consider the report of the Washington health care project commission established under chapter 303, Laws of 1986. Nothing in this chapter requires the ((~~administrator~~)) director to follow any specific recommendation contained in that report except as it may also be included in this chapter or other law.

(6) Whenever feasible and practical, the director shall reduce the administrative costs of operating the program by adopting joint policies and procedures with the administrator to increase administrative efficiencies.

Sec. 12. RCW 70.47.050 and 1987 1st ex.s. c 5 s 7 are each amended to read as follows:

The ((~~administrator~~)) director may promulgate and adopt rules consistent with this chapter to carry out the purposes of this chapter. All rules shall be adopted in accordance with chapter 34.05 RCW.

Sec. 13. RCW 70.47.060 and 1991 sp.s. c 4 s 2 and 1991 c 3 s 339 are each reenacted and amended to read as follows:

The ((~~administrator~~)) director has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, and other services that may be necessary for basic health care, which enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care, shall include all services necessary for prenatal, postnatal, and well-child care, and shall include a separate schedule of basic health care services for children, eighteen years of age and younger, for those enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the ((~~administrator~~)) director shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.42.080, and such other factors as the ((~~administrator~~)) director deems appropriate.

(2) (a) To design and implement a structure of periodic premiums due the ((~~administrator~~)) director from enrollees that is based upon gross family 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 third party may, with the approval of the director, pay the premium on behalf of any enrollee, by arrangement with the enrollee and through a mechanism acceptable to the director, but in no case shall the payment made on behalf of the enrollee by the third party 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~~)) director finds that there is danger of such an overexpenditure, the ((~~administrator~~)) director shall close enrollment until the ((~~administrator~~)) director finds the danger no longer exists.

(6) 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~~)) director 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) 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~~)) director 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~~)) director 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) 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) 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 the federal poverty level, may continue enrollment ((~~unless and until the enrollee's gross family income has remained above twice the poverty level for six 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~~)) director may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to re-enroll in the plan.

(10) To accept applications from small business owners on behalf of themselves and their employees who reside in an area served by the plan. The director 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. Such businesses shall have less than fifty employees and 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 director shall adjust the amount determined to be due on behalf of or from all such enrollees whenever the amount negotiated by the director with the participating managed health care system or systems is modified or the administrative cost of providing the plan to such enrollees changes. No enrollee of a small business group shall be eligible for any subsidy from the plan and at no time shall the director allow the credit of the state or funds from the trust account to be used or extended on their behalf.

(11) To accept applications from individuals residing in areas serviced by the plan, on behalf of themselves and their spouses and dependent children, all under sixty-five years of age and 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. Any such nonsubsidized enrollees must pay the amount negotiated by the director with the participating managed health care system and the administrative cost of providing the plan to such nonsubsidized enrollees and shall not be eligible for any subsidy from the plan.

(12) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the ((~~administrator~~)) director shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the ((~~administrator~~)) director finds relevant.

((~~(11)~~)) (13) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information 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~~)) director shall endeavor to minimize costs, both to the managed health care systems and to the administrator. The ((~~administrator~~)) director 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)~~)) (14) 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~~)) director deems appropriate.

((~~(13)~~)) (15) 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)~~)) (16) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

((~~(15)~~)) (17) 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.

Sec. 14. RCW 70.47.080 and 1987 1st ex.s. c 5 s 10 are each amended to read as follows:

On and after July 1, 1988, the ((~~administrator~~)) director shall accept for enrollment applicants eligible to receive covered basic health care services from the respective managed health care systems which are then participating in the plan. ((~~The administrator shall not allow the total enrollment of those eligible for subsidies to exceed thirty thousand.~~))

Thereafter, ((~~total~~)) the average monthly enrollment of those eligible for subsidies during any biennium shall not exceed the number established by the legislature in any act appropriating funds to the

plan, and total subsidized enrollment shall not result in expenditures that exceed the total amount that has been made available by the legislature in any act appropriating funds to the plan.

((~~Before July 1, 1988, the administrator shall endeavor to secure participation contracts from managed health care systems in discrete geographic areas within at least five congressional districts of the state and in such manner as to allow residents of both urban and rural areas access to enrollment in the plan. The administrator shall make a special effort to secure agreements with health care providers in one such area that meets the requirements set forth in RCW 70.47.060(4).~~))

The ((~~administrator~~)) director shall at all times closely monitor growth patterns of enrollment so as not to exceed that consistent with the orderly development of the plan as a whole, in any area of the state or in any participating managed health care system. The annual or biennial enrollment limitations derived from operation of the plan under this section do not apply to nonsubsidized enrollees as defined in RCW 70.47.020(6).

Sec. 15. RCW 70.47.090 and 1987 1st ex.s. c 5 s 11 are each amended to read as follows:

Any enrollee whose premium payments to the plan are delinquent or who moves his or her residence out of an area served by the plan may be dropped from enrollment status. An enrollee whose premium is the responsibility of the department of social and health services under RCW 70.47.110 may not be dropped solely because of nonpayment by the department. The ((~~administrator~~)) director shall provide delinquent enrollees with advance written notice of their removal from the plan and shall provide for a hearing under chapters 34.05 and 34.12 RCW for any enrollee who contests the decision to drop the enrollee from the plan. Upon removal of an enrollee from the plan, the ((~~administrator~~))

director shall promptly notify the managed health care system in which the enrollee has been enrolled, and shall not be responsible for payment for health care services provided to the enrollee (including, if applicable, members of the enrollee's family) after the date of notification. A managed health care system may contest the denial of payment for coverage of an enrollee through a hearing under chapters 34.05 and 34.12 RCW.

Sec. 16. RCW 70.47.100 and 1987 1st ex.s. c 5 s 12 are each amended to read as follows:

Managed health care systems participating in the plan shall do so by contract with the ((~~administrator~~)) director and shall provide, directly or by contract with other health care providers, covered basic health care services to each enrollee as long as payments from the ((~~administrator~~)) director on behalf of the enrollee are current. A participating managed health care system may offer, without additional cost, health care benefits or services not included in the schedule of covered services under the plan. A participating managed health care system shall not give preference in enrollment to enrollees who accept such additional health care benefits or services. Managed health care systems participating in the plan shall not discriminate against any potential or current enrollee based upon health status, sex, race, ethnicity, or religion. The ((~~administrator~~)) director may receive and act upon complaints from enrollees regarding failure to provide covered services or efforts to obtain payment, other than authorized copayments, for covered services directly from enrollees, but nothing in this chapter empowers the ((~~administrator~~)) director to impose any sanctions under Title 18 RCW or any other professional or facility licensing statute.

The plan shall allow, at least annually, an opportunity for enrollees to transfer their enrollments among participating managed health care systems serving their respective areas. The ((~~administrator~~)) director shall establish a period of at least twenty days in a given year when this opportunity is afforded enrollees, and in those areas served by more than one participating managed health care system the ((~~administrator~~)) director shall endeavor to establish a uniform period for such opportunity. The plan shall allow enrollees to transfer their enrollment to another participating managed health care system at any time upon a showing of good cause for the transfer.

Any contract entered into before June 30, 1990, between a hospital and a participating managed health care system under this chapter is subject to the requirements of RCW 70.39.140(1) regarding negotiated rates.

Prior to negotiating with any managed health care system, the ((~~administrator~~)) director shall determine, on an actuarially sound basis, the reasonable cost of providing the schedule of basic health care services, expressed in terms of upper and lower limits, and recognizing variations in the cost of providing the services through the various systems and in different areas of the state. In negotiating with managed health care systems for participation in the plan, the ((~~administrator~~)) director shall adopt a uniform procedure that includes at least the following:

(1) The ((~~administrator~~)) director shall issue a request for proposals, including standards regarding the quality of services to be provided; financial integrity of the responding systems; and responsiveness to the unmet health care needs of the local communities or populations that may be served;

(2) The ((~~administrator~~)) director shall then review responsive proposals and may negotiate with respondents to the extent necessary to refine any proposals;

(3) The ((~~administrator~~)) director may then select one or more systems to provide the covered services within a local area; and

(4) The ((~~administrator~~)) director may adopt a policy that gives preference to respondents, such as nonprofit community health clinics, that have a history of providing quality health care services to low-income persons.

Sec. 17. RCW 70.47.110 and 1991 sp.s. c 4 s 3 are each amended to read as follows:

The department of social and health services may make payments to the ((~~administrator~~)) director or to participating managed health care systems on behalf of any enrollee who is a recipient of medical care under chapter 74.09 RCW, at the maximum rate allowable for federal matching purposes under Title XIX of the social security act. Any enrollee on whose behalf the department of social and health services makes such payments may continue as an enrollee, making premium payments based on the enrollee's own income as determined under the sliding scale, after eligibility for coverage under chapter 74.09 RCW has ended, as long as the enrollee remains eligible under this chapter. Nothing in this section affects the right of any person eligible for coverage under chapter 74.09 RCW to receive the services offered to other persons under that chapter but not included in the schedule of basic health care services covered by the plan. The ((~~administrator~~)) director shall seek to determine which enrollees or prospective enrollees may be eligible for medical care under chapter 74.09 RCW and may require these individuals to complete the eligibility determination process under chapter 74.09 RCW prior to enrollment or continued

participation in the plan. The ((~~administrator~~)) director and the department of social and health services shall cooperatively adopt procedures to facilitate the transition of plan enrollees and payments on their behalf between the plan and the programs established under chapter 74.09 RCW.

Sec. 18. RCW 70.47.120 and 1987 1st ex.s. c 5 s 14 are each amended to read as follows:

In addition to the powers and duties specified in RCW 70.47.040 and 70.47.060, the ((~~administrator~~)) director has the power to enter into contracts for the following functions and services:

(1) With public or private agencies, to assist the ((~~administrator~~)) director in her or his duties to design or revise the schedule of covered basic health care services, and/or to monitor or evaluate the performance of participating managed health care systems.

(2) With public or private agencies, to provide technical or professional assistance to health care providers, particularly public or private nonprofit organizations and providers serving rural areas, who show serious intent and apparent capability to participate in the plan as managed health care systems.

(3) With public or private agencies, including health care service contractors registered under RCW 48.44.015, and doing business in the state, for marketing and administrative services in connection with participation of managed health care systems, enrollment of enrollees, billing and collection services to the ((~~administrator~~)) director, and other administrative functions ordinarily performed by health care service contractors, other than insurance except that the director may purchase or arrange for the purchase of reinsurance, or self-insure for reinsurance, on behalf of its participating managed health care systems. Any activities of a health care service contractor pursuant

to a contract with the ((~~administrator~~)) director under this section shall be exempt from the provisions and requirements of Title 48 RCW.

Sec. 19. RCW 70.47.150 and 1990 c 54 s 1 are each amended to read as follows:

Notwithstanding the provisions of chapter 42.17 RCW, (1) records obtained, reviewed by, or on file with the plan containing information concerning medical treatment of individuals shall be exempt from public inspection and copying; and (2) actuarial formulas, statistics, and assumptions submitted in support of a rate filing by a managed health care system or submitted to the ((~~administrator~~)) director upon his or her request shall be exempt from public inspection and copying in order to preserve trade secrets or prevent unfair competition.

NEW SECTION. **Sec. 20.** The following acts or parts of acts are each repealed:

(1) RCW 43.131.355 and 1987 1st ex.s. c 5 s 24; and

(2) RCW 43.131.356 and 1987 1st ex.s. c 5 s 25.