5076 AMS DECC S-3470.1

SB 5076 - S AMD TO S AMD #1017 - 001018
By Senators Deccio, West, Moyer, Bluechel and McDonald

NOT ADOPTED 4/23/93 - Roll Call Vote 20-29

Beginning on page 1, line 7, after "Sec. 1." strike the remainder of the amendment and insert the following:

"**Sec. 1.** 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 or make available 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~~)) three hundred percent of the federal poverty guidelines, except as provided for in RCW 70.47.060(11)(b), who share in a portion of the cost or who pay the full 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 make the program available to individuals in the state with incomes below three hundred percent of federal poverty guidelines, except as provided for in RCW 70.47.060(11)(b), 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. It is also the intent of the legislature to allow employers and other financial sponsors to financially assist such individuals in purchasing health care through the program.

Sec. 2. 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 through participating managed health care systems, created by this chapter.

(2) "Administrator" means the Washington basic health plan administrator.

(3) "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 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) "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. Nonsubsidized enrollees shall be considered enrollees unless otherwise specified.

(5) "Nonsubsidized enrollee" means an enrollee who pays the full premium for participation in the plan and shall not be eligible for any subsidy from the plan.

(6) "Subsidy" means the difference between the amount of periodic payment the administrator 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)~~)) (7) "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)~~)) (8) "Rate" means the per capita amount, negotiated by the administrator 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. 3. RCW 70.47.030 and 1992 c 232 s 907 are each 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, 1993, the administrator 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 (11) and (12) 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 administrator 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 administrator may combine funds designated for administration of the plan into a single administrative account.

Sec. 4. RCW 70.47.060 and 1992 c 232 s 908 are each amended to read as follows:

The administrator 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 and shall include all services necessary for prenatal, postnatal, and well-child care. However, for the period ending June 30, 1993, with respect to coverage for groups of subsidized enrollees, the administrator shall not contract for prenatal or postnatal services

that are provided under the medical assistance program under chapter 74.09 RCW except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider, or except to provide any such services associated with pregnancies diagnosed by the managed care provider before July 1, 1992. The schedule of services shall also 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 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 deems appropriate.

(2) To design and implement a structure of periodic premiums due the administrator 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) 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 only of those enrollees, as defined in RCW 70.47.020, whose gross family income at the time of enrollment does not exceed twice the federal poverty level 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 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. Except as provided for in subsection (11)(b) of this section, 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)(a) 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 fifty or fewer 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 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 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.

(b) Notwithstanding income limitations provided for in (a) of this subsection, if seventy-five percent or more of employees in a small business at the time of enrollment have gross family incomes that do not exceed three times the federal poverty level as adjusted for family size and determined by the federal department of health and human services, all employees in the small business will be eligible for enrollment under this subsection. The plan shall annually require participating small businesses enrolled under this subsection (11)(b) to provide evidence of gross family incomes of enrolled employees for purposes of determining continued eligibility of such employees under this subsection (11)(b). To minimize the burden and cost of complying with this reporting requirement, the plan shall accept documentation from the small business that provides such information as may be required by other state agencies. Should more than twenty-five percent of employees of an enrolled small business be found to have gross family incomes exceeding three times the federal poverty level, the plan shall notify the small business that those employees are no longer eligible for enrollment and shall disenroll these employees eighteen months after the notification. The remaining employees of such small businesses who have gross family incomes below three times the federal poverty level will continue to be eligible enrollees under (a) of this subsection.

(12) To accept applications from individuals residing in areas serviced by the plan, on behalf of themselves and their spouses and dependent children, 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 administrator 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.

(13) 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 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 finds relevant. In determining the rate to be paid to a contractor, the administrator shall strive to assure that the rate does not result in adverse cost shifting to other private payers of health care.

((~~(11)~~)) (14) 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 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.

Sec. 5. 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 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 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(5).

Sec. 6. 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 has the power to enter into contracts for the following functions and services:

(1) With public or private agencies, to assist the administrator 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, and other administrative functions ordinarily performed by health care service contractors, other than insurance except that the administrator 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 under this section shall be exempt from the provisions and requirements of Title 48 RCW.

NEW SECTION. **Sec. 7.** BASIC HEALTH PLAN EXPANSION. The Washington basic health plan authorized under chapter 70.47 RCW is expanded for the purposes of enrolling a total of one hundred thousand members during the 1993-95 biennium.

NEW SECTION. **Sec. 8.** The following acts or parts of acts are each repealed:

(1) Part I of chapter . . . (Engrossed Second Substitute Senate Bill No. 5304), Laws of 1993;

(2) Subpart A of Part II of chapter . . . (Engrossed Second Substitute Senate Bill No. 5304), Laws of 1993;

(3) Subpart B of Part II of chapter . . . (Engrossed Second Substitute Senate Bill No. 5304), Laws of 1993;

(4) Subpart C of Part II of chapter . . . (Engrossed Second Substitute Senate Bill No. 5304), Laws of 1993;

(5) Subpart D of Part II of chapter . . . (Engrossed Second Substitute Senate Bill No. 5304), Laws of 1993;

(6) Subpart E of Part II of chapter . . . (Engrossed Second Substitute Senate Bill No. 5304), Laws of 1993;

(7) Subpart F of Part II of chapter . . . (Engrossed Second Substitute Senate Bill No. 5304), Laws of 1993;

(8) Subpart of Part II of chapter . . . (Engrossed Second Substitute Senate Bill No. 5304), Laws of 1993;

(9) Subpart H of Part II of chapter . . . (Engrossed Second Substitute Senate Bill No. 5304), Laws of 1993;

(10) Sections 293 through 296 of Subpart I of chapter . . . (Engrossed Second Substitute Senate Bill No. 5304), Laws of 1993; and

(11) Part IV of chapter . . . (Engrossed Second Substitute Senate Bill No. 5304), Laws of 1993."

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By Senators Deccio, West, Moyer, Bluechel and McDonald

NOT ADOPTED 4/23/93

On page 17, line 4 of the title amendment, after ’reform;" strike the remainder of the title and insert "amending RCW ; creating a new section; and repealing Part I, subparts A, B, C, D, E, F, G, H, and sections 293 through 296 of Subpart I, and Part IV of chapter . . . (Engrossed Second Substitute Senate bill No. 5304), Laws of 1993."

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