ESSB 5386 - H AMD **892 ADOPTED 4/18/95**

By Representative Dyer

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** RCW 70.47.060 and 1994 c 309 s 5 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, prescription drugs and medications, and other services that may be necessary for basic health care ((~~, which~~)). In addition, the administrator may offer as basic health plan services chemical dependency services, mental health services and organ transplant services; however, no one service or any combination of these three services shall increase the actuarial value of the basic health plan benefits by more than five percent excluding inflation, as determined by the office of financial management. All subsidized and nonsubsidized 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, with respect to coverage for groups of subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services 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.

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 subsidized or nonsubsidized 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. ((~~On and after July 1, 1995, the uniform benefits package adopted and from time to time revised by the Washington health services commission pursuant to RCW 43.72.130 shall be implemented by the administrator as the schedule of covered basic health care services.~~))

However, with respect to coverage for subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that the 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.

(2)(a) To design and implement a structure of periodic premiums due the administrator from subsidized enrollees that is based upon gross family income, giving appropriate consideration to family size and 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. The structure of periodic premiums shall be applied to subsidized enrollees entering the plan as individuals pursuant to subsection (9) of this section and to the share of the cost of the plan due from subsidized enrollees entering the plan as employees pursuant to subsection (10) of this section.

(b) To determine the periodic premiums due the administrator from nonsubsidized enrollees. Premiums due from nonsubsidized

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 and the premium tax under RCW 48.14.0201.

(c) An employer or other financial sponsor may, with the prior approval of the administrator, pay the premium, rate, or any other amount on behalf of a subsidized or nonsubsidized 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 the total premiums due from the enrollee.

(d) To develop, as an offering by all health carriers providing coverage identical to the basic health plan, a model plan benefits package with uniformity in enrollee cost-sharing requirements.

(3) To design and implement a structure of ((~~copayments~~)) enrollee cost sharing due a managed health care system from subsidized and nonsubsidized enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, and may utilize copayments, deductibles, and other cost-sharing mechanisms, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services. ((~~On and after July 1, 1995, the administrator shall endeavor to make the copayments structure of the plan consistent with enrollee point of service cost-sharing levels adopted by the Washington health services commission, giving consideration to funding available to the plan.~~))

(4) 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.

(5) To limit the payment of subsidies to subsidized enrollees, as defined in RCW 70.47.020. The level of subsidy provided to

persons who qualify may be based on the lowest cost plans, as defined by the administrator.

(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 or any act appropriating funds for the plan.

(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 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. Contracts with participating managed health care systems shall ensure that basic health plan enrollees who become eligible for medical assistance may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

(8) To receive periodic premiums from or on behalf of subsidized and nonsubsidized 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 as subsidized or nonsubsidized enrollees, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and ((~~at least semiannually thereafter~~)) on a reasonable schedule defined by the authority, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. 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, as a result of an eligibility review, the administrator determines that a subsidized enrollee's income exceeds twice the federal poverty level and that the enrollee knowingly failed to inform the plan of such increase in income, the administrator may bill the enrollee for the subsidy paid on the enrollee's behalf during the period of time that the enrollee's income exceeded twice the federal poverty level. 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) To accept applications from business owners on behalf of themselves and their employees, spouses, and dependent children, as subsidized or nonsubsidized enrollees, 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. The administrator ((~~shall~~)) may require that a business owner pay at least ((~~fifty percent of the nonsubsidized~~)) an amount equal to what the employee pays after the state pays its portion of the subsidized premium cost of the plan on behalf of each employee enrolled in the plan. Enrollment is limited to those not eligible for medicare who wish to enroll in the plan 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.

(11) 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.

(12) 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 plan. 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.

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

(15) To provide, consistent with available funding, assistance for rural residents, underserved populations, and persons of color.

Sec. 2. RCW 70.47.020 and 1994 c 309 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, who also holds the position of administrator of the Washington state health care authority.

(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. ((~~On and after July 1, 1995, "managed health care system" means a certified health plan, as defined in RCW 43.72.010.~~))

(4) "Subsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children, not

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 the administrator determines shall not have, or shall not have voluntarily relinquished health insurance more comprehensive than that offered by the plan as of the effective date of enrollment,~~)) and 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 enrollee" means an individual, or an individual plus the individual's spouse or dependent children, not eligible for medicare, who resides in an area of the state served by a managed health care system participating in the plan, ((~~who the administrator determines shall not have, or shall not have voluntarily relinquished health insurance more comprehensive than that offered by the plan as of the effective date of enrollment,~~)) and who chooses to obtain basic health care coverage from a particular managed health care system, and who pays or on whose behalf is paid the full costs for participation in the plan, without any subsidy from the plan.

(6) "Subsidy" means the difference between the amount of periodic payment the administrator makes to a managed health care system on behalf of a subsidized enrollee plus the administrative cost to the plan of providing the plan to that subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

(7) "Premium" means a periodic payment, based upon gross family income which an individual, their employer or another financial sponsor makes to the plan as consideration for enrollment in the plan as a subsidized enrollee or a nonsubsidized enrollee.

(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 subsidized and nonsubsidized enrollees in the plan and in that system.

NEW SECTION. **Sec. 3.** A new section is added to chapter 70.47 RCW to read as follows:

(1) The legislature recognizes that every individual possesses a fundamental right to exercise their religious beliefs and conscience. The legislature further recognizes that in developing public policy, conflicting religious and moral beliefs must be respected. Therefore, while recognizing the right of conscientious objection to participating in specific health services, the state shall also recognize the right of individuals enrolled with the basic health plan to receive the full range of services covered under the basic health plan.

(2)(a) No individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstances to participate in the provision of or payment for a specific service if they object to so doing for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objection.

(b) The provisions of this section are not intended to result in an enrollee being denied timely access to any service included in the basic health plan. Each health carrier shall:

(i) Provide written notice to enrollees, upon enrollment with the plan, listing services that the carrier refuses to cover for reason of conscience or religion;

(ii) Provide written information describing how an enrollee may directly access services in an expeditious manner; and

(iii) Ensure that enrollees refused services under this section have prompt access to the information developed pursuant to (b)(ii) of this subsection.

(c) The administrator shall establish a mechanism or mechanisms to recognize the right to exercise conscience while ensuring enrollees timely access to services and to assure prompt payment to service providers.

(3)(a) No individual or organization with a religious or moral tenet opposed to a specific service may be required to purchase coverage for that service or services if they object to doing so for reason of conscience or religion.

(b) The provisions of this section shall not result in an enrollee being denied coverage of, and timely access to, any service or services excluded from their benefits package as a result of their employer's or another individual's exercise of the conscience clause in (a) of this subsection.

(c) The administrator shall define the process through which health carriers may offer the basic health plan to individuals and organizations identified in (a) and (b) of this subsection in accordance with the provisions of subsection (2)(c) of this section.

(4) Nothing in this section requires the health care authority, health carriers, health care facilities, or health care providers to provide any basic health plan service without payment of appropriate premium share or enrollee cost sharing.

NEW SECTION. **Sec. 4.** RCW 70.47.065 and 1993 c 494 s 6 are each repealed.

NEW SECTION. **Sec. 5.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect July 1, 1995."

Correct the title accordingly.

EFFECT: Adds chemical dependency services, mental health services and organ transplant services to Basic Health Plan coverage, however, growth is limited to 5% of value of the plan.