
SECOND SUBSTITUTE HOUSE BILL 1714

State of Washington 55th Legislature 1997 Regular Session

By House Committee on Appropriations (originally sponsored by Representative McMorris)

Read first time 03/10/97.

1 AN ACT Relating to basic health plan eligibility for persons
2 eligible for medicare; reenacting and amending RCW 70.47.020 and
3 70.47.060; adding a new section to chapter 70.47 RCW; creating a new
4 section; and providing an effective date.

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

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

8 Individuals who are eligible for medicare are eligible to enroll in
9 the basic health plan as a subsidized enrollee if the individual:

10 (1) Pays all or a portion of medicare part A premiums in order to
11 receive medicare part A coverage;

12 (2) Demonstrates that the individual or his or her spouse worked
13 for an employer who did not provide contributions to social security on
14 behalf of the individual or his or her spouse, and as a result the
15 individual is not eligible to receive premium-free medicare part A
16 coverage; and

17 (3) Meets the eligibility criteria established by the administrator
18 under RCW 70.47.060(16).

1 **Sec. 2.** RCW 70.47.020 and 1995 c 266 s 2 and 1995 c 2 s 3 are each
2 reenacted and amended to read as follows:

3 As used in this chapter:

4 (1) "Washington basic health plan" or "plan" means the system of
5 enrollment and payment on a prepaid capitated basis for basic health
6 care services, administered by the plan administrator through
7 participating managed health care systems, created by this chapter.

8 (2) "Administrator" means the Washington basic health plan
9 administrator, who also holds the position of administrator of the
10 Washington state health care authority.

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

18 (4) "Subsidized enrollee" means an individual, or an individual
19 plus the individual's spouse or dependent children((7)): (a) Who is
20 not eligible for medicare, except as provided in section 1 of this act;
21 (b) who resides in an area of the state served by a managed health care
22 system participating in the plan((7)); (c) whose gross family income at
23 the time of enrollment does not exceed twice the federal poverty level
24 as adjusted for family size and determined annually by the federal
25 department of health and human services((7)); and (d) who chooses to
26 obtain basic health care coverage from a particular managed health care
27 system in return for periodic payments to the plan.

28 (5) "Nonsubsidized enrollee" means an individual, or an individual
29 plus the individual's spouse or dependent children((7)): (a) Who is
30 not eligible for medicare((7)); (b) who resides in an area of the state
31 served by a managed health care system participating in the plan((7
32 and)); (c) who chooses to obtain basic health care coverage from a
33 particular managed health care system((7)); and (d) who pays or on
34 whose behalf is paid the full costs for participation in the plan,
35 without any subsidy from the plan.

36 (6) "Subsidy" means the difference between the amount of periodic
37 payment the administrator makes to a managed health care system on
38 behalf of a subsidized enrollee plus the administrative cost to the
39 plan of providing the plan to that subsidized enrollee, and the amount

1 determined to be the subsidized enrollee's responsibility under RCW
2 70.47.060(2).

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

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

11 (9) "Medicare" means the "health insurance for the aged act," Title
12 XVIII of the social security amendments of 1965, as then constituted or
13 later amended.

14 (10) "Medicare part A" means part A coverage as defined by
15 medicare.

16 **Sec. 3.** RCW 70.47.060 and 1995 c 266 s 1 and 1995 c 2 s 4 are each
17 reenacted and amended to read as follows:

18 The administrator has the following powers and duties:

19 (1) To design and from time to time revise a schedule of covered
20 basic health care services, including physician services, inpatient and
21 outpatient hospital services, prescription drugs and medications, and
22 other services that may be necessary for basic health care. In
23 addition, the administrator may offer as basic health plan services
24 chemical dependency services, mental health services and organ
25 transplant services; however, no one service or any combination of
26 these three services shall increase the actuarial value of the basic
27 health plan benefits by more than five percent excluding inflation, as
28 determined by the office of financial management. All subsidized and
29 nonsubsidized enrollees in any participating managed health care system
30 under the Washington basic health plan shall be entitled to receive
31 (~~covered basic health care services~~) covered basic health care
32 services in return for premium payments to the plan. The schedule of
33 services shall emphasize proven preventive and primary health care and
34 shall include all services necessary for prenatal, postnatal, and well-
35 child care. However, with respect to coverage for groups of subsidized
36 enrollees who are eligible to receive prenatal and postnatal services
37 through the medical assistance program under chapter 74.09 RCW, the
38 administrator shall not contract for such services except to the extent

1 that such services are necessary over not more than a one-month period
2 in order to maintain continuity of care after diagnosis of pregnancy by
3 the managed care provider. The schedule of services shall also include
4 a separate schedule of basic health care services for children,
5 eighteen years of age and younger, for those subsidized or
6 nonsubsidized enrollees who choose to secure basic coverage through the
7 plan only for their dependent children. In designing and revising the
8 schedule of services, the administrator shall consider the guidelines
9 for assessing health services under the mandated benefits act of 1984,
10 RCW 48.42.080, and such other factors as the administrator deems
11 appropriate.

12 However, with respect to coverage for subsidized enrollees who are
13 eligible to receive prenatal and postnatal services through the medical
14 assistance program under chapter 74.09 RCW, the administrator shall not
15 contract for such services except to the extent that the services are
16 necessary over not more than a one-month period in order to maintain
17 continuity of care after diagnosis of pregnancy by the managed care
18 provider.

19 (2)(a) To design and implement a structure of periodic premiums due
20 the administrator from subsidized enrollees that is based upon gross
21 family income, giving appropriate consideration to family size and the
22 ages of all family members. The enrollment of children shall not
23 require the enrollment of their parent or parents who are eligible for
24 the plan. The structure of periodic premiums shall be applied to
25 subsidized enrollees entering the plan as individuals pursuant to
26 subsection (9) of this section and to the share of the cost of the plan
27 due from subsidized enrollees entering the plan as employees pursuant
28 to subsection (10) of this section.

29 (b) To determine the periodic premiums due the administrator from
30 nonsubsidized enrollees. Premiums due from nonsubsidized enrollees
31 shall be in an amount equal to the cost charged by the managed health
32 care system provider to the state for the plan plus the administrative
33 cost of providing the plan to those enrollees and the premium tax under
34 RCW 48.14.0201.

35 (c) An employer or other financial sponsor may, with the prior
36 approval of the administrator, pay the premium, rate, or any other
37 amount on behalf of a subsidized or nonsubsidized enrollee, by
38 arrangement with the enrollee and through a mechanism acceptable to the

1 administrator, but in no case shall the payment made on behalf of the
2 enrollee exceed the total premiums due from the enrollee.

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

6 (3) To design and implement a structure of enrollee cost sharing
7 due a managed health care system from subsidized and nonsubsidized
8 enrollees. The structure shall discourage inappropriate enrollee
9 utilization of health care services, and may utilize copayments,
10 deductibles, and other cost-sharing mechanisms, but shall not be so
11 costly to enrollees as to constitute a barrier to appropriate
12 utilization of necessary health care services.

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

18 (5) To limit the payment of subsidies to subsidized enrollees, as
19 defined in RCW 70.47.020. The level of subsidy provided to persons who
20 qualify may be based on the lowest cost plans, as defined by the
21 administrator.

22 (6) To adopt a schedule for the orderly development of the delivery
23 of services and availability of the plan to residents of the state,
24 subject to the limitations contained in RCW 70.47.080 or any act
25 appropriating funds for the plan.

26 (7) To solicit and accept applications from managed health care
27 systems, as defined in this chapter, for inclusion as eligible basic
28 health care providers under the plan. The administrator shall endeavor
29 to assure that covered basic health care services are available to any
30 enrollee of the plan from among a selection of two or more
31 participating managed health care systems. In adopting any rules or
32 procedures applicable to managed health care systems and in its
33 dealings with such systems, the administrator shall consider and make
34 suitable allowance for the need for health care services and the
35 differences in local availability of health care resources, along with
36 other resources, within and among the several areas of the state.
37 Contracts with participating managed health care systems shall ensure
38 that basic health plan enrollees who become eligible for medical
39 assistance may, at their option, continue to receive services from

1 their existing providers within the managed health care system if such
2 providers have entered into provider agreements with the department of
3 social and health services.

4 (8) To receive periodic premiums from or on behalf of subsidized
5 and nonsubsidized enrollees, deposit them in the basic health plan
6 operating account, keep records of enrollee status, and authorize
7 periodic payments to managed health care systems on the basis of the
8 number of enrollees participating in the respective managed health care
9 systems.

10 (9) To accept applications from individuals residing in areas
11 served by the plan, on behalf of themselves and their spouses and
12 dependent children, for enrollment in the Washington basic health plan
13 as subsidized or nonsubsidized enrollees, to establish appropriate
14 minimum-enrollment periods for enrollees as may be necessary, and to
15 determine, upon application and on a reasonable schedule defined by the
16 authority, or at the request of any enrollee, eligibility due to
17 current gross family income for sliding scale premiums. No subsidy
18 may be paid with respect to any enrollee whose current gross family
19 income exceeds twice the federal poverty level or, subject to RCW
20 70.47.110, who is a recipient of medical assistance or medical care
21 services under chapter 74.09 RCW. If, as a result of an eligibility
22 review, the administrator determines that a subsidized enrollee's
23 income exceeds twice the federal poverty level and that the enrollee
24 knowingly failed to inform the plan of such increase in income, the
25 administrator may bill the enrollee for the subsidy paid on the
26 enrollee's behalf during the period of time that the enrollee's income
27 exceeded twice the federal poverty level. If a number of enrollees
28 drop their enrollment for no apparent good cause, the administrator may
29 establish appropriate rules or requirements that are applicable to such
30 individuals before they will be allowed to reenroll in the plan.

31 (10) To accept applications from business owners on behalf of
32 themselves and their employees, spouses, and dependent children, as
33 subsidized or nonsubsidized enrollees, who reside in an area served by
34 the plan. The administrator may require all or the substantial
35 majority of the eligible employees of such businesses to enroll in the
36 plan and establish those procedures necessary to facilitate the orderly
37 enrollment of groups in the plan and into a managed health care system.
38 The administrator may require that a business owner pay at least an
39 amount equal to what the employee pays after the state pays its portion

1 of the subsidized premium cost of the plan on behalf of each employee
2 enrolled in the plan. Enrollment is limited to those not eligible for
3 medicare who wish to enroll in the plan and choose to obtain the basic
4 health care coverage and services from a managed care system
5 participating in the plan. The administrator shall adjust the amount
6 determined to be due on behalf of or from all such enrollees whenever
7 the amount negotiated by the administrator with the participating
8 managed health care system or systems is modified or the administrative
9 cost of providing the plan to such enrollees changes.

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

21 (12) To monitor the provision of covered services to enrollees by
22 participating managed health care systems in order to assure enrollee
23 access to good quality basic health care, to require periodic data
24 reports concerning the utilization of health care services rendered to
25 enrollees in order to provide adequate information for evaluation, and
26 to inspect the books and records of participating managed health care
27 systems to assure compliance with the purposes of this chapter. In
28 requiring reports from participating managed health care systems,
29 including data on services rendered enrollees, the administrator shall
30 endeavor to minimize costs, both to the managed health care systems and
31 to the plan. The administrator shall coordinate any such reporting
32 requirements with other state agencies, such as the insurance
33 commissioner and the department of health, to minimize duplication of
34 effort.

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

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

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

6 (16) To establish basic health plan eligibility criteria for
7 individuals under section 1 of this act who are eligible for medicare
8 but required to pay all or a portion of medicare part A premiums,
9 including income eligibility criteria based on the relationship of an
10 individual's medicare part A premium payment to his or her monthly
11 income.

12 NEW SECTION. Sec. 4. Sections 1 and 2 of this act take effect
13 January 1, 1998.

14 NEW SECTION. Sec. 5. If specific funding for the purposes of this
15 act, referencing this act by bill or chapter number, is not provided by
16 June 30, 1997, in the omnibus appropriations act, this act is null and
17 void.

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