H-3173.2

HOUSE BILL 2430

State of Washington 57th Legislature 2002 Regular Session

By Representatives Kessler, Cody, Schual-Berke, Veloria, Chase, Dickerson, Santos, Haigh and Kenney

Read first time 01/16/2002. Referred to Committee on Health Care.

AN ACT Relating to access to health insurance for small employers and their employees; amending RCW 48.21.045, 48.44.023, 48.46.066, 48.43.035, and 70.47.020; adding a new section to chapter 48.43 RCW; adding a new section to chapter 70.47 RCW; adding a new section to chapter 74.09 RCW; and providing an effective date.

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

Sec. 1. RCW 48.21.045 and 1995 c 265 s 14 are each amended to read as follows:

(1)(a) An insurer offering any health benefit plan to a small employer shall offer and actively market to the small employer a health benefit plan ((~~providing benefits identical to the schedule of covered health services that are required to be delivered to an individual enrolled in the basic health plan~~)) <u>featuring a limited schedule of covered health services</u>. Nothing in this subsection shall preclude an insurer from offering, or a small employer from purchasing, other health benefit plans that may have more ((~~or less~~)) comprehensive benefits than ((~~the basic health plan, provided such plans are in accordance with this chapter~~)) <u>those included in the product offered under this subsection</u>. An insurer offering a health benefit plan

((~~that does not include benefits in the basic health plan~~)) under this subsection shall clearly disclose ((~~these differences~~)) all covered benefits to the small employer in a brochure approved by the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but ((~~is not subject to~~)) will not include the ((~~requirements of~~)) services identified in RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.143, 48.21.144, 48.21.146, 48.21.148, 48.21.160 through 48.21.197, 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240, 48.21.244, 48.21.250, 48.21.300, 48.21.310, ((~~or~~)) 48.21.320 ((~~if: (i) The health benefit plan is the mandatory offering under (a) of this subsection that provides benefits identical to the basic health plan, to the extent these requirements differ from the basic health plan; or (ii) the health benefit plan is offered to employers with not more than twenty-five employees~~)), 48.43.045(1), 48.43.125, or 48.43.180.

(2) Nothing in this section shall prohibit an insurer from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the ((~~basic health plan services~~)) health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under subsection (1) of this section shall be reasonable in relation to the benefits thereto.

(3) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The insurer shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The insurer shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is

the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection (3).

(d) The permitted rates for any age group shall be no more than ((~~four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and~~)) three hundred seventy-five percent of the lowest rate for all age groups on January 1, 2000, and five hundred percent on January 1, 2003, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs not to exceed twenty percent.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Adjusted community rates established under this section shall pool the medical experience of all small groups purchasing coverage.

(4) ((~~The health benefit plans authorized by this section that are lower than the required offering shall not supplant or supersede any existing policy for the benefit of employees in this state.~~)) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(5)(a) Except as provided in this subsection, requirements used by an insurer in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) An insurer shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) An insurer may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(6) An insurer must offer coverage to all eligible employees of a small employer and their dependents. An insurer may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. An insurer may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

(7) As used in this section, "health benefit plan," "small employer," "basic health plan," "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005.

Sec. 2. RCW 48.44.023 and 1995 c 265 s 16 are each amended to read as follows:

(1)(a) A health care services contractor offering any health benefit plan to a small employer, as that term is defined in RCW 48.43.005, shall offer and actively market to the small employer a health benefit plan ((~~providing benefits identical to the schedule of covered health services that are required to be delivered to an individual enrolled in the basic health plan~~)) featuring a limited schedule of covered health services. Nothing in this subsection shall

preclude a contractor from offering, or a small employer from purchasing, other health benefit plans that may have more ((~~or less~~)) comprehensive benefits than ((~~the basic health plan, provided such plans are in accordance with this chapter~~)) those included in the product offered under this subsection. A contractor offering a health benefit plan ((~~that does not include benefits in the basic health plan~~)) under this subsection shall clearly disclose ((~~these differences~~)) all covered benefits to the small employer in a brochure approved by the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but ((~~is not subject to the requirements of~~)) will not include the services identified in RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310, 48.44.315, 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, ((~~and~~)) 48.44.460 ((~~if: (i) The health benefit plan is the mandatory offering under (a) of this subsection that provides benefits identical to the basic health plan, to the extent these requirements differ from the basic health plan; or (ii) the health benefit plan is offered to employers with not more than twenty-five employees~~)), 48.44.500, 48.43.045(1), 48.43.125, and 48.43.180.

(2) Nothing in this section shall prohibit a health care service contractor from offering, or a purchaser from seeking, health benefits plans with benefits in excess of the ((~~basic health plan services~~)) health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under subsection (1) of this section shall be reasonable in relation to the benefits thereto.

(3) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The contractor shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin

with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The contractor shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection (3).

(d) The permitted rates for any age group shall be no more than ((~~four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and~~)) three hundred seventy-five percent of the lowest rate for all age groups on January 1, 2000, and five hundred percent on January 1, 2003, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs not to exceed twenty percent.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage.

(4) ((~~The health benefit plans authorized by this section that are lower than the required offering shall not supplant or supersede any~~

~~existing policy for the benefit of employees in this state.~~)) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(5)(a) Except as provided in this subsection, requirements used by a contractor in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A contractor shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A contractor may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(6) A contractor must offer coverage to all eligible employees of a small employer and their dependents. A contractor may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A contractor may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 3. RCW 48.46.066 and 1995 c 265 s 18 are each amended to read as follows:

(1)(a) A health maintenance organization offering any health benefit plan to a small employer, as that term is defined in RCW 48.43.005, shall offer and actively market to the small employer a health benefit plan ((~~providing benefits identical to the schedule of covered health services that are required to be delivered to an individual enrolled in the basic health plan~~)) featuring a limited

schedule of covered health services. Nothing in this subsection shall preclude a health maintenance organization from offering, or a small employer from purchasing, other health benefit plans that may have more ((~~or less~~)) comprehensive benefits than ((~~the basic health plan, provided such plans are in accordance with this chapter~~)) those included in the product offered under this subsection. A health maintenance organization offering a health benefit plan ((~~that does not include benefits in the basic health plan~~)) under this subsection shall clearly disclose ((~~these differences~~)) all covered benefits to the small employer in a brochure approved by the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but ((~~is not subject to the requirements of~~)) will not include the services identified in RCW 48.46.272, 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, ((~~and~~)) 48.46.530 ((~~if: (i) The health benefit plan is the mandatory offering under (a) of this subsection that provides benefits identical to the basic health plan, to the extent these requirements differ from the basic health plan; or (ii) the health benefit plan is offered to employers with not more than twenty-five employees~~)), 48.46.565, and 48.46.570.

(2) Nothing in this section shall prohibit a health maintenance organization from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the ((~~basic health plan services~~)) health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

(3) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The health maintenance organization shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection (3).

(d) The permitted rates for any age group shall be no more than ((~~four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and~~)) three hundred seventy-five percent <u>of the lowest rate for all age groups</u> on January 1, 2000, <u>and five hundred percent on January 1, 2003,</u> and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs not to exceed twenty percent.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage.

(4) ((~~The health benefit plans authorized by this section that are lower than the required offering shall not supplant or supersede any existing policy for the benefit of employees in this state.~~)) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(5)(a) Except as provided in this subsection, requirements used by a health maintenance organization in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A health maintenance organization shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A health maintenance organization may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(6) A health maintenance organization must offer coverage to all eligible employees of a small employer and their dependents. A health maintenance organization may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A health maintenance organization may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 4. RCW 48.43.035 and 2000 c 79 s 24 are each amended to read as follows:

For group health benefit plans, the following shall apply:

(1) All health carriers shall accept for enrollment any state resident within the group to whom the plan is offered and within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The insurance commissioner may grant a temporary exemption from this subsection, if, upon application by a health carrier the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a health carrier is required to continue enrollment of additional eligible individuals.

(2) Except as provided in subsection (5) of this section, all health plans shall contain or incorporate by endorsement a guarantee of the continuity of coverage of the plan. For the purposes of this section, a plan is "renewed" when it is continued beyond the earliest date upon which, at the carrier's sole option, the plan could have been terminated for other than nonpayment of premium. The carrier may consider the group's anniversary date as the renewal date for purposes of complying with the provisions of this section.

(3) The guarantee of continuity of coverage required in health plans shall not prevent a carrier from canceling or nonrenewing a health plan for:

(a) Nonpayment of premium;

(b) Violation of published policies of the carrier approved by the insurance commissioner;

(c) Covered persons entitled to become eligible for medicare benefits by reason of age who fail to apply for a medicare supplement plan or medicare cost, risk, or other plan offered by the carrier pursuant to federal laws and regulations;

(d) Covered persons who fail to pay any deductible or copayment amount owed to the carrier and not the provider of health care services;

(e) Covered persons committing fraudulent acts as to the carrier;

(f) Covered persons who materially breach the health plan; or

(g) Change or implementation of federal or state laws that no longer permit the continued offering of such coverage.

(4) ((~~The provisions of~~)) <u>T</u>his section ((~~do~~)) <u>does</u> not apply in the following cases:

(a) A carrier has zero enrollment on a product; or

(b) For group health plans sold to groups other than small employer groups, a carrier replaces a product and the replacement product is provided to all covered persons within that class or line of business, includes all of the services covered under the replaced product, and does not significantly limit access to the kind of services covered under the replaced product. The health plan may also allow unrestricted conversion to a fully comparable product; or

(c) For group health plans offered to small employer groups, no sooner than October 1, 2002, a carrier discontinues offering a particular type of health benefit plan if: (i) The carrier provides notice to each group provided coverage of this type of the discontinuation at least ninety days prior to the date of the discontinuation; (ii) the carrier offers to each group provided coverage of this type the option to enroll in any other small employer group health benefit plan currently being offered by the carrier; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under (c)(ii) of this subsection, the carrier acts uniformly without regard to any health status-related factor of individuals enrolled through the small employer group, individuals who may become eligible for such coverage, or the collective health status of groups enrolled in coverage of this type; or

(d) A carrier discontinues offering all small employer group health coverage in the state and discontinues coverage under all existing small employer group health benefit plans if: (i) The carrier provides notice to the commissioner of its intent to discontinue offering all small employer group health coverage in the state and its intent to discontinue coverage under all existing health benefit plans at least one hundred eighty days prior to the date of the discontinuation of coverage under all existing health benefit plans; and (ii) the carrier provides notice to each covered small employer group of the intent to discontinue his or her existing health benefit plan at least one hundred eighty days prior to the date of the discontinuation and includes information in the notice that can help the small employer group identify alternative sources of coverage. In the case of discontinuation under this subsection, the carrier may not issue any small employer group health coverage in this state for a five-year period beginning on the date of the discontinuation of the last health

plan not so renewed. Nothing in this subsection (3) may be construed to require a carrier to provide notice to the commissioner of its intent to discontinue offering a health benefit plan to new applicants where the carrier does not discontinue coverage of existing enrollees under that health benefit plan; or

(e) A carrier is withdrawing from a service area or from a segment of its service area because the carrier has demonstrated to the insurance commissioner that the carrier's clinical, financial, or administrative capacity to serve enrollees would be exceeded.

(5) The provisions of this section do not apply to health plans deemed by the insurance commissioner to be unique or limited or have a short-term purpose, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

NEW SECTION. **Sec. 5.** A new section is added to chapter 48.43 RCW to read as follows:

(1) On or before July 1, 2003, the commissioner shall, in consultation with carriers, consumers, and other interested organizations, establish the policy and contract forms and benefits levels for five standard health plans to be offered to small employer groups.

(2) The standard health plans must represent a range of health plans sufficiently diverse to meet the needs of small employer groups seeking health insurance coverage in Washington state. One standard health plan shall be a basic benefit plan consistent with RCW 48.21.045, 48.44.023, and 48.46.066. The remaining four plans must include enhanced benefits of proportionally increasing actuarial value. To ensure adequate choice of coverage options for small employer groups, each standard health plan must offer varying levels of consumer cost-sharing, which may include deductibles, coinsurance, or point-of-service cost-sharing.

(3) The commissioner must adopt rules under chapter 34.05 RCW to implement this section, and make information available to the general public that clearly describes the benefits included in each of the plans and compares each plan to the other with respect to services covered and consumer cost-sharing obligations.

(4) On or after January 1, 2004, a carrier that offers group health benefit plans in Washington state must offer each of the small employer

groups standard health plans developed and adopted by the commissioner under this section. Nothing in this section may be construed to limit the ability of a carrier to offer small employer group health benefit plans in addition to the standard health plans adopted under this section.

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

(1) The legislature finds that many low-wage workers and their families are eligible for, or receive health insurance coverage through, the basic health plan and medical assistance programs. Some of these low-wage workers may work for employers who do not offer health insurance or may have access to employer-sponsored health insurance for themselves and their dependents, but that insurance may be unaffordable for the worker. The legislature finds that pilot projects should be established to determine whether it is appropriate to use basic health plan and medical assistance funds to subsidize premium shares for employer-sponsored health insurance when such a subsidy would be cost-effective for the state.

(2) Upon receipt of a reasonable request from an entity that has received funding through the federal health resources and services administration community access program to develop a regional system for increased access to health services and health insurance coverage, the administrator shall develop mechanisms to apply subsidy payments toward premium shares for employer-sponsored health insurance for the employees and their dependents, rather than as direct payments to managed health care systems participating in the basic health plan. The payment mechanisms must be developed in consultation with the requesting entity, the department of social and health services, and other interested entities, and must meet the following criteria:

(a) Subsidy payments may be made only on behalf of individuals who meet the basic health plan eligibility criteria in effect at the time the pilot project is underway;

(b) Subsidy payments toward premium shares for employer-sponsored health insurance must be cost-effective. The payment amount must not exceed the subsidy payment amount that would be made to the benchmark managed health care system participating in the basic health plan in the counties covered by the pilot project if that employee had enrolled directly in the basic health plan; and

(c) A subsidy payment toward premium shares of employer-sponsored health insurance can be made only upon a determination by the administrator that the benefits package of the employer-sponsored health insurance is reasonably comparable to or better than the basic health plan benefits package.

(3) By November 1, 2002, the administrator and the secretary of the department of social and health services must jointly report to the health care committees of the senate and the house of representatives on their progress in developing the payment mechanisms authorized in this act.

Sec. 7. RCW 70.47.020 and 2000 c 79 s 43 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 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: (a) 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, to a defined patient population enrolled in the plan and in the managed health care system; or (b) a self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100(7).

(4) "Subsidized enrollee" means an individual, or an individual plus the individual’s spouse or dependent children: (a) Who is not eligible for medicare; (b) who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator; (c) who resides in an area of the state served by a managed health care system participating in the plan; (d) whose gross family income at the time of enrollment does not exceed two hundred percent of the federal poverty level as adjusted for

family size and determined annually by the federal department of health and human services; and (e) who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan. To the extent that state funds are specifically appropriated for this purpose, with a corresponding federal match, "subsidized enrollee" also means an individual, or an individual's spouse or dependent children, who meets the requirements in (a) through (c) and (e) of this subsection and whose gross family income at the time of enrollment is more than two hundred percent, but less than two hundred fifty-one percent, of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services.

(5) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children: (a) Who is not eligible for medicare; (b) who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator; (c) who resides in an area of the state served by a managed health care system participating in the plan; (d) who chooses to obtain basic health care coverage from a particular managed health care system; and (e) 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 or an entity authorized in section 6 of this act 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 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. 8.** A new section is added to chapter 74.09 RCW to read as follows:

(1) The legislature finds that many low-wage workers and their families are eligible for, or receive health insurance coverage through, the basic health plan and medical assistance programs. Some of these low-wage workers may work for employers who do not offer health insurance or may have access to employer-sponsored health insurance for themselves and their dependents, but that insurance may be unaffordable for the worker. The legislature finds that pilot projects should be established to determine whether it is appropriate to use basic health plan and medical assistance funds to subsidize premium shares for employer-sponsored health insurance when such a subsidy would be cost-effective for the state.

(2) Upon receipt of a request from an entity that has received funding from the federal health resources and services administration community access program to develop a regional system for increased access to health services and health insurance coverage, the secretary shall use his or her existing authority under Title XIX of the federal social security act to pay premium shares for employer-sponsored health insurance for the employees and their dependents. Payment mechanisms must be developed in consultation with the requesting entity, the health care authority, and other interested entities, and must meet the following criteria:

(a) Subsidy payments may be made only on behalf of individuals who meet medical assistance eligibility criteria in effect at the time the pilot project is underway; and

(b) Payments toward premium shares for employer-sponsored health insurance must be cost-effective, as defined in federal law.

NEW SECTION. **Sec. 9.** Section 4 of this act takes effect January 1, 2004.

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