2797-S.E AMS HEA S5063.2

ESHB 2797 - S COMM AMD
By Committee on Health & Long-Term Care

NOT ADOPTED 03/11/2004

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** 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) "Health coverage tax credit program" means the program created by the Trade Act of 2002 (P.L. 107-210) that provides a federal tax credit that subsidizes private health insurance coverage for displaced workers certified to receive certain trade adjustment assistance benefits and for individuals receiving benefits from the pension benefit guaranty corporation.

(4) "Health coverage tax credit eligible enrollee" means individual workers and their qualified family members who lose their jobs due to the effects of international trade and are eligible for certain trade adjustment assistance benefits; or are eligible for benefits under the alternative trade adjustment assistance program; or are people who receive benefits from the pension benefit guaranty corporation and are at least fifty-five years old.

(5) "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)~~)) (6) "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)~~)) (7) "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)~~)) (8) "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)~~)) (9) "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, or a health coverage tax credit eligible enrollee.

((~~(8)~~)) (10) "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, and health coverage tax credit eligible enrollees in the plan and in that system.

Sec. 2. RCW 70.47.030 and 1995 2nd sp.s. c 18 s 913 are each amended to read as follows:

(1) The basic health plan trust account is hereby established in the state treasury. 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.

During the 1995-97 fiscal biennium, the legislature may transfer funds from the basic health plan trust account to the state general fund.

(2) The basic health plan subscription account is created in the custody of the state treasurer. All receipts from amounts due from or on behalf of nonsubsidized enrollees and health coverage tax credit eligible enrollees 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 nonsubsidized enrollees and health coverage tax credit eligible enrollees in the plan and payment of costs of administering the plan. The account is subject to allotment procedures under chapter 43.88 RCW, but no appropriation is required for expenditures.

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

7 **Sec. 3.** RCW 70.47.060 and 2001 c 196 s 13 are each amended to read
8 as follows:
9 The administrator has the following powers and duties:
10 (1) To design and from time to time revise a schedule of covered
11 basic health care services, including physician services, inpatient and
12 outpatient hospital services, prescription drugs and medications, and
13 other services that may be necessary for basic health care. In
14 addition, the administrator may, to the extent that funds are
15 available, offer as basic health plan services chemical dependency
16 services, mental health services and organ transplant services;
17 however, no one service or any combination of these three services
18 shall increase the actuarial value of the basic health plan benefits by
19 more than five percent excluding inflation, as determined by the office
20 of financial management. All subsidized and nonsubsidized enrollees in
21 any participating managed health care system under the Washington basic
22 health plan shall be entitled to receive covered basic health care
23 services in return for premium payments to the plan. The schedule of
24 services shall emphasize proven preventive and primary health care and
25 shall include all services necessary for prenatal, postnatal, and well-
26 child care. However, with respect to coverage for subsidized enrollees
27 who are eligible to receive prenatal and postnatal services through the
28 medical assistance program under chapter 74.09 RCW, the administrator
29 shall not contract for such services except to the extent that such
30 services are necessary over not more than a one-month period in order
31 to maintain continuity of care after diagnosis of pregnancy by the
32 managed care provider. The schedule of services shall also include a
33 separate schedule of basic health care services for children, eighteen
34 years of age and younger, for those subsidized or nonsubsidized
35 enrollees who choose to secure basic coverage through the plan only for
36 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 48.47.030, and such other factors as the administrator deems appropriate.

(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)~~)) (10) 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)~~)) (11) 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) To determine the periodic premiums due the administrator from health coverage tax credit eligible enrollees. Premiums due from health coverage tax credit eligible enrollees must 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. The administrator will consider the impact of eligibility determination by the appropriate federal agency designated by the Trade Act of 2002 (P.L. 107-210) as well as the premium collection and remittance activities by the United States internal revenue service when determining the administrative cost charged for health coverage tax credit eligible enrollees. The administrator and participating managed care system providers shall periodically review the utilization of covered services by health coverage tax credit eligible enrollees relative to other enrollees. The premiums charged health coverage tax credit eligible enrollees may be prospectively adjusted to assure that their premiums cover the full cost of their participation, such that

their participation does not raise the cost charged by a managed health system provider to the state for the plan.

(d) 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. The administrator shall establish a mechanism for receiving premium payments from the United States internal revenue service for health coverage tax credit eligible enrollees.

((~~(d)~~)) (e) To develop, as an offering by every health carrier providing coverage identical to the basic health plan, as configured on January 1, 2001, a basic health plan model plan with uniformity in enrollee cost-sharing requirements.

(3) To end the participation of health coverage tax credit eligible enrollees in the basic health plan if the federal government reduces or terminates premium payments on their behalf through the United States internal revenue service.

(4) To design and implement a structure of enrollee cost-sharing due a managed health care system from subsidized ((~~and~~)), nonsubsidized, and health coverage tax credit eligible 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.

((~~(4)~~)) (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. Such a closure does not apply to health coverage tax credit eligible enrollees who receive a premium subsidy from the United States internal revenue service as long as the enrollees qualify for the health coverage tax credit program.

((~~(5)~~)) (6) To limit the payment of subsidies to subsidized enrollees, as defined in RCW 70.47.020. The level of subsidy provided

1 to persons who qualify may be based on the lowest cost plans, as
2 defined by the administrator.
3 ((~~(6)~~)) <u>(7)</u> To adopt a schedule for the orderly development of the
4 delivery of services and availability of the plan to residents of the
5 state, subject to the limitations contained in RCW 70.47.080 or any act
6 appropriating funds for the plan.
7 ((~~(7)~~)) <u>(8)</u> To solicit and accept applications from managed health
8 care systems, as defined in this chapter, for inclusion as eligible
9 basic health care providers under the plan for ((~~either~~)) subsidized
10 enrollees, ((~~or~~)) nonsubsidized enrollees, or ((~~both~~)) <u>health coverage</u>
11 <u>tax credit eligible enrollees. The administrator may not require a</u>
12 <u>managed health care system that serves subsidized enrollees to also</u>
13 <u>serve nonsubsidized or health coverage tax credit eligible enrollees</u>.
14 The administrator shall endeavor to assure that covered basic health
15 care services are available to any enrollee of the plan from among a
16 selection of two or more participating managed health care systems. In
17 adopting any rules or procedures applicable to managed health care
18 systems and in its dealings with such systems, the administrator shall
19 consider and make suitable allowance for the need for health care
20 services and the differences in local availability of health care
21 resources, along with other resources, within and among the several
22 areas of the state. Contracts with participating managed health care
23 systems shall ensure that basic health plan enrollees who become
24 eligible for medical assistance may, at their option, continue to
25 receive services from their existing providers within the managed
26 health care system if such providers have entered into provider
27 agreements with the department of social and health services.
28 ((~~(8)~~)) <u>(9)</u> To receive periodic premiums from or on behalf of
29 subsidized ((~~and~~))<u>,</u> nonsubsidized<u>, and health coverage tax credit</u>
30 <u>eligible</u> enrollees, deposit them in the basic health plan operating
31 account, keep records of enrollee status, and authorize periodic
32 payments to managed health care systems on the basis of the number of
33 enrollees participating in the respective managed health care systems.
34 ((~~(9)~~)) <u>(10)</u> To accept applications from individuals residing in
35 areas served by the plan, on behalf of themselves and their spouses and
36 dependent children, for enrollment in the Washington basic health plan
37 as subsidized ((~~or~~))<u>,</u> nonsubsidized<u>, or health coverage tax credit</u>

1 eligible enrollees, to establish appropriate minimum-enrollment periods
2 for enrollees as may be necessary, and to determine, upon application
3 and on a reasonable schedule defined by the authority, or at the
4 request of any enrollee, eligibility due to current gross family income
5 for sliding scale premiums. Funds received by a family as part of
6 participation in the adoption support program authorized under RCW
7 26.33.320 and 74.13.100 through 74.13.145 shall not be counted toward
8 a family's current gross family income for the purposes of this
9 chapter. When an enrollee fails to report income or income changes
10 accurately, the administrator shall have the authority either to bill
11 the enrollee for the amounts overpaid by the state or to impose civil
12 penalties of up to two hundred percent of the amount of subsidy
13 overpaid due to the enrollee incorrectly reporting income. The
14 administrator shall adopt rules to define the appropriate application
15 of these sanctions and the processes to implement the sanctions
16 provided in this subsection, within available resources. No subsidy
17 may be paid with respect to any enrollee whose current gross family
18 income exceeds twice the federal poverty level or, subject to RCW
19 70.47.110, who is a recipient of medical assistance or medical care
20 services under chapter 74.09 RCW. If a number of enrollees drop their
21 enrollment for no apparent good cause, the administrator may establish
22 appropriate rules or requirements that are applicable to such
23 individuals before they will be allowed to reenroll in the plan.
24 ((~~(10)~~)) (11) To accept applications from business owners on behalf
25 of themselves and their employees, spouses, and dependent children, as
26 subsidized or nonsubsidized enrollees, who reside in an area served by
27 the plan. The administrator may require all or the substantial
28 majority of the eligible employees of such businesses to enroll in the
29 plan and establish those procedures necessary to facilitate the orderly
30 enrollment of groups in the plan and into a managed health care system.
31 The administrator may require that a business owner pay at least an
32 amount equal to what the employee pays after the state pays its portion
33 of the subsidized premium cost of the plan on behalf of each employee
34 enrolled in the plan. Enrollment is limited to those not eligible for
35 medicare who wish to enroll in the plan and choose to obtain the basic
36 health care coverage and services from a managed care system
37 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)~~)) (12) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same or actuarially equivalent 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)~~)) (13) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the administrator 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)~~)) (14) 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)~~)) (15) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

1 ((~~(15)~~)) (16) To provide, consistent with available funding,
2 assistance for rural residents, underserved populations, and persons of
3 color.
4 ((~~(16)~~)) (17) In consultation with appropriate state and local
5 government agencies, to establish criteria defining eligibility for
6 persons confined or residing in government-operated institutions.
7 ((~~(17)~~)) (18) To administer the premium discounts provided under
8 RCW 48.41.200(3)(a) (i) and (ii) pursuant to a contract with the
9 Washington state health insurance pool.

10 **Sec. 4.** RCW 48.43.015 and 2001 c 196 s 7 are each amended to read
11 as follows:
12 (1) For a health benefit plan offered to a group, every health
13 carrier shall reduce any preexisting condition exclusion, limitation,
14 or waiting period in the group health plan in accordance with the
15 provisions of section 2701 of the federal health insurance portability
16 and accountability act of 1996 (42 U.S.C. Sec. 300gg).
17 (2) For a health benefit plan offered to a group other than a small
18 group:
19 (a) If the individual applicant's immediately preceding health plan
20 coverage terminated during the period beginning ninety days and ending
21 sixty-four days before the date of application for the new plan and
22 such coverage was similar and continuous for at least three months,
23 then the carrier shall not impose a waiting period for coverage of
24 preexisting conditions under the new health plan.
25 (b) If the individual applicant's immediately preceding health plan
26 coverage terminated during the period beginning ninety days and ending
27 sixty-four days before the date of application for the new plan and
28 such coverage was similar and continuous for less than three months,
29 then the carrier shall credit the time covered under the immediately
30 preceding health plan toward any preexisting condition waiting period
31 under the new health plan.
32 (c) For the purposes of this subsection, a preceding health plan
33 includes an employer-provided self-funded health plan, the basic health
34 plan's offering to health coverage tax credit eligible enrollees as
35 established by this act, and plans of the Washington state health
36 insurance pool.

(3) For a health benefit plan offered to a small group:

(a) If the individual applicant's immediately preceding health plan coverage terminated during the period beginning ninety days and ending sixty-four days before the date of application for the new plan and such coverage was similar and continuous for at least nine months, then the carrier shall not impose a waiting period for coverage of preexisting conditions under the new health plan.

(b) If the individual applicant's immediately preceding health plan coverage terminated during the period beginning ninety days and ending sixty-four days before the date of application for the new plan and such coverage was similar and continuous for less than nine months, then the carrier shall credit the time covered under the immediately preceding health plan toward any preexisting condition waiting period under the new health plan.

(c) For the purpose of this subsection, a preceding health plan includes an employer-provided self-funded health plan, the basic health plan's offering to health coverage tax credit eligible enrollees as established by this act, and plans of the Washington state health insurance pool.

(4) For a health benefit plan offered to an individual, other than an individual to whom subsection (5) of this section applies, every health carrier shall credit any preexisting condition waiting period in that plan for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the new health plan in a group health benefit plan or an individual health benefit plan, other than a catastrophic health plan, and (a) the benefits under the previous plan provide equivalent or greater overall benefit coverage than that provided in the health benefit plan the individual seeks to purchase; or (b) the person is seeking an individual health benefit plan due to his or her change of residence from one geographic area in Washington state to another geographic area in Washington state where his or her current health plan is not offered, if application for coverage is made within ninety days of relocation; or (c) the person is seeking an individual health benefit plan: (i) Because a health care provider with whom he or she has an established care relationship and from whom he or she has received treatment within the past twelve months is no longer part of the

1 carrier's provider network under his or her existing Washington
2 individual health benefit plan; and (ii) his or her health care
3 provider is part of another carrier's provider network; and (iii)
4 application for a health benefit plan under that carrier's provider
5 network individual coverage is made within ninety days of his or her
6 provider leaving the previous carrier's provider network. The carrier
7 must credit the period of coverage the person was continuously covered
8 under the immediately preceding health plan toward the waiting period
9 of the new health plan. For the purposes of this subsection (4), a
10 preceding health plan includes an employer-provided self-funded health
11 plan, the basic health plan's offering to health coverage tax credit
12 eligible enrollees as established by this act, and plans of the
13 Washington state health insurance pool.
14 (5) Every health carrier shall waive any preexisting condition
15 waiting period in its individual plans for a person who is an eligible
16 individual as defined in section 2741(b) of the federal health
17 insurance portability and accountability act of 1996 (42 U.S.C. Sec.
18 300gg-41(b)).
19 (6) Subject to the provisions of subsections (1) through (5) of
20 this section, nothing contained in this section requires a health
21 carrier to amend a health plan to provide new benefits in its existing
22 health plans. In addition, nothing in this section requires a carrier
23 to waive benefit limitations not related to an individual or group's
24 preexisting conditions or health history."

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25 On page 1, beginning on line 3 of the title, after "(P.L. 107-
26 210);" strike the remainder of the title and insert "and amending RCW
27 70.47.020, 70.47.030, 70.47.060, and 48.43.015."

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