H-1325.2

HOUSE BILL 1777

State of Washington 58th Legislature 2003 Regular Session

By Representatives Morrell, DeBolt, Cody, Benson, Sullivan, Woods, Pettigrew, McDonald, Wallace, Priest, Simpson, Roach, Grant, Hinkle, Santos, Jarrett, Hunt, Blake, Dunshee, Conway, Kirby, Hankins, Clibborn, Linville, Kagi, Kessler, Kenney, Schual-Berke, Darneille, Rockefeller, Wood, Lovick, Campbell, McDermott and Hudgins

Read first time 02/10/2003. Referred to Committee on Appropriations.

AN ACT Relating to implementing the collective bargaining agreement between the home care quality authority and individual home care providers; amending RCW 70.47.020, 70.47.060, and 70.47.100; creating a new section; making appropriations; providing an effective date; and declaring an emergency.

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

NEW SECTION. **Sec. 1.** (1) The legislature finds that the voters of Washington state expressed their strong support for home-based long-term care services through their overwhelming approval of Initiative Measure No. 775 in 2001. With passage of the initiative, the state has been directed to increase the quality of state-funded long-term care services provided to elderly and disabled persons in their own homes through recruitment and training of in-home individual providers, referral of qualified individual providers to seniors and persons with disabilities seeking a provider, and stabilization of the individual provider work force. The legislature further finds that the quality of care our elders and people with disabilities receive is highly dependent upon the quality and stability of the individual provider

work force, and that the demand for the services of these providers will increase as our population ages.

(2) The legislature intends to stabilize the state-funded individual provider work force by providing funding to implement the collective bargaining agreement between the home care quality authority and the exclusive bargaining representative of individual providers. The agreement reflects the value and importance of the work done by individual providers to support the needs of elders and people with disabilities in Washington state.

Sec. 2. 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:

(a) An individual, or an individual plus the individual's spouse or dependent children: ((~~(a)~~)) (i) Who is not eligible for medicare; ((~~(b)~~)) (ii) who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator; ((~~(c)~~)) (iii) who resides in an area of the state served by a managed health care system participating in the plan; ((~~(d)~~)) (iv) 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)~~)) (v) who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan((~~.~~));

(b) 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)(i) through ((~~(c)~~)) (iii) and ((~~(e)~~)) (v) 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; or

(c) An individual provider, as defined in RCW 74.39A.240, under contract with the department of social and health services who, solely for the purposes of collective bargaining, is employed by the home care quality authority as provided in RCW 74.39A.270. Eligibility for these enrollees will be determined by the terms of any applicable collective bargaining agreement between the home care quality authority and the exclusive bargaining representative of individual providers, to the extent that funds are appropriated specifically for that purpose.

(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 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. Premiums for subsidized enrollees defined under subsection (4)(c) of this section shall be determined by the terms of any applicable collective bargaining agreement between the home care quality authority and the exclusive bargaining representative of individual providers.

(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.

Sec. 3. RCW 70.47.060 and 2001 c 196 s 13 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. In addition, the administrator may, to the extent that funds are available, 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 covered basic health care services 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 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 48.47.030, 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~~)) according to the following: (i) For enrollees defined under RCW 70.47.020(4) (a) and (b) the premium structure shall be based upon gross family income, giving appropriate consideration to family size and the ages of all family members; and (ii) for enrollees defined under RCW 70.47.020(4)(c) the monthly premium shall be determined by the terms of any applicable collective bargaining agreement between the home care quality authority and the exclusive bargaining representative of individual providers. 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.

(d) 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 design and implement a structure of 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.

(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 for either subsidized enrollees, or nonsubsidized enrollees, or both. 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 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. Funds received by a family as part of participation in the adoption support program authorized under RCW 26.33.320 and 74.13.100 through 74.13.145 shall not be counted toward a family's current gross family income for the purposes of this chapter. When an enrollee fails to report income or income changes accurately, the administrator shall have the authority either to bill the enrollee for the amounts overpaid by the state or to impose civil penalties of up to two hundred percent of the amount of subsidy overpaid due to the enrollee incorrectly reporting income. The administrator shall adopt rules to define the appropriate application of these sanctions and the processes to implement the sanctions provided in this subsection, within available resources. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level<u>, with the exception of subsidized enrollees as defined under RCW 70.47.020(4) (b) and (c),</u> or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to reenroll 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 may require that a business owner pay at least 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 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) 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.

(16) In consultation with appropriate state and local government agencies, to establish criteria defining eligibility for persons confined or residing in government-operated institutions.

(17) To administer the premium discounts provided under RCW 48.41.200(3)(a) (i) and (ii) pursuant to a contract with the Washington state health insurance pool.

Sec. 4. RCW 70.47.100 and 2000 c 79 s 35 are each amended to read as follows:

(1) A managed health care system participating in the plan shall do so by contract with the administrator and shall provide, directly or by contract with other health care providers, covered basic health care services to each enrollee covered by its contract with the administrator as long as payments from the administrator on behalf of the enrollee are current. A participating managed health care system may offer, without additional cost, health care benefits or services not included in the schedule of covered services under the plan. A participating managed health care system shall not give preference in enrollment to enrollees who accept such additional health care benefits or services. Managed health care systems participating in the plan shall not discriminate against any potential or current enrollee based upon health status, sex, race, ethnicity, or religion. The administrator may receive and act upon complaints from enrollees regarding failure to provide covered services or efforts to obtain

payment, other than authorized copayments, for covered services directly from enrollees, but nothing in this chapter empowers the administrator to impose any sanctions under Title 18 RCW or any other professional or facility licensing statute.

(2) The plan shall allow, at least annually, an opportunity for enrollees to transfer their enrollments among participating managed health care systems serving their respective areas. The administrator shall establish a period of at least twenty days in a given year when this opportunity is afforded enrollees, and in those areas served by more than one participating managed health care system the administrator shall endeavor to establish a uniform period for such opportunity. The plan shall allow enrollees to transfer their enrollment to another participating managed health care system at any time upon a showing of good cause for the transfer.

(3) Prior to negotiating with any managed health care system, the administrator shall determine, on an actuarially sound basis, the reasonable cost of providing the schedule of basic health care services, expressed in terms of upper and lower limits, and recognizing variations in the cost of providing the services through the various systems and in different areas of the state.

(4) In negotiating with managed health care systems for participation in the plan, the administrator shall adopt a uniform procedure that includes at least the following:

(a) The administrator shall issue a request for proposals, including standards regarding the quality of services to be provided; financial integrity of the responding systems; and responsiveness to the unmet health care needs of the local communities or populations that may be served;

(b) The administrator shall then review responsive proposals and may negotiate with respondents to the extent necessary to refine any proposals;

(c) The administrator may then select one or more systems to provide the covered services within a local area; and

(d) The administrator may adopt a policy that gives preference to respondents, such as nonprofit community health clinics, that have a history of providing quality health care services to low-income persons.

(5) The administrator may contract with a managed health care system to provide covered basic health care services to either subsidized enrollees, or nonsubsidized enrollees, or both. The administrator, in the request for proposals, may bid any one of the three categories of subsidized enrollee as defined under RCW 70.47.020(4) separately to reduce potential adverse impacts on the cost of coverage.

(6) The administrator may establish procedures and policies to further negotiate and contract with managed health care systems following completion of the request for proposal process in subsection (4) of this section, upon a determination by the administrator that it is necessary to provide access, as defined in the request for proposal documents, to covered basic health care services for enrollees.

(7)(a) The administrator shall implement a self-funded or self-insured method of providing insurance coverage to subsidized enrollees, as provided under RCW 41.05.140, if one of the following conditions is met:

(i) The authority determines that no managed health care system other than the authority is willing and able to provide access, as defined in the request for proposal documents, to covered basic health care services for all subsidized enrollees in an area; or

(ii) The authority determines that no other managed health care system is willing to provide access, as defined in the request for proposal documents, for one hundred thirty-three percent of the statewide benchmark price or less, and the authority is able to offer such coverage at a price that is less than the lowest price at which any other managed health care system is willing to provide such access in an area.

(b) The authority shall initiate steps to provide the coverage described in (a) of this subsection within ninety days of making its determination that the conditions for providing a self-funded or self-insured method of providing insurance have been met.

(c) The administrator may not implement a self-funded or self-insured method of providing insurance in an area unless the administrator has received a certification from a member of the American academy of actuaries that the funding available in the basic health plan self-insurance reserve account is sufficient for the self-

funded or self-insured risk assumed, or expected to be assumed, by the administrator.

NEW SECTION. **Sec. 5.** The sum of nineteen million three hundred two thousand dollars, or as much thereof as may be necessary, is appropriated for the fiscal year ending June 30, 2004, from the general fund--state, the sum of forty-two million seventy-one thousand dollars, or as much thereof as may be necessary, is appropriated for the fiscal year ending June 30, 2005, from the general fund--state, and the sum of fifty-nine million six hundred fifty-three thousand dollars, or as much thereof as may be necessary, from the general fund--federal is appropriated to the department of social and health services for the biennium ending June 30, 2005, solely to increase the wages of state-funded individual providers from the current hourly rate of seven dollars and sixty-eight cents per hour to eight dollars and seventy cents per hour beginning July 1, 2003, and to nine dollars and seventy-five cents per hour beginning July 1, 2004.

NEW SECTION. **Sec. 6.** The sum of two million seven hundred forty-eight thousand dollars, or as much thereof as may be necessary, is appropriated for the fiscal year ending June 30, 2004, from the general fund--state, the sum of thirteen million forty-four thousand dollars, or as much thereof as may be necessary, is appropriated for the fiscal year ending June 30, 2005, from the general fund--state, and the sum of fifteen million three hundred thirty-two thousand dollars, or as much thereof as may be necessary, from the general fund--federal is appropriated to the department of social and health services for the biennium ending June 30, 2005, solely to provide health insurance coverage to state-funded individual providers through the basic health plan or an equivalent health plan determined by the terms of the collective bargaining agreement between the home care quality authority and the exclusive bargaining representative of individual providers.

NEW SECTION. **Sec. 7.** The sum of seventy-seven thousand dollars, or as much thereof as may be necessary, from the general fund--state is appropriated for the fiscal year ending June 30, 2004, and the sum of seventy-three thousand dollars, or as much thereof as may be necessary, from the general fund--state for the fiscal year ending June 30, 2005,

is appropriated to the health care authority solely for administrative costs associated with providing health insurance coverage to state-funded individual providers through the basic health plan or an equivalent health plan determined by the terms of the collective bargaining agreement between the home care quality authority and the exclusive bargaining representative of individual providers. If an equivalent health plan is purchased under the terms of the collective bargaining agreement, the health care authority shall transfer the funds in this appropriation to the department of social and health services.

NEW SECTION. **Sec. 8.** The sum of nine million seven hundred seventy thousand dollars, or as much thereof as may be necessary, is appropriated for the fiscal year ending June 30, 2004, from the general fund--state, the sum of ten million five hundred twenty-three thousand dollars, or as much thereof as may be necessary, is appropriated for the fiscal year ending June 30, 2005, from the general fund--state, and the sum of nineteen million seven hundred twenty-four thousand dollars, or as much thereof as may be necessary, from the general fund--federal is appropriated to the department of social and health services for the biennium ending June 30, 2005, solely to provide workers' compensation benefits to state-funded individual providers through the department of labor and industries.

NEW SECTION. **Sec. 9.** The sum of one hundred thirty-two thousand dollars, or as much thereof as may be necessary, is appropriated for the fiscal year ending June 30, 2004, from the general fund--state and the sum of three hundred forty-five thousand dollars, or as much thereof as may be necessary, is appropriated for the fiscal year ending June 30, 2005, from the general fund--state solely for costs associated with ongoing administrative, labor, and employment relations costs determined by the terms of the collective bargaining agreement between the home care quality authority and the exclusive bargaining representative of individual providers.

NEW SECTION. **Sec. 10.** 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 takes effect July 1, 2003.

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