S-1222.3

SENATE BILL 5807

State of Washington 58th Legislature 2003 Regular Session

By Senators Parlette, Deccio, Brandland, Mulliken, Carlson, Honeyford, Hewitt, Stevens, Oke, Sheahan and Winsley

Read first time 02/13/2003. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to the basic health plan; amending RCW 70.47.010, 70.47.020, 70.47.030, 70.47.040, 70.47.060, 70.47.100, and 70.47.130; reenacting and amending RCW 48.43.005; adding new sections to chapter 70.47 RCW; repealing RCW 70.47.015, 70.47.080, 70.47.090, and 70.47.115; and declaring an emergency.

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

Sec. 1. RCW 70.47.010 and 2000 c 79 s 42 are each amended to read as follows:

(1)(a) The legislature finds that limitations on access to health care services for enrollees in the state, such as in rural and underserved areas, are particularly challenging for the basic health plan. Statutory restrictions have reduced the options available to the administrator to address the access needs of basic health plan enrollees. It is the intent of the legislature to authorize the administrator to develop alternative purchasing strategies to ensure access to basic health plan enrollees in all areas of the state, including: (i) The use of differential rating for managed health care systems based on geographic differences in costs; and (ii) limited use

of self-insurance in areas where adequate access cannot be assured through other options.

(b) In developing alternative purchasing strategies to address health care access needs, the administrator shall consult with interested persons including health carriers, health care providers, and health facilities, and with other appropriate state agencies including the office of the insurance commissioner and the office of community and rural health. In pursuing such alternatives, the administrator shall continue to give priority to prepaid managed care as the preferred method of assuring access to basic health plan enrollees followed, in priority order, by preferred providers, fee for service, and self-funding.

(2) The legislature further finds that:

(a) A significant percentage of the population of this state does not have reasonably available insurance or other coverage of the costs of necessary basic health care services;

(b) This lack of basic health care coverage is detrimental to the health of the individuals lacking coverage and to the public welfare, and results in substantial expenditures for emergency and remedial health care, often at the expense of health care providers, health care facilities, and all purchasers of health care, including the state; and

(c) The use of managed health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state generally, and by low-income pregnant women, and at-risk children and adolescents who need greater access to managed health care.

(3) The purpose of this chapter is to provide or make more readily available necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization of necessary health care services. To that end, this chapter establishes a program to be made available to those residents not eligible for medicare who share in a portion of the cost ((~~or who pay the full cost~~)) of receiving basic health care services from a managed health care system.

(4) It is not the intent of this chapter to provide health care services for those persons who are presently covered through private employer-based health plans, nor to replace employer-based health

plans. However, the legislature recognizes that cost-effective and affordable health plans may not always be available to small business employers. Further, it is the intent of the legislature to expand, wherever possible, the availability of private health care coverage and to discourage the decline of employer-based coverage.

(5)(a) It is the purpose of this chapter to acknowledge the initial success of this program that has (i) assisted thousands of families in their search for affordable health care; (ii) demonstrated that low-income, uninsured families are willing to pay for their own health care coverage to the extent of their ability to pay; and (iii) proved that local health care providers are willing to enter into a public-private partnership as a managed care system.

(b) ((~~As a consequence, the legislature intends to extend an option to enroll to certain citizens above two hundred percent of the federal poverty guidelines within the state who reside in communities where the plan is operational and who collectively or individually wish to exercise the opportunity to purchase health care coverage through the basic health plan if the purchase is done at no cost to the state.~~)) It is ((~~also~~)) the intent of the legislature to allow employers and other financial sponsors to financially assist such individuals to purchase health care through the program so long as such purchase does not result in a lower standard of coverage for employees.

(c) The legislature intends that, to the extent of available funds, the program be available throughout Washington state ((~~to subsidized and nonsubsidized enrollees. It is also the intent of the legislature to enroll subsidized enrollees first, to the maximum extent feasible~~)).

(d) The legislature directs that the basic health plan administrator identify enrollees who are likely to be eligible for medical assistance and assist these individuals in applying for and receiving medical assistance. When possible, the administrator and the department of social and health services shall implement a seamless system to coordinate eligibility determinations and benefit coverage for enrollees of the basic health plan and medical assistance recipients.

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) "Loss ratio" means incurred claims expense as a percentage of rate charged.

(4) "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)~~)) (6).

((~~(4) "Subsidized enrollee"~~)) (5) "Resource" means any asset, tangible or intangible, which can be applied towards meeting the applicant's need, either directly or by conversion into money or its equivalent. The administrator may by rule designate resources that an applicant may retain and not be ineligible for enrollment because of such resources. Exempt resources include, but are not limited to:

(a) A home that an applicant, enrollee, or his or her dependents are living in, including the surrounding property;

(b) Household furnishings and personal effects;

(c) A motor vehicle, other than a motor home, used and useful having an equity value not to exceed five thousand dollars;

(d) A motor vehicle necessary to transport a physically disabled household member. This exclusion is limited to one vehicle per physically disabled person; and

(e) Any resource that the administrator determines is necessary and is being used by the applicant or enrollee to increase his or her income.

(6) "Eligible person" means an individual, or an individual plus the individual's spouse or dependent children: (a) Who is not eligible

for medicaid or medicare; (b) who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator in consultation with appropriate state and local government agencies; (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~~)) one hundred fifty 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) whose household resources do not exceed seven thousand five hundred dollars; (f) who has not been enrolled in the basic health plan for a lifetime total of more than sixty months; and (g) 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)~~)) (7) "Subsidy" means the difference between the amount of periodic payment the administrator makes to a managed health care system on behalf of ((~~a subsidized~~)) an 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). The level of subsidy provided may be based on the lowest cost plans, as defined by the administrator.

((~~(7)~~)) (8) "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~~)) an enrollee.

((~~(8)~~)) (9) "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 70.47.030 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 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 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.~~

~~(3) The administrator shall take every precaution to see that none of the funds in the separate accounts created in this section or that any premiums paid either by subsidized or nonsubsidized enrollees are~~

~~commingled in any way, except that the administrator may combine funds designated for administration of the plan into a single administrative account.~~))

Sec. 4. RCW 70.47.040 and 1993 c 492 s 211 are each amended to read as follows:

(1) The Washington basic health plan is created as a program within the Washington state health care authority. The administrative head and appointing authority of the plan shall be the administrator of the Washington state health care authority. ((~~The administrator shall appoint a medical director. The medical director and up to five other employees of the plan shall be exempt from the civil service law, chapter 41.06 RCW.~~))

(2) The administrator shall employ such other staff as are necessary to fulfill the responsibilities and duties of the administrator((~~, such staff to be~~)). Except for a maximum of six employees designated as exempt by the administrator, such staff is subject to the civil service law, chapter 41.06 RCW. In addition, the administrator may contract with third parties for services necessary to carry out its activities where this will promote economy, avoid duplication of effort, and make best use of available expertise. Any such contractor or consultant shall be prohibited from releasing, publishing, or otherwise using any information made available to it under its contractual responsibility without specific permission of the plan. The administrator may call upon other agencies of the state to provide available information as necessary to assist the administrator in meeting its responsibilities under this chapter, which information shall be supplied as promptly as circumstances permit.

(3) The administrator may appoint such technical or advisory committees as he or she deems necessary. The administrator shall appoint a standing technical advisory committee that is representative of health care professionals, health care providers, and those directly involved in the purchase, provision, or delivery of health care services, as well as consumers and those knowledgeable of the ethical issues involved with health care public policy. Individuals appointed to any technical or other advisory committee shall serve without compensation for their services as members, but may be reimbursed for their travel expenses pursuant to RCW 43.03.050 and 43.03.060.

(4) The administrator may apply for, receive, and accept grants, gifts, and other payments, including property and service, from any governmental or other public or private entity or person, and may make arrangements as to the use of these receipts, including the undertaking of special studies and other projects relating to health care costs and access to health care.

(5) Whenever feasible, the administrator shall reduce the administrative cost of operating the program by adopting joint policies or procedures applicable to both the basic health plan and employee health plans.

Sec. 5. 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~~)) shall:

(1) ((~~To~~)) Design and ((~~from time to time~~)) periodically revise a schedule of covered ((~~basic health care~~)) services pursuant to section 8 of this act, 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 based upon gross family income and wellness activities, giving appropriate consideration to family size and the ages of all family members. ((~~The enrollment of children shall not require the enrollment of their parent or parents who are eligible for the plan. The structure of periodic premiums shall be applied to subsidized enrollees entering the plan as individuals pursuant to subsection (9) of this section and to the share of the cost of the plan due from subsidized enrollees entering the plan as employees pursuant to subsection (10) of this section.~~

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

~~(c)~~)) (a) All enrollees in any participating managed health care system shall be entitled to receive covered basic health care services in return for premium payments to the plan. Premiums, at a minimum, shall be as follows:

(i) Twelve dollars and fifty cents per month for those whose gross family income is less than sixty-five percent of the federal poverty level;

(ii) Nineteen dollars per month for those whose gross family income is between sixty-five and ninety-nine percent of the federal poverty level; and

(iii) Twenty-two dollars and fifty cents per month for those whose gross family income is at least one hundred percent of the federal poverty level.

(b) 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~~)) an enrollee for a period not to exceed two years, by arrangement with the enrollee and through a mechanism acceptable to the administrator. Organizations and individuals paid to deliver basic health plan services which choose to sponsor enrollment shall pay at least twenty dollars per enrollee per month for enrollees whose family income is below one hundred percent of the federal poverty level, and at least twenty-five dollars per enrollee per month for persons whose family income is one hundred percent to one hundred twenty-five percent of the federal poverty level.

((~~(d) To~~)) (3) Develop, as an offering by every health carrier providing coverage identical to the basic health plan, as configured on January 1, ((~~2001~~)) 2004, a basic health plan model plan with uniformity in enrollee cost-sharing requirements.

((~~(3) To~~)) (4) Design and implement a structure of enrollee cost-sharing consistent with section 8 of this act 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~~)) (5) Limit enrollment ((~~of persons who qualify for subsidies~~)) so as to prevent an overexpenditure of appropriations for ((~~such purposes~~)) the basic health plan. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment and, if necessary, disenroll persons, until the administrator finds the danger no longer exists. Any such disenrollment shall be in reverse order of income with enrollees with higher household incomes disenrolled first. Between persons with the same level of income, the one who has been on the plan the longest shall be disenrolled first. Any person disenrolled under this subsection who remains eligible and wishes to reenroll shall be given priority over new applicants when enrollment is reopened.

((~~(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~~)) (6) 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~~)) pursuant to section 9 of this act. 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.~~))

(7) Subject to subsection (4) of this section, enroll any eligible person for whom a completed application is submitted.

(a) In determining eligibility, the administrator shall:

(i) Require submission of income tax returns, or verification that income tax returns were not filed, and recent pay history for any applicant, the applicant's spouse, and his or her dependents;

(ii) Not count 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 as income.

(b) The administrator may establish minimum enrollment periods and conditions under which those who disenroll for no apparent good cause may reenroll.

(c) The enrollment of a child does not require the enrollment of his or her parent or parents.

(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 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~~)) persons eligible pursuant to RCW 70.47.020. 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~~)) (10) 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~~)) (11) 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~~)) (12) 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~~)) (13)(a) Disenroll any enrollee:

(i) Whose premium payments to the plan are delinquent;

(ii) Who, as reported by health care providers and confirmed by the administrator, repeatedly fails to pay the required copayments or coinsurance in full on a timely basis;

(iii) Who does not meet the eligibility standards established in RCW 70.47.020(5); or

(iv) As necessary to meet the requirements of subsection (5) of this section;

(b) To verify continued eligibility, check employment security payroll records at least once every twelve months on all enrollees; require any enrollee whose income as indicated by payroll records exceeds that upon which his or her enrollment and subsidy level is based to document his or her current income as a condition of continued eligibility; and require any enrollee for whom employment security payroll records cannot be obtained to document his or her current income at least once every six months;

(c) Provide an enrollee subject to disenrollment with advance written notice. Upon disenrollment, the administrator shall promptly notify the managed health care system in which the enrollee has been enrolled, and shall not be responsible for payment of health care services provided to the enrollee, including if applicable members of the enrollee's family, after the date of notification.

(14) 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. 6. 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.~~

~~(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)~~)) (6)(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. 7.** A new section is added to chapter 70.47 RCW to read as follows:

If the administrator determines that a person, because he or she incorrectly reported information upon which eligibility is based, was enrolled and subsidized at a level for which he or she was not eligible, the administrator shall either bill the enrollee for the amounts overpaid by the state or impose civil penalties of up to two hundred percent of the amount of subsidy overpaid due to the enrollee's incorrect information.

NEW SECTION. **Sec. 8.** A new section is added to chapter 70.47 RCW to read as follows:

The basic health plan shall reflect the conscientious, explicit, and judicious use of current best evidence with regard to patient care. In designing the schedule of benefits and enrollee cost-sharing, the administrator shall:

(1) Include preventive care services, based on the recommendations of the United States preventive services task force, with no enrollee cost-sharing;

(2) Include all services necessary for prenatal, postnatal, and well child care. However, with respect to coverage for enrollees who are eligible to receive prenatal and postnatal services through the

medical assistance program under chapter 74.09 RCW, the plan shall not cover such services except to the extent that they 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;

(3) Include other benefits and enrollee cost-sharing reasonably expected to result in a plan with an actuarial value twenty-five percent less than the actuarial value of the plan in place on January 1, 2003;

(4) Include a separate schedule of basic health care services for those eighteen years of age and younger; and

(5) Structure enrollee cost-sharing to discourage inappropriate utilization, encourage enrollee responsibility including the use of cost-effective services and products, and promote quality care. Costs imposed on enrollees should not be a barrier to utilization of appropriate and necessary health care services.

NEW SECTION. **Sec. 9.** A new section is added to chapter 70.47 RCW to read as follows:

In contracting with a participating managed health care system, the administrator shall:

(1) 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;

(2) Ensure that the system actively encourages enrollees to engage in wellness activities and receive preventive services consistent with the recommendations of the United States preventive services task force;

(3) Ensure that the system actively seeks to identify and encourage quality, cost-effective care by its providers based on evidence of best practices, and promote the use of quality providers by its enrollees;

(4) Ensure that the system actively assists the administrator in identifying enrollees with chronic or other high-cost conditions and provides them with coordinated care through disease and demand management programs;

(5) Ensure that the system actively encourages innovative health

care service delivery methods that improve enrollee access to care and health outcomes.

(6) Ensure that the rate charged by the system is reasonably expected to result in a loss ratio to the system for the basic health plan, of no less than eighty-seven percent.

Sec. 10. RCW 70.47.130 and 2000 c 5 s 21 are each amended to read as follows:

((~~(1)~~)) The activities and operations of the Washington basic health plan under this chapter, including those of managed health care systems to the extent of their participation in the plan, are exempt from the provisions and requirements of Title 48 RCW except:

((~~(a)~~)) (1) Benefits as provided in RCW 70.47.070;

((~~(b)~~)) (2) Managed health care systems are subject to the provisions of RCW 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 43.70.235, 48.43.545, 48.43.550, 70.02.110, and 70.02.900; and

((~~(c)~~)) (3) Persons appointed or authorized to solicit applications for enrollment in the basic health plan, including employees of the health care authority, must comply with chapter 48.17 RCW. For purposes of this subsection ((~~(1)(c)~~)) (3), "solicit" does not include distributing information and applications for the basic health plan and responding to questions((~~; and~~

~~(d) Amounts paid to a managed health care system by the basic health plan for participating in the basic health plan and providing health care services for nonsubsidized enrollees in the basic health plan must comply with RCW 48.14.0201.~~

~~(2) The purpose of the 1994 amendatory language to this section in chapter 309, Laws of 1994 is to clarify the intent of the legislature that premiums paid on behalf of nonsubsidized enrollees in the basic health plan are subject to the premium and prepayment tax. The legislature does not consider this clarifying language to either raise existing taxes nor to impose a tax that did not exist previously~~)).

Sec. 11. RCW 48.43.005 and 2001 c 196 s 5 and 2001 c 147 s 1 are each reenacted and amended to read as follows:

Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Adjusted community rate" means the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities.

(2) "Basic health plan" means the plan described under chapter 70.47 RCW, as revised from time to time.

(3) "Basic health plan model plan" means a health plan as required in RCW 70.47.060((~~(2)(d)~~)) (3).

(4) "Basic health plan services" means that schedule of covered health services, including the description of how those benefits are to be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

(5) "Catastrophic health plan" means:

(a) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand dollars; and

(b) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least five thousand five hundred dollars; or

(c) Any health benefit plan that provides benefits for hospital inpatient and outpatient services, professional and prescription drugs provided in conjunction with such hospital inpatient and outpatient services, and excludes or substantially limits outpatient physician services and those services usually provided in an office setting.

(6) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

(7) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(8) "Covered person" or "enrollee" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

(9) "Dependent" means, at a minimum, the enrollee's legal spouse and unmarried dependent children who qualify for coverage under the enrollee's health benefit plan.

(10) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty or more hours. The term includes a self-employed individual, including a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not work less than thirty hours per week and derives at least seventy-five percent of his or her income from a trade or business through which he or she has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form. Persons covered under a health benefit plan pursuant to the consolidated omnibus budget reconciliation act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements of chapter 265, Laws of 1995.

(11) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(12) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

(13) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(14) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding: (a) Denial of payment for medical services or nonprovision of medical services included in the

covered person's health benefit plan, or (b) service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

(15) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

(16) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(17) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(18) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020.

(19) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care services offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(20) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

(21) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(22) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(23) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

(24) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term "small employer" includes a self-employed individual or sole proprietor. The term "small employer" also includes a self-employed individual or sole proprietor who derives at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year.

(25) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

(26) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

NEW SECTION. **Sec. 12.** The following acts or parts of acts are each repealed:

(1) RCW 70.47.015 (Expanded enrollment--Findings--Intent--Enrollee premium share--Expedited application and enrollment process--Commission for agents and brokers) and 1997 c 337 s 1 & 1995 c 265 s 1;

(2) RCW 70.47.080 (Enrollment of applicants--Participation limitations) and 1993 c 492 s 213 & 1987 1st ex.s. c 5 s 10;

(3) RCW 70.47.090 (Removal of enrollees) and 1987 1st ex.s. c 5 s 11; and

(4) RCW 70.47.115 (Enrollment of persons in timber impact areas) and 1992 c 21 s 7 & 1991 c 315 s 22.

NEW SECTION. **Sec. 13.** 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 immediately, except that changes to the basic health plan benefit design and eligibility standards are not required to be implemented until January 1, 2004.

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