H-2225.1

SUBSTITUTE HOUSE BILL 2060

State of Washington 59th Legislature 2005 Regular Session

By House Committee on Health Care (originally sponsored by Representatives Cody, Schual-Berke, Appleton, Morrell, Moeller, Green, Clibborn, Kenney, Upthegrove, Conway, Chase, Darneille, Haigh and Santos)

READ FIRST TIME 03/07/05.

1 AN ACT Relating to expanding participation in state purchased
2 health care programs; and amending RCW 70.47.020, 70.47.060, 48.43.018,
3 and 48.41.090.

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

5 **Sec. 1.** RCW 70.47.020 and 2004 c 192 s 1 are each amended to read
6 as follows:
7 As used in this chapter:
8 (1) "Washington basic health plan" or "plan" means the system of
9 enrollment and payment for basic health care services, administered by
10 the plan administrator through participating managed health care
11 systems, created by this chapter.
12 (2) "Administrator" means the Washington basic health plan
13 administrator, who also holds the position of administrator of the
14 Washington state health care authority.
15 (3) "Health coverage tax credit program" means the program created
16 by the Trade Act of 2002 (P.L. 107-210) that provides a federal tax
17 credit that subsidizes private health insurance coverage for displaced
18 workers certified to receive certain trade adjustment assistance

1 benefits and for individuals receiving benefits from the pension
2 benefit guaranty corporation.
3 (4) "Health coverage tax credit eligible enrollee" means individual
4 workers and their qualified family members who lose their jobs due to
5 the effects of international trade and are eligible for certain trade
6 adjustment assistance benefits; or are eligible for benefits under the
7 alternative trade adjustment assistance program; or are people who
8 receive benefits from the pension benefit guaranty corporation and are
9 at least fifty-five years old.
10 (5) "Managed health care system" means: (a) Any health care
11 organization, including health care providers, insurers, health care
12 service contractors, health maintenance organizations, or any
13 combination thereof, that provides directly or by contract basic health
14 care services, as defined by the administrator and rendered by duly
15 licensed providers, to a defined patient population enrolled in the
16 plan and in the managed health care system; or (b) a self-funded or
17 self-insured method of providing insurance coverage to subsidized
18 enrollees provided under RCW 41.05.140 and subject to the limitations
19 under RCW 70.47.100(7).
20 (6) "Subsidized enrollee" means an individual, or an individual
21 plus the individual's spouse or dependent children: (a) Who is not
22 eligible for medicare; (b) who is not confined or residing in a
23 government-operated institution, unless he or she meets eligibility
24 criteria adopted by the administrator; (c) who resides in an area of
25 the state served by a managed health care system participating in the
26 plan; (d) whose gross family income at the time of enrollment does not
27 exceed two hundred percent of the federal poverty level as adjusted for
28 family size and determined annually by the federal department of health
29 and human services; and (e) who chooses to obtain basic health care
30 coverage from a particular managed health care system in return for
31 periodic payments to the plan. To the extent that state funds are
32 specifically appropriated for this purpose, with a corresponding
33 federal match, "subsidized enrollee" also means an individual, or an
34 individual's spouse or dependent children, who meets the requirements
35 in (a) through (c) and (e) of this subsection and whose gross family
36 income at the time of enrollment is more than two hundred percent, but
37 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.

(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 is accepted for enrollment by the administrator as provided in RCW 48.43.018, either because the potential enrollee cannot be required to complete the standard health questionnaire under RCW 48.43.018, or, based upon the results of the standard health questionnaire, the potential enrollee would not qualify for coverage under the Washington state health insurance pool; (d) who resides in an area of the state served by a managed health care system participating in the plan; ((~~(d)~~)) (e) who chooses to obtain basic health care coverage from a particular managed health care system; and ((~~(e)~~)) (f) who pays or on whose behalf is paid the full costs for participation in the plan, without any subsidy from the plan.

(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).

(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, a nonsubsidized enrollee, or a health coverage tax credit eligible enrollee.

(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, nonsubsidized, and health coverage tax credit eligible enrollees in the plan and in that system.

Sec. 2. RCW 70.47.060 and 2004 c 192 s 3 are each amended to read as follows:

The administrator has the following powers and duties:

1 (1) To design and from time to time revise a schedule of covered
2 basic health care services, including physician services, inpatient and
3 outpatient hospital services, prescription drugs and medications, and
4 other services that may be necessary for basic health care. In
5 addition, the administrator may, to the extent that funds are
6 available, offer as basic health plan services chemical dependency
7 services, mental health services and organ transplant services;
8 however, no one service or any combination of these three services
9 shall increase the actuarial value of the basic health plan benefits by
10 more than five percent excluding inflation, as determined by the office
11 of financial management. All subsidized and nonsubsidized enrollees in
12 any participating managed health care system under the Washington basic
13 health plan shall be entitled to receive covered basic health care
14 services in return for premium payments to the plan. The schedule of
15 services shall emphasize proven preventive and primary health care and
16 shall include all services necessary for prenatal, postnatal, and well-
17 child care. However, with respect to coverage for subsidized enrollees
18 who are eligible to receive prenatal and postnatal services through the
19 medical assistance program under chapter 74.09 RCW, the administrator
20 shall not contract for such services except to the extent that such
21 services are necessary over not more than a one-month period in order
22 to maintain continuity of care after diagnosis of pregnancy by the
23 managed care provider. The schedule of services shall also include a
24 separate schedule of basic health care services for children, eighteen
25 years of age and younger, for those subsidized or nonsubsidized
26 enrollees who choose to secure basic coverage through the plan only for
27 their dependent children. In designing and revising the schedule of
28 services, the administrator shall consider the guidelines for assessing
29 health services under the mandated benefits act of 1984, RCW 48.47.030,
30 and such other factors as the administrator deems appropriate.
31 (2)(a) To design and implement a structure of periodic premiums due
32 the administrator from subsidized enrollees that is based upon gross
33 family income, giving appropriate consideration to family size and the
34 ages of all family members. The enrollment of children shall not
35 require the enrollment of their parent or parents who are eligible for
36 the plan. The structure of periodic premiums shall be applied to
37 subsidized enrollees entering the plan as individuals pursuant to

subsection (11) 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 (12) 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.

(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.

(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 evaluate, with the cooperation of participating managed health care system providers, the impact on the basic health plan of enrolling health coverage tax credit eligible enrollees. The administrator shall issue to the appropriate committees of the legislature preliminary evaluations on June 1, 2005, and January 1, 2006, and a final evaluation by June 1, 2006. The evaluation shall

address the number of persons enrolled, the duration of their enrollment, their utilization of covered services relative to other basic health plan enrollees, and the extent to which their enrollment contributed to any change in the cost of the basic health plan.

(4) 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.

(5) To design and implement a structure of enrollee cost-sharing due a managed health care system from subsidized, 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.

(6) 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.

(7) 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.

(8) 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.

(9) 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 both subsidized ((~~enrollees,~~)) and nonsubsidized enrollees, or health coverage tax credit eligible enrollees. Managed health care systems that do not offer individual health benefit plans under chapter 48.21, 48.44, or 48.46 RCW shall be

given the option to apply to serve nonsubsidized enrollees, but may not be required to do so as a condition of contracting to serve subsidized enrollees. 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.

(10) To receive periodic premiums from or on behalf of subsidized, nonsubsidized, and health coverage tax credit eligible 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.

(11) 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, nonsubsidized, or health coverage tax credit eligible 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.

(12) 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.

(13) 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.

(14) 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.

(15) 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.

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

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

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

(19) 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. 3. RCW 48.43.018 and 2004 c 244 s 3 are each amended to read as follows:

(1) Except as provided in (a) through (e) of this subsection, a health carrier may require any person applying for an individual health benefit plan <u>and the health care authority may require any person</u>

<u>applying for nonsubsidized enrollment in the basic health plan</u> to complete the standard health questionnaire designated under chapter 48.41 RCW.

(a) If a person is seeking an individual health benefit plan <u>or enrollment in the basic health plan as a nonsubsidized enrollee</u> 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, completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of relocation.

(b) If a person is seeking an individual health benefit plan <u>or enrollment in the basic health plan as a nonsubsidized enrollee</u>:

(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 carrier's provider network under his or her existing Washington individual health benefit plan; and

(ii) His or her health care provider is part of another carrier's <u>or a basic health plan managed care system's</u> provider network; and

(iii) Application for a health benefit plan under that carrier's provider network individual coverage <u>or for basic health plan nonsubsidized enrollment</u> is made within ninety days of his or her provider leaving the previous carrier's provider network; then completion of the standard health questionnaire shall not be a condition of coverage.

(c) If a person is seeking an individual health benefit plan <u>or enrollment in the basic health plan as a nonsubsidized enrollee</u> due to his or her having exhausted continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of exhaustion of continuation coverage. A health carrier <u>or the health care authority as administrator of basic health plan nonsubsidized coverage</u> shall accept an application without a standard health questionnaire from a person currently covered by such continuation coverage if application is made within ninety days prior to the date the continuation coverage would be exhausted and the effective date of the individual coverage applied for

is the date the continuation coverage would be exhausted, or within ninety days thereafter.

(d) If a person is seeking an individual health benefit plan or enrollment in the basic health plan as a nonsubsidized enrollee due to his or her receiving notice that his or her coverage under a conversion contract is discontinued, completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of discontinuation of eligibility under the conversion contract. A health carrier or the health care authority as administrator of basic health plan nonsubsidized coverage shall accept an application without a standard health questionnaire from a person currently covered by such conversion contract if application is made within ninety days prior to the date eligibility under the conversion contract would be discontinued and the effective date of the individual coverage applied for is the date eligibility under the conversion contract would be discontinued, or within ninety days thereafter.

(e) If a person is seeking an individual health benefit plan or enrollment in the basic health plan as a nonsubsidized enrollee and, but for the number of persons employed by his or her employer, would have qualified for continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of the standard health questionnaire shall not be a condition of coverage if: (i) Application for coverage is made within ninety days of a qualifying event as defined in 29 U.S.C. Sec. 1163; and (ii) the person had at least twenty-four months of continuous group coverage immediately prior to the qualifying event. A health carrier or the health care authority as administrator of basic health plan nonsubsidized coverage shall accept an application without a standard health questionnaire from a person with at least twenty-four months of continuous group coverage if application is made no more than ninety days prior to the date of a qualifying event and the effective date of the individual coverage applied for is the date of the qualifying event, or within ninety days thereafter.

(2) If, based upon the results of the standard health questionnaire, the person qualifies for coverage under the Washington state health insurance pool, the following shall apply:

(a) The carrier may decide not to accept the person's application for enrollment in its individual health benefit plan and the health

care authority, as administrator of basic health plan nonsubsidized coverage, shall not accept the person's application for enrollment as a nonsubsidized enrollee; and

(b) Within fifteen business days of receipt of a completed application, the carrier or the health care authority as administrator of basic health plan nonsubsidized coverage shall provide written notice of the decision not to accept the person's application for enrollment to both the person and the administrator of the Washington state health insurance pool. The notice to the person shall state that the person is eligible for health insurance provided by the Washington state health insurance pool, and shall include information about the Washington state health insurance pool and an application for such coverage. If the carrier or the health care authority as administrator of basic health plan nonsubsidized coverage does not provide or postmark such notice within fifteen business days, the application is deemed approved.

(3) If the person applying for an individual health benefit plan: (a) Does not qualify for coverage under the Washington state health insurance pool based upon the results of the standard health questionnaire; (b) does qualify for coverage under the Washington state health insurance pool based upon the results of the standard health questionnaire and the carrier elects to accept the person for enrollment; or (c) is not required to complete the standard health questionnaire designated under this chapter under subsection (1)(a) or (b) of this section, the carrier or the health care authority as administrator of basic health plan nonsubsidized coverage shall accept the person for enrollment if he or she resides within the carrier's or the basic health plan's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The commissioner may grant a temporary exemption from this subsection if, upon application by a health carrier, the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a health carrier is required to continue enrollment of additional eligible individuals.

1 **Sec. 4.** RCW 48.41.090 and 2000 c 79 s 11 are each amended to read
2 as follows:
3 (1) Following the close of each accounting year, the pool
4 administrator shall determine the net premium (premiums less
5 administrative expense allowances), the pool expenses of
6 administration, and incurred losses for the year, taking into account
7 investment income and other appropriate gains and losses.
8 (2)(a) Each member's proportion of participation in the pool shall
9 be determined annually by the board based on annual statements and
10 other reports deemed necessary by the board and filed by the member
11 with the commissioner; and shall be determined by multiplying the total
12 cost of pool operation by a fraction. The numerator of the fraction
13 equals that member's total number of resident insured persons,
14 including spouse and dependents, covered under all health plans in the
15 state by that member during the preceding calendar year. The
16 denominator of the fraction equals the total number of resident insured
17 persons, including spouses and dependents, covered under all health
18 plans in the state by all pool members during the preceding calendar
19 year.
20 (b) For purposes of calculating the numerator and the denominator
21 under (a) of this subsection:
22 (i) All health plans in the state by the state health care
23 authority include only the uniform medical plan <u>and nonsubsidized basic</u>
24 <u>health plan coverage</u>; and
25 (ii) Each ten resident insured persons, including spouse and
26 dependents, under a stop loss plan or the uniform medical plan shall
27 count as one resident insured person.
28 (c) Except as provided in RCW 48.41.037, any deficit incurred by
29 the pool shall be recouped by assessments among members apportioned
30 under this subsection pursuant to the formula set forth by the board
31 among members.
32 (3) The board may abate or defer, in whole or in part, the
33 assessment of a member if, in the opinion of the board, payment of the
34 assessment would endanger the ability of the member to fulfill its
35 contractual obligations. If an assessment against a member is abated
36 or deferred in whole or in part, the amount by which such assessment is
37 abated or deferred may be assessed against the other members in a

1 manner consistent with the basis for assessments set forth in
2 subsection (2) of this section. The member receiving such abatement or
3 deferment shall remain liable to the pool for the deficiency.

4 (4) If assessments exceed actual losses and administrative expenses
5 of the pool, the excess shall be held at interest and used by the board
6 to offset future losses or to reduce pool premiums. As used in this
7 subsection, "future losses" includes reserves for incurred but not
8 reported claims.

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