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SENATE BILL 5637

State of Washington 59th Legislature 2005 Regular Session

By Senators Keiser, Thibaudeau, Franklin, Kline, Prentice, McAuliffe and Kohl-Welles

Read first time 01/31/2005. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to expanding access to health insurance coverage; amending RCW 70.47.010, 70.47.020, 70.47.030, 70.47.060, and 70.47.080; adding new sections to chapter 70.47 RCW; adding a new section to chapter 48.21 RCW; adding a new section to chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; adding a new section to chapter 74.09 RCW; adding a new chapter to Title 50 RCW; and creating new sections.

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

PART 1
EXPANDING ACCESS TO HEALTH INSURANCE THROUGH FEES ON LARGE EMPLOYERS

NEW SECTION. **Sec. 101.** (1) The legislature finds that:

(a) Most working Washingtonians obtain their health insurance coverage through their employment;

(b) In 2004, more than six hundred thousand Washingtonians were uninsured, and, among uninsured working age adults, most have either one or two workers in their family;

(c) People who are covered by health insurance have better health outcomes than those who lack coverage. Persons without health

insurance are more likely to be in poor health, more likely to have missed needed medications and treatment, and more likely to have chronic conditions that are not properly managed;

(d) Persons without health insurance are at significant risk of financial ruin or personal bankruptcy;

(e) The unpaid cost of health services provided to uninsured people is shifted to paying patients, which increases the cost of health services for employers, individuals, and state and local government. Controlling health care costs can be more readily achieved if a greater share of working people and their families have health benefits; and

(f) The state of Washington provides health insurance to low-income working families through medicaid, the state children's health insurance program, and the basic health plan. These programs are paying the cost of coverage for some people who work for large employers who do not offer affordable health care coverage to their employees. The state also funds hospitals, community clinics, and other safety net providers that provide care to those working people whose employers do not provide affordable health coverage to their workers as well as to other uninsured persons.

(2) It is therefore the intent of the legislature to:

(a) Expand access to health care by increasing the number of large employers who provide health benefits to their employees and imposing a fee on large employers who do not offer such benefits. Fee revenues will be used to fund basic health plan coverage for as many employees of employers paying the fee as the fee revenues can support. However, consistent with this act, large employers can reduce or eliminate their fee through expenditures on health services for their employees;

(b) Maintain existing protections in law for persons eligible for medical assistance programs, the state children's health insurance program, and the basic health plan.

(3) In enacting this act, it is not the intent of the legislature to influence the content or administration of employee benefit plans, and the legislature is neutral as to whether large employers choose to pay the tax or provide health services to their employees and dependents.

NEW SECTION. **Sec. 102.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Administrator" means the administrator of the state health care authority, as established in chapter 41.05 RCW.

(2) "Authority" means the state health care authority, as established in chapter 41.05 RCW.

(3) "Basic health plan" means the program established in chapter 70.47 RCW.

(4) "Employee" means a person in employment under Title 50 RCW who has worked for an employer for at least three months.

(5) "Fee" means the fee as determined in sections 103 and 104 of this act.

(6) "Large employer" means an employer as defined in RCW 50.04.080 who, on at least fifty percent of its working days during the preceding calendar quarter, had fifty or more people in employment within this state, and is not formed primarily for purposes of buying health insurance. In determining the number of people in employment, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, are considered an employer.

(7) "Medicaid" means Title XIX of the federal social security act, as administered by the department of social and health services under chapter 74.09 RCW.

(8) "State children's health insurance program" means the program established under RCW 74.09.450 and administered by the department of social and health services.

NEW SECTION. **Sec. 103.** (1) Except as otherwise provided in this chapter, beginning January 1, 2006, each large employer shall pay a fee to the extent required in this section.

(2) The administrator shall establish the amount of the fee as follows:

(a) On a calendar year basis, based upon the results of its basic health plan procurement for that calendar year, the administrator shall determine the monthly cost of providing basic health plan coverage to an adult. That amount shall be multiplied by 0.85. The administrator shall add to this amount a calculation of the monthly per capita cost associated with the administration of this act, including those costs associated with collection of the fee and its enforcement by the employment security department;

(b) The amount calculated in (a) of this subsection is then divided by eighty-six. The result is the hourly fee applicable for that calendar year.

(3)(a) On a monthly basis, each large employer shall calculate the aggregate fee due for that month by:

(i) Multiplying the hourly fee by the total number of hours that each of its employees has worked during that month, up to a maximum of eighty-six hours per month per employee; and

(ii) Deducting from the amount resulting from the calculation in (a) of this subsection the aggregate amount paid by the employer to provide health insurance coverage for its employees, allowable for the current quarter by the internal revenue service as a deductible business expense. A nonincorporated large employer may deduct its aggregate expenses for providing health insurance coverage or other health care benefits for its employees as reported and allowed pursuant to rules adopted by the employment security department.

(b) Each large employer shall pay an aggregate monthly fee equal to the amount remaining after the deductions provided for in this section. A deduction for a large employer may not reduce the aggregate monthly fee due below zero. The employer shall transmit any applicable fee to the department on a quarterly basis.

(4) The program implemented under this act shall be fully supported by the fees and basic health plan enrollee premium contributions collected under this section and section 205 of this act.

(5) The fees collected under this act may not be used for any purpose other than providing basic health plan coverage to fee supported enrollees, as defined in RCW 70.47.020, as well as costs associated with the administration of the basic health plan and with collection of the fee under this chapter and its enforcement by the employment security department.

NEW SECTION. **Sec. 104.** (1) The administrator shall provide notice to the employment security department of the hourly fee in a time and manner that permits the employment security department to provide notice to all large employers of the estimated hourly fee for the calendar year.

(2) Revenue from the fee must be deposited into the basic health plan employer fee account established in RCW 70.47.030.

(3) If a large employer fails to pay the required fee, for whatever reason, the large employer is responsible to the basic health plan employer fee account for payment of a penalty of two hundred percent of the amount of any fee that would have otherwise been paid by the large employer. The penalty must be made to the administrator and must be paid into the basic health plan employer fee account created in RCW 70.47.030.

(4) If amounts due under this section, including penalties, are not paid on the date on which they are due and payable as prescribed by the administrator, the whole or part thereof remaining unpaid bears interest at the rate of one percent per month or fraction thereof from and after such date until payment plus accrued interest is received by the administrator. The date as of which payment of contributions, if mailed, is deemed to have been received may be determined by rule. Interest collected under this section must be paid into the basic health plan employer fee account created in RCW 70.47.030.

(5) Nothing in this section precludes a large employer from purchasing additional benefits or coverage, in addition to paying the fee.

NEW SECTION. **Sec. 105.** Sections 101 through 104 of this act constitute a new chapter in Title 50 RCW.

PART 2
BASIC HEALTH PLAN MODIFICATIONS AND RELATED PROVISIONS

Sec. 201. 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)~~)) (2) 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)~~)) (3)(a) The legislature further finds that many small employers struggle with the cost of providing employer-sponsored health

insurance coverage to their employees and their employees' families, while others are unable to offer employer-sponsored health insurance due to its high cost. Low-wage workers also struggle with the burden of paying their share of the costs of employer-sponsored health insurance, while others turn down their employer's offer of coverage due to its costs.

(b) 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 and that the basic health plan provides an opportunity to blend private and public funds in a manner that makes employer-based health plans more affordable for low-wage employees. ((~~Further, it is the intent of the legislature to expand, wherever possible,~~)) By blending private and public funds, the legislature intends to expand the availability of private health care coverage and to discourage the decline of employer-based coverage.

((~~(5)~~)) (4)(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. 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.

(5)(a) The legislature further 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 ensured 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.

Sec. 202. RCW 70.47.020 and 2004 c 192 s 1 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 or as provided in RCW 70.47.060(11), created by this chapter.

(2) "Administrator" means the Washington basic health plan administrator, who also holds the position of administrator of the Washington state health care authority.

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

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

(5) "Managed health care system" means: (a) Any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the administrator and rendered by duly licensed providers, to a defined patient population enrolled in the plan and in the managed health care system; or (b) a self-funded or self-insured method of providing insurance coverage to subsidized or fee supported enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100(7).

(6) "Subsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children: (a) Who is not eligible for medicare; (b) who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator; (c) who resides in an area of the state served by a managed health care system participating in the plan; (d) whose gross family income at the time of enrollment does not exceed two hundred percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services; and (e) who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan. To the extent that state funds are specifically appropriated for this purpose, with a corresponding federal match, "subsidized enrollee" also means an individual, or an individual's spouse or dependent children, who meets the requirements

in (a) through (c) and (e) of this subsection and whose gross family income at the time of enrollment is more than two hundred percent, but less than two hundred fifty-one percent, of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services.

(7) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children: (a) Who is not eligible for medicare; (b) who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator; (c) who resides in an area of the state served by a managed health care system participating in the plan; (d) who chooses to obtain basic health care coverage from a particular managed health care system; and (e) who pays or on whose behalf is paid the full costs for participation in the plan, without any subsidy from the plan.

(8) "Fee supported enrollee" means an individual not eligible for medicare whose employer has paid a fee deposited in the basic health plan employer fee account according to section 103 of this act, who works at least eighty-six hours per month for the employer that has paid the fee, and who chooses to obtain basic health plan coverage from a participating managed health care system in return for periodic payments to the plan.

(9) "Premium assistance enrollee" means an individual or an individual plus the individual's spouse and 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) 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; (d) who resides within the state of Washington; and (e) who qualifies for and chooses to participate in the small employer premium assistance option under RCW 70.47.060(11).

(10) "Subsidy" means the difference between the amount of periodic payment the administrator makes to a managed health care system on behalf of a subsidized or fee supported enrollee or the amount of a periodic payment made under RCW 70.47.060(11) on behalf of a premium assistance enrollee plus the administrative cost to the plan of

providing the plan to that subsidized, fee supported, or premium assistance enrollee, and the amount determined to be the subsidized, fee supported, or premium assistance enrollee's responsibility under ((~~RCW 70.47.060(2)~~)) section 205 of this act.

((~~(9)~~)) (11) "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 fee supported enrollee, a premium assistance enrollee, a nonsubsidized enrollee, or a health coverage tax credit eligible enrollee.

((~~(10)~~)) (12) "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, fee supported, nonsubsidized, and health coverage tax credit eligible enrollees in the plan and in that system.

(13) "Small employer" has the same meaning as defined in RCW 48.43.005.

Sec. 203. RCW 70.47.030 and 2004 c 192 s 2 are each amended to read as follows:

(1) The basic health plan trust account is hereby established in the state treasury. Any nongeneral fund-state funds collected for this program shall be deposited in the basic health plan trust account and may be expended without further appropriation. Moneys in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of enrollees in the plan and payment of costs of administering the plan.

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

(2) The basic health plan subscription account is created in the custody of the state treasurer. All receipts from amounts due from or on behalf of nonsubsidized enrollees and health coverage tax credit eligible enrollees shall be deposited into the account. Funds in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of nonsubsidized enrollees and health coverage tax credit

eligible enrollees in the plan and payment of costs of administering the plan. The account is subject to allotment procedures under chapter 43.88 RCW, but no appropriation is required for expenditures.

(3) The basic health plan employer fee account is created in the custody of the state treasurer. All receipts from fees collected under sections 103 and 104 of this act must be deposited in the account. Expenditures from the account may be used only for the purposes of this chapter, including payments to participating managed health care systems for fee supported enrollees in the basic health plan and payment of costs of administering the basic health plan coverage. Only the administrator or the administrator's designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

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

((~~(5)~~)) (4) To design and implement a structure of enrollee cost-sharing due a managed health care system from subsidized, fee supported, 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)~~)) (5) To limit enrollment of persons who qualify for subsidies, as subsidized or fee supported enrollees, or premium assistance enrollees 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)~~)) (6) To limit the payment of subsidies or premium assistance to subsidized enrollees, fee supported enrollees, and premium assistance enrollees, as defined in RCW 70.47.020, except to the extent authorized in section 207 of this act. The level of subsidy provided to persons who qualify may be based on the lowest cost plans, as defined by the administrator.

((~~(8)~~)) (7) 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)~~)) (8) 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 subsidized enrollees, fee supported enrollees, nonsubsidized enrollees, or health coverage tax credit eligible 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)~~)) (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, fee supported, premium assistance, 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. Applications from individuals as fee supported enrollees may be submitted for calendar years beginning January 1, 2006. Applications from individuals as premium assistance enrollees may be accepted by the administrator only during those biennia for which the biennial appropriations act includes funding sufficient to support enrollment of at least one hundred thousand subsidized or fee supported enrollees. If appropriations in a subsequent biennium are not sufficient to support enrollment of at least one hundred thousand subsidized or fee supported enrollees, current premium assistance enrollees will maintain their enrolled status. 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. If a fee supported enrollee loses their fee supported enrollee status, the individual may apply to convert their enrollment to enrollment as a subsidized enrollee. If subsidized enrollment is subject to a reservation or waiting list at the time of the application, the enrollee must be given the opportunity to place their name on the reservation or waiting list.

((~~(12)~~)) (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.

((~~(13)~~)) (11)(a) To accept applications from individuals as premium assistance enrollees, on behalf of themselves and their spouses and dependent children, for assistance in payment of their share of their small employer's health plan premiums, 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 premium assistance. The amount of the enrollee's premium assistance shall be based upon the premium schedule for subsidized enrollees. The administrator may use basic health plan funds on behalf of premium assistance enrollees when:

(i) The cost of paying the premium assistance enrollee's premium obligation would be less than the subsidy that would be paid if the individual, or the individual plus his or her spouse and dependent children, were to enroll in a participating managed care system;

(ii) The small employer health benefit plan for which the enrollee is seeking premium assistance meets any standards for minimum thresholds of coverage established by the administrator. The office of the insurance commissioner, under Title 48 RCW, will certify small employer health benefit plans that meet any standards adopted under this subsection (11);

(iii) The premium assistance enrollee agrees to provide verification of continued enrollment in his or her small employer's health benefit plan on a semiannual basis, or to notify the administrator whenever his or her enrollment status changes, whichever is earlier. Verification or notification may be made directly by the employee, or through their employer or the carrier providing the small employer health benefit plan.

(b) The administrator, in consultation with small employers, carriers, and the office of the insurance commissioner, shall determine the most efficient method for payment of premium assistance, with a goal of minimizing the administrative burden on small employers.

(c) 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. The enrollee reporting and sanctions provisions of subsection (9) of this section apply to premium assistance enrollees. No premium assistance 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.

(12) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health

care services to enrollees in the system. Although the schedule of covered basic health care services will be the same or actuarially equivalent for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the administrator shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant.

((~~(14)~~)) (13) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed health care systems and to the plan. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

((~~(15)~~)) (14) To evaluate the effects this chapter has on private employer-based health care coverage and to take appropriate measures consistent with state and federal statutes that will discourage the reduction of such coverage in the state.

((~~(16)~~)) (15) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

((~~(17)~~)) (16) To provide, consistent with available funding, assistance for rural residents, underserved populations, and persons of color.

((~~(18)~~)) (17) In consultation with appropriate state and local government agencies, to establish criteria defining eligibility for persons confined or residing in government-operated institutions.

((~~(19)~~)) (18) 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.

NEW SECTION. **Sec. 205.** A new section is added to chapter 70.47 RCW to read as follows:

(1) The administrator shall:

(a) Design and implement a structure of periodic premiums due from subsidized and premium assistance enrollees that is based upon gross family income, giving appropriate consideration to family size and the ages of all family members. A subsidized enrollee's premium may not exceed twenty percent of the age-adjusted rate paid to the participating managed health care system that the subsidized enrollee has chosen to enroll in. The enrollment of children does not require the enrollment of their parent or parents who are eligible for the plan. The structure of periodic premiums must be applied to subsidized enrollees entering the plan as individuals under RCW 70.47.060(9), and to the share of the cost of their small employer-sponsored health insurance coverage due from premium assistance enrollees entering the plan under RCW 70.47.060(11);

(b) Design and implement a structure of periodic premiums due from fee supported enrollees. A fee supported enrollee's premium will be fifteen percent of the age-adjusted rate paid to the participating managed health care system that the fee supported enrollee has chosen to enroll in;

(c) Determine the periodic premiums due the administrator from nonsubsidized enrollees. Premiums due from nonsubsidized 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.

(2) 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.

(3) The administrator shall receive periodic premiums from or on behalf of subsidized, fee supported, and nonsubsidized enrollees, deposit them in the appropriate 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.

Sec. 206. RCW 70.47.080 and 1993 c 492 s 213 are each amended to read as follows:

(1)(a) On and after July 1, 1988, the administrator shall accept for enrollment applicants eligible to receive covered basic health care services from the respective managed health care systems which are then participating in the plan.

(b) Thereafter, total subsidized enrollment shall not result in expenditures that exceed the total amount that has been made available by the legislature in any act appropriating funds to the plan. To the extent that new funding is appropriated for expansion, the administrator shall endeavor to secure participation contracts from managed health care systems in geographic areas of the state that are unserved by the plan at the time at which the new funding is appropriated. In the selection of any such areas the administrator shall take into account the levels and rates of unemployment in different areas of the state, the need to provide basic health care coverage to a population reasonably representative of the portion of the state's population that lacks such coverage, and the need for geographic, demographic, and economic diversity.

(c) The administrator shall at all times closely monitor growth patterns of enrollment so as not to exceed that consistent with the orderly development of the plan as a whole, in any area of the state or in any participating managed health care system. The annual or biennial enrollment limitations derived from operation of the plan under this section do not apply to nonsubsidized enrollees as defined in RCW 70.47.020((~~(5)~~)) (7).

(2) Total fee supported enrollment shall not result in expenditures that exceed the total amount that has been deposited into the basic health plan employer fee account under section 203 of this act.

NEW SECTION. **Sec. 207.** A new section is added to chapter 70.47 RCW to read as follows:

(1) To the extent that savings result from the conversion of subsidized enrollees to fee supported enrollees under sections 101

through 104 of this act and to the extent that such savings are appropriated for this purpose by the legislature, the administrator may establish an option for small employer group enrollment in the basic health plan. Under this option, as distinguished from individual enrollment, the administrator may accept applications for group coverage from small employers who meet the requirements of this section on behalf of themselves and their employees, spouses, and dependent children who reside in an area served by the plan.

(2) A small employer seeking coverage through the basic health plan must certify upon application, and annually thereafter, that at least seventy-five percent of the small employer's employees have wages or salary that are at or below two hundred percent of the federal poverty guidelines as adjusted for a family of three and determined annually by the federal department of health and human services. Small employer group coverage through the basic health plan is not conditioned upon all of the employer's employees meeting the eligibility requirements for subsidized enrollees as defined in RCW 70.47.020. The administrator may not require employers to report total household income of their employees as a condition of receiving group coverage through the basic health plan.

(3) The administrator may require a substantial majority of the eligible employees of small employers to enroll in the plan and establish those procedures necessary to facilitate the orderly enrollment of small employer groups in the plan and into a managed health care system.

(4) Basic health plan coverage must be purchased for small employer group enrollees through the basic health plan subsidized enrollee pool, even though not all employees in the group may be subsidized enrollees as defined in RCW 70.47.020.

(5) Enrollment is limited to small employer groups who wish to enroll in the plan and choose to obtain basic health care coverage and services from a managed care system participating in the plan. For each employee of the small employer group with wages below the level established in subsection (2) of this section, the employer must pay at least forty percent, the employee must pay a maximum of twenty percent, and the plan must pay forty percent, of the age-adjusted rate paid to the participating managed health care system that the small employer group has chosen to enroll in. No state subsidy may be paid on behalf

of employees with wages in excess of the level established in subsection (2) of this section. The administrator shall adjust the amount determined to be due from small employer group 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.

NEW SECTION. **Sec. 208.** A new section is added to chapter 48.21 RCW to read as follows:

On or after July 1, 2005, regardless of any applicable open enrollment period, an insurer shall enroll any individual or family member of an individual who requests enrollment in a group disability insurance contract for health care within thirty days after becoming eligible for a basic health plan small employer-sponsored health insurance premium assistance under RCW 70.47.060(11).

NEW SECTION. **Sec. 209.** A new section is added to chapter 48.44 RCW to read as follows:

On or after July 1, 2005, regardless of any applicable open enrollment period, a health care service contractor shall enroll any individual or family member of an individual who requests enrollment in a group health care service contract within thirty days after becoming eligible for a basic health plan small employer-sponsored health insurance premium assistance under RCW 70.47.060(11).

NEW SECTION. **Sec. 210.** A new section is added to chapter 48.46 RCW to read as follows:

On or after July 1, 2005, regardless of any applicable open enrollment period, a health maintenance organization shall enroll any individual or family member of an individual who requests enrollment in a group health maintenance agreement within thirty days after becoming eligible for a basic health plan small employer-sponsored health insurance premium assistance under RCW 70.47.060(11).

NEW SECTION. **Sec. 211.** A new section is added to chapter 74.09 RCW to read as follows:

(1) The department shall make every effort to maximize opportunities to blend public and private funds through subsidization

of small employer-sponsored health insurance premiums on behalf of individuals eligible for medical assistance and children eligible for the state children's health insurance program when such subsidization is cost-effective for the state. In developing policies under this section, the department shall consult with the health care authority and, to the extent allowed by federal law, develop policies that are consistent with those developed by the health care authority under RCW 70.47.060(11) so that entire families will have the opportunity to enroll in the same small employer-sponsored health insurance plan.

(2) If a federal waiver is necessary to achieve consistency with health care authority policies under RCW 70.47.060(11), the department shall notify the relevant fiscal and policy committees of the legislature on or before January 1, 2006. The notification must include recommendations regarding federal waiver options that would provide the flexibility needed to optimize the use of medical assistance and state children's health insurance program funds to subsidize small employer-sponsored health insurance premiums on behalf of low-income families.

PART 3
MISCELLANEOUS

NEW SECTION. **Sec. 301.** If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state or the eligibility of employers in this state for federal unemployment tax credits, the conflicting part of this act is inoperative solely to the extent of the conflict, and the finding or determination does not affect the operation of the remainder of this act. Rules adopted under this act must meet federal requirements that are a necessary condition to the receipt of federal funds by the state or the granting of federal unemployment tax credits to employers in this state.

NEW SECTION. **Sec. 302.** This act shall be known as the "health care responsibility act."

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