S-2167.3

SUBSTITUTE SENATE BILL 5748

State of Washington 59th Legislature 2005 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored by Senators Kastama, Keiser, Poulsen and Rockefeller)

READ FIRST TIME 03/02/05.

AN ACT Relating to the use of information and data to improve health care decision making; amending RCW 70.47.060; adding new sections to chapter 41.05 RCW; creating a new section; and making appropriations.

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

NEW SECTION. **Sec. 1.** The legislature finds:

(1) Assuring the well-being of our state's residents through a viable, accessible health care system is one of our fundamental responsibilities. The current system, however, is broken and unsustainable. Medical expenditures threaten to overwhelm government budgets, displacing other essential public goods. Double digit cost increases have become routine, dampening our economy and denying an increasing number of people even their basic health care needs. Yet the product of these expenditures is too often poor; too much is spent on that which contributes little to quality or length of life;

(2) The state must be a leader in the development of an affordable, effective, and sustainable health care system, that acknowledges that resources are limited, and directs the use of those limited resources to those things that do the most to maintain and improve the health

status of our population as a whole. We cannot promise every service to every resident, but we can assure everyone's access to a basic level of care, and the best health outcomes given the resources available;

(3) The foundation of such a system is good information, and the use of that information by all to reduce the need and demand for medical treatment, and assure that when treatment is necessary, it provides the best expected result at the lowest possible cost; and

(4) Recent efforts in this state to collect, analyze, and act on information to improve health care decision making have not been sufficiently comprehensive or coordinated. Our continued reliance on incomplete information, and a lack of uniform standards, will only perpetuate current inefficiencies. A statewide, systematic approach is necessary to more clearly define the purpose of our health care system, and align its various components to serve that purpose.

NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05 RCW to read as follows:

(1) The authority shall promote and coordinate on a statewide basis the use and application of the best available information and data in support of:

(a) The proper allocation of financial and human resources within the health care system, including public health, to best maintain and improve the health status of all Washington residents;

(b) Intelligent and informed purchasing and reimbursement decisions by state agencies, employers, health carriers, and others responsible for financing medical treatment;

(c) Treatment decisions by health care providers that result in the best health outcomes at the lowest possible cost; and

(d) Consumer choices to improve their own health, reduce the demand for medical treatment, and when treatment is necessary, receive only the most efficacious and cost-effective treatment available.

(2) All state agencies shall cooperate with the authority in the implementation of its duties.

NEW SECTION. **Sec. 3.** A new section is added to chapter 41.05 RCW to read as follows:

The authority shall:

(1) Design and periodically update the schedule of benefits included in the basic health plan to reflect the conscientious, explicit, and judicious use of current best information and data with regard to patient care. In designing the schedule of benefits and enrollee cost-sharing, the authority shall:

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

(b) Include other benefits determined to be the most efficacious and cost-effective use of the funds available within the limits established in this section. Any benefit otherwise mandated by state law, requiring coverage of certain types of providers, services, or conditions, shall not be included unless explicitly determined by the authority to meet the requirements of this subsection;

(c) Structure enrollee cost-sharing to discourage demand for inappropriate or unnecessary treatment, encourage enrollee responsibility, including the use of efficacious and cost-effective services and products, and promote quality care. Costs imposed on enrollees should not be a barrier to the appropriate use of necessary health care services; and

(d) Assure that the actuarial value of the plan on January 1st of each year is no greater than its actuarial value on January 1, 2006, adjusted annually to reflect the rate of medical inflation;

(2) Develop and incorporate contract standards for the administration of the basic health plan which address the role of the managed care plan administrator in:

(a) Educating enrollees regarding proper health care decision making, engaging them in health promotion and wellness activities, and assuring their receipt of appropriate preventive services;

(b) Identifying and encouraging appropriate, efficacious, and cost-effective care by providers based on evidence of best practices, and promoting the use of quality providers by enrollees;

(c) Identifying enrollees with, or with the potential for, chronic or other high-cost conditions and providing them coordinated care through disease and demand management programs;

(d) Encouraging innovative, efficient, and patient-centered facility designs and service delivery methods that improve enrollee access to care and health outcomes; and

(3) Develop and incorporate contract standards for the medical treatment of enrollees by providers in the basic health plan to assure the receipt of appropriate, efficacious, and cost-effective care.

NEW SECTION. **Sec. 4.** A new section is added to chapter 41.05 RCW to read as follows:

The authority shall design and implement a centralized technology assessment pilot project to strengthen the capacity of state health care agencies and others to obtain and evaluate scientific evidence regarding evolving health care procedures, services, devices, and technology in support of appropriate purchasing, coverage, and medical necessity decisions and criteria. A preliminary evaluation of the project is due to the legislature by May 2007 with a final evaluation by March 2008.

Sec. 5. 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~~)) under section 3 of this act. 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, 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) 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 consistent with section 3 of this act 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 subsidized 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) 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.

NEW SECTION. **Sec. 6.** (1) The sum of one million dollars, or as much thereof as may be necessary, is appropriated for the fiscal year ending June 30, 2006, from the general fund to the health care authority for the purposes of this act.

(2) The sum of one million dollars, or as much thereof as may be necessary, is appropriated for the fiscal year ending June 30, 2007, from the general fund to the health care authority for the purposes of this act.

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