SSB 6583 - H COMM AMD
By Committee on Appropriations

ADOPTED AND ENGROSSED 03/06/2008

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** RCW 74.09.510 and 2007 c 315 s 1 are each amended to read as follows:

(1) Medical assistance may be provided in accordance with eligibility requirements established by the department, as defined in the social security Title XIX state plan for mandatory categorically needy persons and:

((~~(1)~~)) (a) Individuals who would be eligible for cash assistance except for their institutional status;

((~~(2)~~)) (b) Individuals who are under twenty-one years of age, who would be eligible for medicaid, but do not qualify as dependent children and who are in ((~~(a)~~)) (i) foster care, ((~~(b)~~)) (ii) subsidized adoption, ((~~(c)~~)) (iii) a nursing facility or an intermediate care facility for persons who are mentally retarded, or ((~~(d)~~)) (iv) inpatient psychiatric facilities;

((~~(3)~~)) (c) Individuals who:

((~~(a)~~)) (i) Are under twenty-one years of age;

((~~(b)~~)) (ii) On or after July 22, 2007, were in foster care under the legal responsibility of the department or a federally recognized tribe located within the state; and

((~~(c)~~)) (iii) On their eighteenth birthday, were in foster care under the legal responsibility of the department or a federally recognized tribe located within the state;

((~~(4)~~)) (d) Persons who are aged, blind, or disabled who: ((~~(a)~~)) (i) Receive only a state supplement, or ((~~(b)~~)) (ii) would not be eligible for cash assistance if they were not institutionalized;

((~~(5)~~)) (e) Categorically eligible individuals who meet the income and resource requirements of the cash assistance programs;

((~~(6)~~)) (f) Individuals who are enrolled in managed health care systems, who have otherwise lost eligibility for medical assistance, but who have not completed a current six-month enrollment in a managed health care system, and who are eligible for federal financial participation under Title XIX of the social security act;

((~~(7)~~)) (g) Children and pregnant women allowed by federal statute for whom funding is appropriated;

((~~(8)~~)) (h) Working individuals with disabilities authorized under section 1902(a)(10)(A)(ii) of the social security act for whom funding is appropriated;

((~~(9)~~)) (i) Other individuals eligible for medical services under RCW 74.09.035 and 74.09.700 for whom federal financial participation is available under Title XIX of the social security act;

((~~(10)~~)) (j) Persons allowed by section 1931 of the social security act for whom funding is appropriated; and

((~~(11)~~)) (k) Women who: ((~~(a)~~)) (i) Are under sixty-five years of age; ((~~(b)~~)) (ii) have been screened for breast and cervical cancer under the national breast and cervical cancer early detection program administered by the department of health or tribal entity and have been identified as needing treatment for breast or cervical cancer; and ((~~(c)~~)) (iii) are not otherwise covered by health insurance. Medical assistance provided under this subsection (1)(k) is limited to the period during which the woman requires treatment for breast or cervical cancer, and is subject to any conditions or limitations specified in the omnibus appropriations act.

(2) To the extent permitted under federal law, the department shall set the categorically needy income level for adults who are sixty-five years of age or older, blind, or disabled, at eighty percent of the federal poverty level as adjusted annually beginning July 1, 2009. As used in this section, "federal poverty level" refers to the poverty guidelines updated periodically in the federal register by the United States department of health and human services under the authority of 42 U.S.C. Sec. 9902(2).

Sec. 2. RCW 74.09.530 and 2007 c 315 s 2 are each amended to read as follows:

(1) The amount and nature of medical assistance and the determination of eligibility of recipients for medical assistance shall

be the responsibility of the department of social and health services. The department shall establish reasonable standards of assistance and resource and income exemptions which shall be consistent with the provisions of the Social Security Act and with the regulations of the secretary of health, education and welfare for determining eligibility of individuals for medical assistance and the extent of such assistance to the extent that funds are available from the state and federal government. The department shall not consider resources in determining continuing eligibility for recipients eligible under section 1931 of the social security act.

(2) Individuals eligible for medical assistance under RCW 74.09.510((~~(3)~~)) (1)(c) shall be transitioned into coverage under that subsection immediately upon their termination from coverage under RCW 74.09.510((~~(2)(a)~~)) (1)(b)(i). The department shall use income eligibility standards and eligibility determinations applicable to children placed in foster care. The department, in consultation with the health care authority, shall provide information regarding basic health plan enrollment and shall offer assistance with the application and enrollment process to individuals covered under RCW 74.09.510((~~(3)~~)) (1)(c) who are approaching their twenty-first birthday.

NEW SECTION. **Sec. 3.** The department of social and health services shall prepare a fiscal analysis of the increases in the medicaid categorically needy income level to eighty percent of the federal poverty level as described in RCW 74.09.510. In developing the fiscal analysis, the department shall present both costs and cost offsets related to continuous access to health services including: Per capita cost reductions that resulted from current medically needy clients having access to continuous coverage through the categorically needy program; any reductions in the number of clients receiving long-term care services; the impact on department staffing needs, including savings associated with reduced medically needy caseloads; shifts in enrollment from the Washington basic health plan to medicaid coverage; and the impact on regional support networks, including additional medicaid revenues, reduced demand for nonmedicaid funded services, and changes in utilization of emergency room and hospital services. The

department shall submit the analysis to the governor and the health policy and fiscal committees of the legislature by November 1, 2010.

Sec. 4. RCW 48.41.100 and 2007 c 259 s 30 are each amended to read as follows:

(1) The following persons who are residents of this state are eligible for pool coverage:

(a) Any person who provides evidence of a carrier's decision not to accept him or her for enrollment in an individual health benefit plan as defined in RCW 48.43.005 based upon, and within ninety days of the receipt of, the results of the standard health questionnaire designated by the board and administered by health carriers under RCW 48.43.018;

(b) Any person who continues to be eligible for pool coverage based upon the results of the standard health questionnaire designated by the board and administered by the pool administrator pursuant to subsection (3) of this section;

(c) Any person who resides in a county of the state where no carrier or insurer eligible under chapter 48.15 RCW offers to the public an individual health benefit plan other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to the pool, and who makes direct application to the pool; and

(d) Any medicare eligible person upon providing evidence of rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a preexisting conditions limitation on a medicare supplemental insurance policy under chapter 48.66 RCW, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk by at least one member within six months of the date of application.

(2) The following persons are not eligible for coverage by the pool:

(a) Any person having terminated coverage in the pool unless (i) twelve months have lapsed since termination, or (ii) that person can show continuous other coverage which has been involuntarily terminated for any reason other than nonpayment of premiums. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

(b) Any person on whose behalf the pool has paid out two million dollars in benefits;

(c) Inmates of public institutions, and those persons ((~~whose benefits are duplicated under public programs~~)) who become eligible for medical assistance after June 30, 2008, as defined in RCW 74.09.010. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

(d) Any person who resides in a county of the state where any carrier or insurer regulated under chapter 48.15 RCW offers to the public an individual health benefit plan other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to the pool and who does not qualify for pool coverage based upon the results of the standard health questionnaire, or pursuant to subsection (1)(d) of this section.

(3) When a carrier or insurer regulated under chapter 48.15 RCW begins to offer an individual health benefit plan in a county where no carrier had been offering an individual health benefit plan:

(a) If the health benefit plan offered is other than a catastrophic health plan as defined in RCW 48.43.005, any person enrolled in a pool plan pursuant to subsection (1)(c) of this section in that county shall no longer be eligible for coverage under that plan pursuant to subsection (1)(c) of this section, but may continue to be eligible for pool coverage based upon the results of the standard health questionnaire designated by the board and administered by the pool administrator. The pool administrator shall offer to administer the questionnaire to each person no longer eligible for coverage under subsection (1)(c) of this section within thirty days of determining that he or she is no longer eligible;

(b) Losing eligibility for pool coverage under this subsection (3) does not affect a person's eligibility for pool coverage under subsection (1)(a), (b), or (d) of this section; and

(c) The pool administrator shall provide written notice to any person who is no longer eligible for coverage under a pool plan under this subsection (3) within thirty days of the administrator's determination that the person is no longer eligible. The notice shall: (i) Indicate that coverage under the plan will cease ninety days from the date that the notice is dated; (ii) describe any other coverage

options, either in or outside of the pool, available to the person; (iii) describe the procedures for the administration of the standard health questionnaire to determine the person's continued eligibility for coverage under subsection (1)(b) of this section; and (iv) describe the enrollment process for the available options outside of the pool.

(4) The board shall ensure that an independent analysis of the eligibility standards for the pool coverage is conducted, including examining the eight percent eligibility threshold, eligibility for medicaid enrollees and other publicly sponsored enrollees, and the impacts on the pool and the state budget. The board shall report the findings to the legislature by December 1, 2007.

NEW SECTION. **Sec. 5.** This act takes effect July 1, 2009, if specific funding for purposes of this act, referencing this act by bill or chapter number, is provided by June 30, 2009, in the omnibus operating appropriations act. If funding is not so provided, this act is null and void."

Correct the title.

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