S-3966.4

SENATE BILL 6221

State of Washington 60th Legislature 2008 Regular Session

By Senators Keiser and Kohl-Welles

Read first time 01/14/08. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to creating the Washington health partnership; adding new sections to chapter 41.05 RCW; adding a new section to chapter 74.09 RCW; adding a new section to chapter 43.370 RCW; adding a new section to chapter 74.38 RCW; adding a new section to chapter 48.02 RCW; and adding a new chapter to Title 82 RCW.

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

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

(1) Nationally and locally health care costs are inflating faster than the consumer price index and wages;

(2) Since 1980, health care costs have increased from nine percent to sixteen percent of the nation's gross domestic product, and are expected to exceed twenty percent by 2016;

(3) Other industrialized nations provide universal health care coverage, but spend much less. Some spend less than half as much per person;

(4) In 2007, the average annual premium for family coverage was more than twelve thousand dollars, of which over three thousand dollars are paid by the worker;

(5) In 2008, of Washingtonians under the age of sixty-five, over one million three hundred thousand will spend more than ten percent of their pretax family income on health care costs. Eighty-four of these people have insurance;

(6) Every thirty seconds, someone in this country files for bankruptcy in the aftermath of a serious health problem. Of those who file for bankruptcy, sixty-eight percent had health insurance;

(7) In Washington state, approximately thirty cents of every dollar received by hospitals and doctors' offices is consumed by the administrative expenses of the health plans and the providers. Before the doctors and hospitals receive the funds for delivering the care, approximately fourteen percent of the insurance premium has already been consumed by health plan administration;

(8) In 2006, hospitals, physicians, community clinics, and other providers spent a combined total of five hundred eighty-four million dollars in uncompensated care for the uninsured, a twenty-eight percent increase since 2002;

(9) The institute of medicine estimates that between thirty and forty cents associated with every health care dollar is spent on costs of poor quality - overuse, underuse, misuse, duplication, system failures, unnecessary repetition, poor communication, and adverse events attributable to medical errors;

(10) Rising costs have led to a decline in employer-provided health benefits. In Washington, since 1993, employer-based coverage declined from seventy-one percent to sixty-five percent;

(11) In 2007, fewer than half of small employers in Washington are able to offer coverage to their employees;

(12) Rising costs are seriously threatening the physical and fiscal well-being of Washingtonians, the ability of Washington businesses to compete globally, farms to thrive, government to provide needed services, schools to educate, and local citizens to form new and successful business ventures.

NEW SECTION. **Sec. 2.** (1) The Washington health partnership is established as a public-private entity to provide comprehensive health coverage to all residents of the state of Washington.

(2) In establishing and administering the health care system, the Washington health partnership shall seek to attain the following goals:

(a) By 2012, every resident of this state shall have access to affordable, comprehensive health care services;

(b) Services shall be provided through the private health care sector;

(c) The plan shall maintain and improve choice of health care providers and high quality health care services in this state; and

(d) The plan shall include cost-containment strategies that retain and assure affordable coverage for all Washingtonians.

NEW SECTION. **Sec. 3.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Board" means the board of trustees of the partnership.

(2) "Eligible person" means a person who meets the eligibility requirements of section 8 of this act.

(3) "Enrollee" means an eligible person who is enrolled in a partnership plan.

(4) "Medical home" means a health care provider who provides primary care for the enrollee and who is identified as the key professional responsible for coordinating all medical care for a given enrollee, including referral to a specialist. "Medical home" includes general practice physicians, family practitioners, internists, pediatricians, obstetricians and gynecologists, advanced practice nurses, certified nurse midwives, and physician assistants. "Medical home" may also include a specialist who is treating a person with a chronic medical condition, disability, or special health care needs for which regular treatment by a specialist is medically necessary.

(5) "Medical inflation" means changes in the consumer price index for all consumers, United States city average, for the medical care group, including medical care commodities and medical care services, as determined by the United States department of labor.

(6) "Network" means:

(a) A carrier as defined under RCW 48.41.030; or

(b) A coordinated group of health care providers that is regulated under Title 48 RCW and is comprised of primary care physicians, medical specialists, physician assistants, nurses, clinics, one or more hospitals, and other health care providers and facilities, including providers and facilities that specialize in mental health services and alcohol or other drug abuse treatment.

(7) "Partnership" means the Washington health partnership, the public-private program sponsored and administered by the board.

(8) "Plan" means a "health plan" as defined under chapter 48.41 RCW that is offered by the Washington health partnership.

(9) "Public employee" means an individual who retired or who terminated employment due to disability from any of the entities described in (a) through (d) of this subsection, and who is not eligible for parts A and B of medicare; or an individual employed by:

(a) The state of Washington;

(b) A school district or educational service district;

(c) A public institution of higher education; or

(d) A political subdivision of the state.

NEW SECTION. **Sec. 4.** (1) The Washington health partnership is governed by a board composed of members nominated by the governor, with the advice and consent of the senate, and appointed for staggered six-year terms as follows:

(a) The administrator of the health care authority who shall serve as the initial chairperson of the board until such time as the board elects a chairperson;

(b) Two members selected from a list of names submitted by statewide labor or union coalitions, one of whom must be a public employee who is a union member;

(c) Two members selected from a list of names submitted by statewide business and employer organizations, one of whom must be a public employer;

(d) One member selected from a list of names submitted by statewide public school teacher labor organizations;

(e) One member selected from a list of names submitted by statewide small business organizations;

(f) One member who is a self-employed person;

(g) Two members selected from a list of names submitted by statewide health care consumer organizations; and

(h) Four members with experience in health benefit management and cost containment.

(2) The terms of all members of the board expire on July 1st. Each member of the board holds office until a successor is appointed and

qualified unless the member vacates or is removed from his or her office.

(a) A member who serves as a result of holding another office or position vacates his or her office as a member when he or she vacates the other office or position.

(b) A vacancy on the board must be filled in the same manner as the original appointment to the board for the remainder of the unexpired term, if any.

(c) A majority of the members of the board constitutes a quorum for the purpose of conducting its business and exercising its powers and for all other purposes, notwithstanding the existence of any vacancies. Action may be taken by the board upon a vote of a majority of the members present.

(d) Members of the board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

(e) The board and employees of the board shall not be civilly or criminally liable and shall not have any penalty or cause of action of any nature arise against them for any action taken or not taken, including any discretionary decision or failure to make a discretionary decision, when the action or inaction is done in good faith and in the performance of the powers and duties under this chapter. Nothing in this section prohibits legal actions against the board to enforce the board's statutory or contractual duties or obligations.

NEW SECTION. **Sec. 5.** The board shall:

(1) Establish, fund, and manage the partnership as provided in this chapter;

(2) Establish and appoint a technical advisory committee and may seek the advice of technical experts when necessary to execute the powers and duties included in this section;

(3) Have discretion to delegate any powers and duties the board considers proper to one or more of its members or its executive director;

(4) Provide for mechanisms to enroll every eligible resident in the state. Contracts entered into by the board with providers and brokers must include provisions to enroll all eligible persons at the point of

service, and outreach programs to assure every eligible person becomes enrolled in the plan;

(5) Consistent with Title 48 RCW and in coordination with the insurance commissioner, establish a patient bill of rights that includes a program for consumer protection and a process to resolve disputes with networks or providers;

(6) Establish an independent and binding appeals process for resolving disputes over eligibility and other determinations made by the board. Any person who is adversely affected by a board eligibility determination or any other determination is entitled to review of the determination;

(7) Submit an annual report on its activities to the governor and each chamber of the legislature;

(8) Contract for annual, independent program evaluations and financial audits that measure the extent to which the plan is achieving the goals under section 1 of this act. The board may not enter into a contract with the same auditor for more than five years;

(9) Accept bids from networks in accordance with the criteria set out in section 13 of this act or make payments to fee-for-service providers in accordance with this act. The board shall consult with the health care authority in determining the most effective and efficient way to purchase health care benefits; and

(10) Monitor networks and providers to assure their services meet the plan objectives and criteria under this chapter.

NEW SECTION. **Sec. 6.** The board shall have all the powers necessary or convenient to carry out the purposes and provisions of this chapter. In addition to all other powers granted the board under this chapter, the board may:

(1) Adopt, amend, and repeal bylaws and policies and procedures for the regulation of its affairs and the conduct of its business;

(2) Maintain an office;

(3) Sue and be sued;

(4) Accept gifts, grants, loans, or other contributions from private or public sources;

(5) Monitor the fiscal management of the partnership;

(6) Execute contracts and other instruments, including contracts for any professional services required for the authority;

(7) Employ any officers, agents, and employees that it may require and determine their qualifications and compensation;

(8) Procure liability insurance;

(9) Contract for studies on issues, as identified by the board;

(10) Borrow money, as necessary on a short-term basis, to address cash flow issues; and

(11) Compel witnesses to attend meetings and to testify upon any necessary matter concerning the plan.

NEW SECTION. **Sec. 7.** For the purpose of establishing the partnership, the board shall define all of the following terms:

(1) "Place of permanent residence";

(2) "Substantial presence in this state." In defining "substantial presence in this state," the board shall consider such factors as the amount of time per year that a person is actually present in the state and the amount of taxes that a person pays in this state, except that:

(a) If the person attends school outside of this state and is under twenty-four years of age, the factors shall include the amount of time that the person's parent or guardian is actually present in the state and the amount of taxes that the person's parent or guardian pays in this state; and

(b) If the person is in active service with the United States armed forces outside of this state, the factors shall include the amount of time that the person's parent, guardian, or spouse is actually present in the state and the amount of taxes that the person's parent, guardian, or spouse pays in this state.

(3) "Immediate family"; and

(4) "Gainfully employed." The definition must include employment by persons who are self-employed and persons who work on farms.

NEW SECTION. **Sec. 8.** (1) A person and the members of the person's immediate family are eligible to participate in the partnership if the person satisfies all of the following criteria:

(a) The person has maintained his or her place of permanent residence, as defined by the board, in this state for at least twelve months;

(b) The person maintains a substantial presence in this state, as defined by the board; and

(c) The person is not:

(i) Eligible for health care coverage from a foreign government or the federal government, including medicare and medicaid;

(ii) An inmate of a state correctional institution, as defined in RCW 9.94.049; or

(iii) Placed or confined in, or committed to, an institution for the mentally ill or developmentally disabled as described in 42 U.S.C. Sec. 1396 et seq.

(2) A child under age eighteen who resides in this state with his or her parent is eligible to participate in the plan regardless of the length of time the child has resided in this state, and regardless of whether the parent met the residency requirements, subject to requirements outlined in subsection (1)(c)(i) of this section.

(3) A pregnant woman who resides in this state who does not yet meet the residency requirements is eligible to participate in the plan regardless of the length of time the pregnant woman has resided in this state, subject to requirements outlined in subsection (1)(c)(i) of this section.

(4) Public employees as defined in section 3 of this act, and by rules established by the board, shall receive health coverage under the partnership, effective January 1, 2010.

(5) A person who is eligible to participate in the partnership under subsection (1), (2), or (4) of this section and who receives health care coverage under a collective bargaining agreement that is in effect on January 1, 2010, is eligible to participate in the partnership on the day on which the collective bargaining agreement expires or the day after the collective bargaining agreement is extended, modified, or renewed to reflect the intention of group participation in the partnership.

NEW SECTION. **Sec. 9.** The partnership shall implement outreach and education efforts to facilitate informed enrollment.

(1) The partnership may contract with insurance brokers, associations, local government, and not-for-profit organizations to perform the outreach and educational functions specified in this section.

(2) The partnership shall:

(a) Employ various methods and media to communicate information to the public about the partnership;

(b) Actively engage in outreach to eligible individuals and assist eligible persons to enroll in their choice of health care coverage under the partnership;

(c) Assist eligible persons in choosing health care coverage by providing cost, quality, and geographic coverage information regarding choice of available networks and providers;

(d) Assist eligible persons to select a medical home;

(e) Inform plan enrollees of the role they can play in holding down health care costs by taking advantage of preventive care, enrolling in chronic disease management programs if appropriate, responsibly using medical services such as emergency rooms and specialists, and engaging in healthy lifestyles. The partnership shall inform enrollees of networks or workplaces which provide healthy lifestyle incentives;

(f) Consistent with Title 48 RCW and in coordination with the insurance commissioner and the board, establish a process for resolving disputes with providers;

(g) Act as an advocate for plan enrollees having questions, difficulties, or complaints about their health care services or coverage, including investigating and attempting to resolve the complaint;

(h) If an enrollee's complaint cannot be successfully resolved, inform the enrollee of any legal or other means of recourse for his or her complaint, consistent with the patient bill of rights in section 5 of this act. If the complaint involves a dispute over covered benefits or services provided, the enrollee must be directed to the appeals process established under Title 48 RCW. If the complaint involves a dispute over eligibility or other determinations made by the board, the enrollee must be directed to the appeals process for board decisions; and

(i) Provide information to the public, agencies, legislators, and others regarding problems and concerns of plan enrollees and make recommendations for resolving those problems and concerns.

(3) The partnership and its employees and contractors shall not have any conflict of interest relating to the performance of their duties. When a conflict of interest is discovered, the office shall

modify or terminate its relationship with that entity to remove the conflict of interest.

NEW SECTION. **Sec. 10.** (1) The partnership shall establish a health care program that will take effect on January 1, 2010. The program shall provide a standardized set of covered services, subject to limitations as determined by the board and consistent with the cost-sharing requirements in section 11 of this act, including:

(a) Air and ground ambulance services;

(b) Diabetic education;

(c) Diagnostic testing;

(d) Durable medical equipment, supplies, and prostheses;

(e) Emergency room;

(f) Hearing examination and hardware;

(g) Home health care;

(h) Hospital services, including:

(i) Inpatient facility services;

(ii) Inpatient professional services;

(iii) Outpatient surgery facility services; and

(iv) Outpatient surgery professional services;

(i) Inpatient and outpatient chemical dependency services;

(j) Inpatient and outpatient mental health care;

(k) Integrated long-term health coverage, including home health, hospice, and skilled nursing care;

(l) Neurodevelopmental therapy for children ages six and younger;

(m) Obstetric and well newborn care;

(n) Office and clinic visits;

(o) Organ transplants;

(p) Physical, occupational, speech, and massage therapies;

(q) Prescription drugs, insulin, and disposable diabetic supplies;

(r) Preventive care;

(s) Radiation and chemotherapy services;

(t) Skilled nursing;

(u) Spinal manipulations;

(v) Temporomandibular joint (TMJ) disorder treatment; and

(w) Vision exams and hardware.

(2) The board:

(a) May adjust the covered services or payment methods to provide additional or different treatment options if they are cost-effective and there is scientific evidence that the options are likely to reduce health care costs, avoid health risks, or result in better health outcomes;

(b) May offer enrollees incentives that promote healthy life styles or compliance with evidence-based treatment;

(c) Shall review recommendations from the health technology clinical committee, as described under RCW 70.14.090, and modify benefits to reflect the recommendations of that committee;

(d) Shall review research on evidence-based best practices and take steps to promote such practices in the partnership, including:

(i) Educating networks and providers on evidence-based best practices;

(ii) Sharing data with networks and providers on the extent to which they follow evidence-based best practices; and

(iii) Providing incentives or disincentives, when appropriate, to promote use of evidence-based best practices; and

(e) Consistent with chapter 19.68 RCW, shall establish regulations to restrict or prohibit arrangements where a health provider, or family member, would financially benefit by the health provider referring patients to a specific health service. Such financial arrangements include, but are not limited to, referrals to diagnostic imaging services, pathology services, or ambulatory surgical services where the referring health provider has a financial interest.

(3) If cost-effective, the board may establish or contract for a toll-free hotline that is available twenty-four hours a day, seven days a week, staffed by persons qualified to advise enrollees on health care issues.

(4) A union may bargain or an employer may pay for:

(a) Benefits not covered by subsection (1) of this section; and

(b) Some or all employee cost-sharing charges.

NEW SECTION. **Sec. 11.** (1) The following evidence-based, covered services are not subject to any point-of-service cost-sharing requirement:

(a) Prenatal care for pregnant women;

(b) Well baby care;

(c) Well child examinations and immunizations for children up to eighteen years of age;

(d) Other preventive services or procedures, as determined by the board, for which there is scientific evidence that exemption from cost sharing is likely to reduce health care costs or avoid health risks; and

(e) Chronic care services, provided that the enrollee receiving the services is participating in, and complying with, a chronic disease management program, as defined by the board.

(2)(a) The board shall set maximum deductible amounts for each calendar year enrollment period, and shall consider separate deductibles for:

(i) An enrollee who is eighteen years of age or older on January 1st of that year; and

(ii) A family consisting of two or more enrollees who are eighteen years of age or older on January 1st of that year.

(b) The board shall determine whether an enrollee who is under eighteen years of age on January 1st of that year must pay any deductible.

(c) The board shall establish rules to assure that deductibles do not pose a barrier to enrollees receiving medically necessary services.

(3) The board shall establish, and update, not more often than annually, a system of copayments and/or coinsurance that will promote appropriate use of health care services, but not pose a barrier to enrollees receiving appropriate care. At a minimum, the board shall set copayments that promote:

(a) Appropriate emergency room use;

(b) Appropriate use of specialists;

(c) Evidence-based, cost-effective use of prescription drugs based on presence on the formulary or generic status of a drug, except that all enrollees, regardless of age, shall pay no more for a prescription drug than the actual cost of the prescription drug plus the negotiated dispensing fee.

(4) The board shall establish a maximum amount for cost-sharing, including deductibles, copayments and coinsurance that an individual or a family shall pay in a calendar year enrollment period. In establishing maximum amounts, the board shall consider mechanisms to

reduce cost-sharing for individuals below two hundred percent of the federal poverty level.

(5) The board shall establish a premium-sharing schedule for all partnership enrollees. In designing the premium-sharing schedule, the board shall charge enrollees in a benchmark plan a zero premium. The board shall establish higher premiums for higher-cost networks and may charge an enrollee in a higher-cost network a monthly premium equal to the full price bid by that network less the full price bid by the lowest-cost network.

NEW SECTION. **Sec. 12.** (1) The board may establish areas in the state, which may be single counties, multicounty regions, or other areas, for the purpose of receiving bids from networks. These areas shall be established to maximize the level and quality of competition or to increase the number of provider choices available to eligible persons and enrollees in the areas.

(2) In each area designated by the board under subsection (1) of this section, the board shall offer one or more network options, if available. Each network must be certified and meet the qualifying criteria in section 13 of this act.

(3) The board shall also offer a "fee-for-service option" across the state. The board shall:

(a) Establish fee-for-service payment rates for all health care services and articles covered under the plan;

(b) Contract with one or more plan administrators selected through a competitive procurement process to administer the fee-for-service option;

(c) Ensure that the fee-for-service option meets the requirements of section 13(2) (b) through (f) of this act;

(d) Ensure that enrollees selecting the fee-for-service option choose a medical home.

NEW SECTION. **Sec. 13.** (1) The partnership shall annually solicit sealed premium bids from competing networks for the purpose of offering health care coverage to enrollees in the Washington health partnership. After three full years of operation, the partnership may solicit bids no less frequently than every three years.

(2) A network is a qualifying network if it demonstrates to the satisfaction of the board that:

(a) The fixed monthly risk-adjusted amount that it bids reasonably reflects its estimated actual costs for providing enrollees with such benefits, except that the network may not artificially underbid for the purpose of gaining market share;

(b) It spends at least eighty-eight percent of the revenue it receives under this chapter on:

(i) Payments to health care providers to provide the health care benefits specified in this act to enrollees who choose the network; or

(ii) Investments, such as capital improvements, that the network can reasonably demonstrate to the board will improve the overall quality or lower the overall cost of patient care;

(c) It meets standards of access, as determined by the board in coordination with the office of the insurance commissioner under Title 48 RCW, that assure enrollees can gain reasonable access to services from physicians, physician assistants, nurses, clinics, hospitals, and other health care providers and facilities, including providers and facilities that specialize in mental health services and alcohol or other drug abuse treatment;

(d) It provides each enrollee with medically appropriate and high quality health care services as established in section 10 of this act or as modified by the board, in a highly coordinated manner, including:

(i) Appropriate use of primary care, medical specialists, medications, and hospital emergency rooms;

(ii) Preventive care with early identification of and response to high-risk individuals and groups; and

(iii) Chronic care management with early identification of chronic diseases;

(e) If its network of participating providers is insufficient to meet the medical needs of enrollees, it contracts with out-of-network medical specialists, hospitals, and other facilities, including medical centers of excellence;

(f) It has in place or is participating in, by a date specified by the board and based on standards established by the health care authority under this chapter, a comprehensive, shared, electronic patient records and treatment tracking system and an electronic provider payment system. The system shall comply with federal and

state confidentiality requirements, and enable providers to readily obtain clinical information on inpatient and outpatient services, laboratory and radiological results, and other clinical data to improve quality and continuity of care;

(g) It has a program to promote health care quality and increase the transparency of health care cost and quality information;

(h) It has adopted and implemented a strong policy to safeguard against conflicts of interest; and

(i) It agrees to enroll and provide the benefits specified in this chapter to all partnership enrollees who choose the network, regardless of the enrollee's age, sex, race, religion, national origin, sexual orientation, health status, marital status, disability status, or employment status, except that a health care network may limit the number of new enrollees it accepts if the network certifies to the board that accepting more than a specified number of enrollees would make it impossible to provide all enrollees with the benefits specified in this chapter or maintain quality of care.

(3) The board shall:

(a) Review the bids submitted under this section and other evidence provided to the board demonstrating a particular bidder's qualifications. The board may make available to consumers quality and value scores for each plan;

(b) Certify which networks are qualifying bidders; and

(c) Classify the certified networks according to price and quality measures after comparing their risk-adjusted per-month bids and assessing their quality. The board shall classify the network that bids the lowest price as the lowest-cost benchmark network, and may classify as a low-cost benchmark network any network that has bid a price that is close to the price bid by the lowest-cost network, as determined by the board. The board shall classify any other network as a higher-cost network.

NEW SECTION. **Sec. 14.** (1) The board shall provide an annual open enrollment period during which each enrollee may select a certified health care network from among those offered, or a fee-for-service option. An enrollee who does not select a certified health care network or the fee-for-service option will be assigned randomly to one of the lowest-cost benchmark networks. If an enrollee enrolled in a

higher-cost network fails to pay the additional payment for a higher-cost network, the board may reassign the enrollee to a benchmark network.

(2) The board:

(a) Shall pay the network monthly for each enrolled enrollee. The amount shall be the full risk-adjusted per-member per-month amount that was bid by the lowest-cost network. The board may actuarially adjust the payment for an enrollee based on age, sex, and other risk factors determined by the board. In addition, enrollees in a higher-cost plan shall monthly pay the network a premium as defined in section 11 of this act;

(b) May retain a percentage of the dollar amounts established for each enrollee to reimburse networks that have incurred disproportionate risk not fully compensated for by the actuarial adjustment in the amount established for each eligible person. Any payment to a certified network under this subsection shall reflect the disproportionate risk incurred by the network.

(3)(a) The board shall establish payment rates to pay providers of covered services and articles under the fee-for-service option, as described under section 13 of this act. The payment rates must be sufficient to ensure participation by high quality medical practitioners and promote participation by primary care providers. The board shall coordinate its fee-for-service rate-setting efforts with those of the department of social and health services, where such coordination would benefit access to services for both partnership and medicaid enrollees. The board may adjust provider payments annually; such adjustments should restrain health care inflation while assuring continued access to a broad network of providers and quality services.

(b) Except for deductibles, copayments, coinsurance, and any other cost sharing required or authorized under the plan, a provider or network must accept as payment in full for a covered service or article the payment rate determined by the board and may not bill a enrollee who receives the service or article any additional amount.

(4) Except for prescription drugs to which a deductible applies, the board may assume the risk for, and pay directly for, less copayments, prescription drugs provided to all enrollees. In implementing this requirement, the board shall employ the services of

the prescription drug consortium, as defined under chapter 70.14 RCW, unless the board determines that another approach would be more cost-effective, such as:

(a) Joining another state's prescription drug purchasing arrangement to form a multistate purchasing group to negotiate with prescription drug manufacturers and distributors for reduced prescription drug prices;

(b) Permitting a network or networks to maintain its own formulary; or

(c) Contracting with a third party, such as a private pharmacy benefits manager, to negotiate with prescription drug manufacturers and distributors for reduced prescription drug prices.

NEW SECTION. **Sec. 15.** A new section is added to chapter 74.09 RCW to read as follows:

(1) By March 31, 2010, the department shall submit amendments to the social security Title XIX state plan to expand the categorically needy medicaid program effective January 1, 2010, to cover families and aged, blind, and disabled individuals up to two hundred percent of the federal poverty level. To the degree possible, the eligible population shall include enrollees in the basic health program.

(2) The department, working with the board, as defined in section 3 of this act, and consistent with the federal social security act, shall review payment rates under the state medical assistance program and may modify payment rates to more closely reflect those paid by the board under the fee-for-service option, as described under section 12 of this act.

NEW SECTION. **Sec. 16.** (1) In this chapter:

(a) "Board" means the board of trustees of the Washington health partnership.

(b) "Department" means the department of revenue.

(c) "Dependent" means a spouse, an unmarried child under the age of nineteen years, an unmarried child who is a full-time student under the age of twenty-four years and who is financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

(d) "Eligible person" means a person who is eligible to participate in the plan, other than an employee or a self-employed person.

(e) "Employee" means a person who has an employer.

(f) "Employer" means a person who is required under the internal revenue code to file form 941.

(g) "Medical inflation" means the percentage change between the United States consumer price index for all urban consumers, United States city average, for the medical care group only, including medical care commodities and medical care services, for the month of August of the previous year and the United States consumer price index for all urban consumers, United States city average, for the medical care group only, including medical care commodities and medical care services, for the month of August 2007, as determined by the United States department of labor.

(h) "Poverty line" means the federal poverty line, as defined under 42 U.S.C. Sec. 9902(2), for a family the size of the individual's family.

(i) "Self-employed individual" means an individual who is required under the internal revenue code to file schedule SE.

(j) "Social security wages" means:

(i) The amount of wages, as defined in section 3121(a) of the internal revenue code, paid to an employee by an employer in a taxable year, up to a maximum amount that is equal to the social security wage base;

(ii) The amount of net earnings from self-employment, as defined in section 1402(a) of the internal revenue code, received by an individual in a taxable year, up to a maximum amount that is equal to the social security wage base; and

(iii) The amount of wages, as defined in section 3121(a) of the internal revenue code, paid by an employer in a taxable year with respect to employment, as defined in section 3121(b) of the internal revenue code, up to a maximum amount that is equal to the social security wage base multiplied by the number of the employer's employees.

NEW SECTION. **Sec. 17.** (1) The board shall calculate the following assessments for individuals, based on its anticipated revenue needs:

(a) For an employee who is under the age of sixty-five, a percent of social security wages that is at least two percent and not more than four percent; and

(b) For a self-employed individual who is under the age of sixty-five, a percent of social security wages that is at least nine percent and not more than ten percent.

(2) The board shall calculate an assessment for employers, based on the revenue required to fully fund the partnership. The assessment shall be no less than nine percent and shall not exceed twelve percent of aggregate social security wages.

(3) Beginning January 1, 2010, the department shall collect the individual and employer assessment amounts that the board calculates through a method devised by the department. The amounts collected by the department shall be deposited into the Washington health partnership trust fund created under section 18 of this act.

(4) The administrative and enforcement provisions in chapter 82.32 RCW apply to this section.

NEW SECTION. **Sec. 18.** There is established a separate, dedicated trust fund designated as the Washington health partnership trust fund, consisting of all amounts appropriated or transferred to or deposited in the fund, within the state treasury.

NEW SECTION. **Sec. 19.** If any taxing district, as defined in RCW 84.04.120, which reduces the costs of providing health care coverage to the district's employees as a result of providing that coverage under the Washington health partnership, as created by this act, together with any supplemental coverage needed to ensure that the health care coverage provided to employees of the taxing district is substantially actuarially equivalent to the coverage they received in 2008, the taxing district shall distribute at least fifty percent of the savings to the property taxpayers in the taxing district as a reduction in the property tax assessments. The reduction shall be calculated based on the assessed value of the property and shall reduce the property taxes otherwise payable in that year.

NEW SECTION. **Sec. 20.** Section 19 of this act applies to taxes levied for collection in 2010 and thereafter.

NEW SECTION. **Sec. 21.** The board and the partnership are entitled to the right of subrogation for reimbursement to the extent that an enrollee may recover reimbursement for health care services and items in an action or claim against any third party.

NEW SECTION. **Sec. 22.** Nothing in this chapter prevents an employer, or a Taft-Hartley trust on behalf of an employer, from paying all or part of any cost sharing described under this act, or from providing any health care benefits not provided under the plan, for any of the employer's employees.

NEW SECTION. **Sec. 23.** A new section is added to chapter 43.370 RCW to read as follows:

The office of financial management strategic health planning shall collaborate with the University of Washington center for health workforce studies, the department of health, and the higher education coordinating board, to develop a plan to increase the number and availability of primary care providers in the state. By November 1, 2009, the office shall submit a report to the legislature that includes:

(1) Estimates of the number of primary care providers, including types of providers by region, needed to provide the health care services under this act for all state residents; and

(2) Recommended actions to address identified shortages including, but not limited to:

(a) Changes to reimbursement and fee structures under this act;

(b) Changes to the loan forgiveness and conditional scholarship programs described in chapter 28B.115 RCW; and

(c) Modifications to the higher education admission and educational requirements that would enhance the supply of primary care providers.

NEW SECTION. **Sec. 24.** A new section is added to chapter 74.38 RCW to read as follows:

By December 1, 2010, the board shall submit a report to the governor and the legislature regarding establishing a long-term care insurance plan. The report shall include recommendations regarding the provision of a guaranteed long-term care benefit to every Washingtonian including:

(1) Eligibility requirements including whether eligibility requirements should be the same as those used for the partnership, as described under section 8 of this act;

(2) Composition of a long-term care benefit package, including skilled nursing and a community-based service;

(3) Length of time enrollees may receive benefits and the number of episodes of coverage;

(4) Standards for long-term care services and providers offering such services; and

(5) Sources of revenue for the long-term care insurance plan, including the advisability of securing a federal waiver that would permit continued use of medicaid funds for the purposes of long-term care.

NEW SECTION. **Sec. 25.** A new section is added to chapter 48.02 RCW to read as follows:

The insurance commissioner shall establish requirements in rule for a "network" as defined under section 3 of this act. Requirements may be similar to those established for carriers under chapter 41.46 RCW; however, the insurance commissioner may reduce requirements in consideration of the oversight provided by the Washington health partnership under this act.

NEW SECTION. **Sec. 26.** The board may adopt rules to implement the provisions of this act.

NEW SECTION. **Sec. 27.** The department of revenue may adopt rules to implement the provisions of this chapter.

NEW SECTION. **Sec. 28.** (1) Sections 1 through 14, 21, 22, and 26 of this act are each added to chapter 41.05 RCW.

(2) Sections 16 through 20 and 27 of this act constitute a new chapter in Title 82 RCW.

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