SSB 5436 - H COMM AMD
By Committee on Health Care & Wellness

ADOPTED 04/08/2009

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** RCW 48.150.010 and 2007 c 267 s 3 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Direct patient-provider primary care practice" and "direct practice" means a provider, group, or entity that meets the following criteria in (a), (b), (c), and (d) of this subsection:

(a)(i) A health care provider who furnishes primary care services through a direct agreement;

(ii) A group of health care providers who furnish primary care services through a direct agreement; or

(iii) An entity that sponsors, employs, or is otherwise affiliated with a group of health care providers who furnish only primary care services through a direct agreement, which entity is wholly owned by the group of health care providers or is a nonprofit corporation exempt from taxation under section 501(c)(3) of the internal revenue code, and is not otherwise regulated as a health care service contractor, health maintenance organization, or disability insurer under Title 48 RCW. Such entity is not prohibited from sponsoring, employing, or being otherwise affiliated with other types of health care providers not engaged in a direct practice;

(b) Enters into direct agreements with direct patients or parents or legal guardians of direct patients;

(c) Does not accept payment for health care services provided to direct patients from any entity subject to regulation under Title 48 RCW, plans administered under chapter 41.05, 70.47, or 70.47A RCW, or self-insured plans, except as specifically authorized as a pilot site

under section 2, chapter . . . (Substitute Senate Bill No. 5891), Laws of 2009; and

(d) Does not provide, in consideration for the direct fee, services, procedures, or supplies such as prescription drugs, hospitalization costs, major surgery, dialysis, high level radiology (CT, MRI, PET scans or invasive radiology), rehabilitation services, procedures requiring general anesthesia, or similar advanced procedures, services, or supplies.

(2) "Direct patient" means a person who is party to a direct agreement and is entitled to receive primary care services under the direct agreement from the direct practice.

(3) "Direct fee" means a fee charged by a direct practice as consideration for being available to provide and providing primary care services as specified in a direct agreement.

(4) "Direct agreement" means a written agreement entered into between a direct practice and an individual direct patient, or the parent or legal guardian of the direct patient or a family of direct patients, whereby the direct practice charges a direct fee as consideration for being available to provide and providing primary care services to the individual direct patient. A direct agreement must (a) describe the specific health care services the direct practice will provide; and (b) be terminable at will upon written notice by the direct patient.

(5) "Health care provider" or "provider" means a person regulated under Title 18 RCW or chapter 70.127 RCW to practice health or health-related services or otherwise practicing health care services in this state consistent with state law.

(6) "Health carrier" or "carrier" has the same meaning as in RCW 48.43.005.

(7) "Primary care" means routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury.

(8) "Network" means the group of participating providers and facilities providing health care services to a particular health carrier's health plan or to plans administered under chapter 41.05, 70.47, or 70.47A RCW.

Sec. 2. RCW 48.150.040 and 2007 c 267 s 6 are each amended to read as follows:

(1) Direct practices may not:

(a) Enter into a participating provider contract as defined in RCW 48.44.010 or 48.46.020 with any carrier or with any carrier's contractor or subcontractor, or plans administered under chapter 41.05, 70.47, or 70.47A RCW, to provide health care services through a direct agreement except as set forth in subsection (2) of this section;

(b) Except as provided in RCW 48.150.010(1)(c), submit a claim for payment to any carrier or any carrier's contractor or subcontractor, or plans administered under chapter 41.05, 70.47, or 70.47A RCW, for health care services provided to direct patients as covered by their agreement;

(c) With respect to services provided through a direct agreement, be identified by a carrier or any carrier's contractor or subcontractor, or plans administered under chapter 41.05, 70.47, or 70.47A RCW, as a participant in the carrier's or any carrier's contractor or subcontractor network for purposes of determining network adequacy or being available for selection by an enrollee under a carrier's benefit plan; or

(d) Pay for health care services covered by a direct agreement rendered to direct patients by providers other than the providers in the direct practice or their employees, except as described in subsection (2)(b) of this section.

(2) Direct practices and providers may:

(a) Enter into a participating provider contract as defined by RCW 48.44.010 and 48.46.020 or plans administered under chapter 41.05, 70.47, or 70.47A RCW for purposes other than payment of claims for services provided to direct patients through a direct agreement. Such providers shall be subject to all other provisions of the participating provider contract applicable to participating providers including but not limited to the right to:

(i) Make referrals to other participating providers;

(ii) Admit the carrier's members to participating hospitals and other health care facilities;

(iii) Prescribe prescription drugs; and

(iv) Implement other customary provisions of the contract not dealing with reimbursement of services;

(b) Pay for charges associated with the provision of routine lab and imaging services ((~~provided in connection with wellness physical examinations~~)). In aggregate such payments per year per direct patient are not to exceed fifteen percent of the total annual direct fee charged that direct patient. Exceptions to this limitation may occur in the event of short-term equipment failure if such failure prevents the provision of care that should not be delayed; and

(c) Charge an additional fee to direct patients for supplies, medications, and specific vaccines provided to direct patients that are specifically excluded under the agreement, provided the direct practice notifies the direct patient of the additional charge, prior to their administration or delivery.

Sec. 3. RCW 70.47.060 and 2007 c 259 s 36 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 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 subsidized enrollees under RCW 70.47.020(6)(b). Premiums due for foster parents with gross family income up to two hundred percent of the federal poverty level shall be set at the minimum premium amount charged to enrollees with income below sixty-five percent of the federal poverty level. Premiums due for foster parents with gross family income between two hundred percent and three hundred percent of the federal poverty level shall not exceed one hundred dollars per month.

(c) 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.

(d) 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.

(e) 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.

(f) To develop, as an offering by every health carrier providing coverage identical to the basic health plan, as configured on January 1, 2001, a basic health plan model plan with uniformity in enrollee cost-sharing requirements.

(3) To evaluate, with the cooperation of participating managed health care system providers, the impact on the basic health plan of enrolling health coverage tax credit eligible enrollees. The administrator shall issue to the appropriate committees of the legislature preliminary evaluations on June 1, 2005, and January 1, 2006, and a final evaluation by June 1, 2006. The evaluation shall address the number of persons enrolled, the duration of their enrollment, their utilization of covered services relative to other basic health plan enrollees, and the extent to which their enrollment contributed to any change in the cost of the basic health plan.

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

(5) To design and implement a structure of enrollee cost-sharing due a managed health care system from subsidized, nonsubsidized, and health coverage tax credit eligible enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, and may utilize copayments, deductibles, and other cost-sharing

mechanisms, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(6) To limit enrollment of persons who qualify for subsidies so as to prevent an overexpenditure of appropriations for such purposes. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment until the administrator finds the danger no longer exists. Such a closure does not apply to health coverage tax credit eligible enrollees who receive a premium subsidy from the United States internal revenue service as long as the enrollees qualify for the health coverage tax credit program.

(7) To limit the payment of subsidies to subsidized enrollees, as defined in RCW 70.47.020. The level of subsidy provided to persons who qualify may be based on the lowest cost plans, as defined by the administrator.

(8) To adopt a schedule for the orderly development of the delivery of services and availability of the plan to residents of the state, subject to the limitations contained in RCW 70.47.080 or any act appropriating funds for the plan.

(9) Except to the extent to be designated as a medical home pilot site as provided in section 2, chapter . . . (Substitute Senate Bill No. 5891), Laws of 2009, 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 give priority to members of the Washington national guard and reserves who served in Operation Enduring Freedom, Operation Iraqi Freedom, or Operation Noble Eagle, and their spouses and dependents, for enrollment in the Washington basic health plan, 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.

(20) To give priority in enrollment to persons who disenrolled from the program in order to enroll in medicaid, and subsequently became ineligible for medicaid coverage.

NEW SECTION. **Sec. 4.** The insurance commissioner shall work with health maintenance organizations under chapter 48.46 RCW to determine how they can operate as a direct practice as defined in RCW 48.150.010. Recommendations for any necessary statutory changes must be submitted to the legislature by December 1, 2009."

Correct the title.

EFFECT: Maintains the prohibition against receiving a direct payment from an employer on behalf of a patient. Maintains the

prohibition against accepting payment for health care services provided to patients covered by self-insured plans. Authorizes direct patient-provider practices to participate as a pilot site for medical home reimbursement purposes.

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