
HOUSE BILL 2341

State of Washington 61st Legislature 2009 Regular Session

By Representatives Cody and Kelley

Read first time 04/13/09. Referred to Committee on Ways & Means.

1 AN ACT Relating to changes in the basic health plan program
2 necessary to implement the 2009-2011 operating budget; amending RCW
3 70.47.010, 70.47.020, 70.47.060, 70.47.100, and 74.09.053; and
4 repealing RCW 70.47.170.

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

6 **Sec. 1.** RCW 70.47.010 and 2000 c 79 s 42 are each amended to read
7 as follows:

8 (1)(a) The legislature finds that limitations on access to health
9 care services for enrollees in the state, such as in rural and
10 underserved areas, are particularly challenging for the basic health
11 plan. Statutory restrictions have reduced the options available to the
12 administrator to address the access needs of basic health plan
13 enrollees. It is the intent of the legislature to authorize the
14 administrator to develop alternative purchasing strategies to ensure
15 access to basic health plan enrollees in all areas of the state,
16 including: (i) The use of differential rating for managed health care
17 systems based on geographic differences in costs; and (ii) limited use
18 of self-insurance in areas where adequate access cannot be assured
19 through other options.

1 (b) In developing alternative purchasing strategies to address
2 health care access needs, the administrator shall consult with
3 interested persons including health carriers, health care providers,
4 and health facilities, and with other appropriate state agencies
5 including the office of the insurance commissioner and the office of
6 community and rural health. In pursuing such alternatives, the
7 administrator shall continue to give priority to prepaid managed care
8 as the preferred method of assuring access to basic health plan
9 enrollees followed, in priority order, by preferred providers, fee for
10 service, and self-funding.

11 (2) The legislature further finds that:

12 (a) A significant percentage of the population of this state does
13 not have reasonably available insurance or other coverage of the costs
14 of necessary basic health care services;

15 (b) This lack of basic health care coverage is detrimental to the
16 health of the individuals lacking coverage and to the public welfare,
17 and results in substantial expenditures for emergency and remedial
18 health care, often at the expense of health care providers, health care
19 facilities, and all purchasers of health care, including the state; and

20 (c) The use of managed health care systems has significant
21 potential to reduce the growth of health care costs incurred by the
22 people of this state generally, and by low-income pregnant women, and
23 at-risk children and adolescents who need greater access to managed
24 health care.

25 (3) The purpose of this chapter is to provide or make more readily
26 available necessary basic health care services in an appropriate
27 setting to working persons and others who lack coverage, at a cost to
28 these persons that does not create barriers to the utilization of
29 necessary health care services. To that end, this chapter establishes
30 a program to be made available to those residents not eligible for
31 medicare who share in a portion of the cost or who pay the full cost of
32 receiving basic health care services from a managed health care system.

33 (4) It is not the intent of this chapter to provide health care
34 services for those persons who are presently covered through private
35 employer-based health plans, nor to replace employer-based health
36 plans. However, the legislature recognizes that cost-effective and
37 affordable health plans may not always be available to small business

1 employers. Further, it is the intent of the legislature to expand,
2 wherever possible, the availability of private health care coverage and
3 to discourage the decline of employer-based coverage.

4 (5)(a) It is the purpose of this chapter to acknowledge the initial
5 success of this program that has (i) assisted thousands of families in
6 their search for affordable health care; (ii) demonstrated that low-
7 income, uninsured families are willing to pay for their own health care
8 coverage to the extent of their ability to pay; and (iii) proved that
9 local health care providers are willing to enter into a public-private
10 partnership as a managed care system.

11 (b) As a consequence, the legislature intends to extend an option
12 to enroll to certain citizens above two hundred percent of the federal
13 poverty guidelines within the state who reside in communities where the
14 plan is operational and who collectively or individually wish to
15 exercise the opportunity to purchase health care coverage through the
16 basic health plan if the purchase is done at no cost to the state. It
17 is also the intent of the legislature to allow employers and other
18 financial sponsors to financially assist such individuals to purchase
19 health care through the program so long as such purchase does not
20 result in a lower standard of coverage for employees.

21 (c) The legislature intends that, to the extent of available funds,
22 the program be available throughout Washington state to subsidized and
23 nonsubsidized enrollees. It is also the intent of the legislature to
24 enroll subsidized enrollees first, to the maximum extent feasible.

25 (d) The legislature directs that the basic health plan
26 administrator identify enrollees who are likely to be eligible for
27 medical assistance and assist these individuals in applying for and
28 receiving medical assistance. The administrator and the department of
29 social and health services shall implement a seamless system to
30 coordinate eligibility determinations and benefit coverage for
31 enrollees of the basic health plan and medical assistance recipients.
32 Enrollees receiving medical assistance are not eligible for the
33 Washington basic health plan.

34 **Sec. 2.** RCW 70.47.020 and 2007 c 259 s 35 are each amended to read
35 as follows:

36 As used in this chapter:

1 (1) "Washington basic health plan" or "plan" means the system of
2 enrollment and payment for basic health care services, administered by
3 the plan administrator through participating managed health care
4 systems, created by this chapter.

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

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

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

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

31 (6) "Subsidized enrollee" means:

32 (a) An individual, or an individual plus the individual's spouse or
33 dependent children:

34 (i) Who is not eligible for medicare;

35 (ii) Who is not confined or residing in a government-operated
36 institution, unless he or she meets eligibility criteria adopted by the
37 administrator;

1 (iii) Who is not a full-time student who has received a temporary
2 visa to study in the United States;

3 (iv) Who resides in an area of the state served by a managed health
4 care system participating in the plan;

5 (v) Whose gross family income at the time of enrollment does not
6 exceed two hundred percent of the federal poverty level as adjusted for
7 family size and determined annually by the federal department of health
8 and human services; (~~and~~)

9 (vi) Who chooses to obtain basic health care coverage from a
10 particular managed health care system in return for periodic payments
11 to the plan; and

12 (vii) Who is not receiving medical assistance administered by the
13 department of social and health services;

14 (b) An individual who meets the requirements in (a)(i) through (iv)
15 (~~and~~), (vi), and (vii) of this subsection and who is a foster parent
16 licensed under chapter 74.15 RCW and whose gross family income at the
17 time of enrollment does not exceed three hundred percent of the federal
18 poverty level as adjusted for family size and determined annually by
19 the federal department of health and human services; and

20 (c) To the extent that state funds are specifically appropriated
21 for this purpose, with a corresponding federal match, an individual, or
22 an individual's spouse or dependent children, who meets the
23 requirements in (a)(i) through (iv) (~~and~~), (vi), and (vii) of this
24 subsection and whose gross family income at the time of enrollment is
25 more than two hundred percent, but less than two hundred fifty-one
26 percent, of the federal poverty level as adjusted for family size and
27 determined annually by the federal department of health and human
28 services.

29 (7) "Nonsubsidized enrollee" means an individual, or an individual
30 plus the individual's spouse or dependent children: (a) Who is not
31 eligible for medicare; (b) who is not confined or residing in a
32 government-operated institution, unless he or she meets eligibility
33 criteria adopted by the administrator; (c) who is accepted for
34 enrollment by the administrator as provided in RCW 48.43.018, either
35 because the potential enrollee cannot be required to complete the
36 standard health questionnaire under RCW 48.43.018, or, based upon the
37 results of the standard health questionnaire, the potential enrollee
38 would not qualify for coverage under the Washington state health

1 insurance pool; (d) who resides in an area of the state served by a
2 managed health care system participating in the plan; (e) who chooses
3 to obtain basic health care coverage from a particular managed health
4 care system; and (f) who pays or on whose behalf is paid the full costs
5 for participation in the plan, without any subsidy from the plan.

6 (8) "Subsidy" means the difference between the amount of periodic
7 payment the administrator makes to a managed health care system on
8 behalf of a subsidized enrollee plus the administrative cost to the
9 plan of providing the plan to that subsidized enrollee, and the amount
10 determined to be the subsidized enrollee's responsibility under RCW
11 70.47.060(2).

12 (9) "Premium" means a periodic payment, which an individual, their
13 employer or another financial sponsor makes to the plan as
14 consideration for enrollment in the plan as a subsidized enrollee, a
15 nonsubsidized enrollee, or a health coverage tax credit eligible
16 enrollee.

17 (10) "Rate" means the amount, negotiated by the administrator with
18 and paid to a participating managed health care system, that is based
19 upon the enrollment of subsidized, nonsubsidized, and health coverage
20 tax credit eligible enrollees in the plan and in that system.

21 **Sec. 3.** RCW 70.47.060 and 2007 c 259 s 36 are each amended to read
22 as follows:

23 The administrator has the following powers and duties:

24 (1) To design and from time to time revise a schedule of covered
25 basic health care services, including physician services, inpatient and
26 outpatient hospital services, prescription drugs and medications, and
27 other services that may be necessary for basic health care. In
28 addition, the administrator may, to the extent that funds are
29 available, offer as basic health plan services chemical dependency
30 services, mental health services, and organ transplant services(~~(+~~
31 ~~however, no one service or any combination of these three services~~
32 ~~shall increase the actuarial value of the basic health plan benefits by~~
33 ~~more than five percent excluding inflation, as determined by the office~~
34 ~~of financial management)). All subsidized and nonsubsidized enrollees
35 in any participating managed health care system under the Washington
36 basic health plan shall be entitled to receive covered basic health
37 care services in return for premium payments to the plan. The~~

1 administrator may utilize factors including smoking status or obesity
2 as a differential status in premium rating for the provision of basic
3 health services and contract for incentive programs for smoking
4 cessation or obesity management. The schedule of services shall
5 emphasize proven preventive and primary health care and shall include
6 all services necessary for prenatal, postnatal, and well-child care.
7 However, with respect to coverage for subsidized enrollees who are
8 eligible to receive prenatal and postnatal services through the medical
9 assistance program under chapter 74.09 RCW, the administrator shall not
10 contract for such services except to the extent that such services are
11 necessary over not more than a one-month period in order to maintain
12 continuity of care after diagnosis of pregnancy by the managed care
13 provider. The schedule of services shall also include a separate
14 schedule of basic health care services for children, eighteen years of
15 age and younger, for those subsidized or nonsubsidized enrollees who
16 choose to secure basic coverage through the plan only for their
17 dependent children. In designing and revising the schedule of
18 services, the administrator shall consider the guidelines for assessing
19 health services under the mandated benefits act of 1984, RCW 48.47.030,
20 and such other factors as the administrator deems appropriate. The
21 administrator may mandate that enrollees continually enrolled on basic
22 health for a period of one year or more must complete a health risk
23 assessment and participate in programs approved by the administrator
24 that may include wellness and chronic disease management programs in
25 order to maintain basic health coverage. Accounts with breaks in
26 coverage not exceeding a single month at any one time are considered
27 continually enrolled. In approving programs, the administrator shall
28 consider evidence that any such programs are proven to improve enrollee
29 health status.

30 (2)(a) To design and implement a structure of periodic premiums due
31 the administrator from subsidized enrollees that is based upon gross
32 family income, giving appropriate consideration to family size and the
33 ages of all family members. The enrollment of children shall not
34 require the enrollment of their parent or parents who are eligible for
35 the plan. The structure of periodic premiums shall be applied to
36 subsidized enrollees entering the plan as individuals pursuant to
37 subsection (11) of this section and to the share of the cost of the

1 plan due from subsidized enrollees entering the plan as employees
2 pursuant to subsection (12) of this section.

3 (b) To determine the periodic premiums due the administrator from
4 subsidized enrollees under RCW 70.47.020(6)(b). Premiums due for
5 foster parents with gross family income up to two hundred percent of
6 the federal poverty level shall be set at the minimum premium amount
7 charged to enrollees with income below sixty-five percent of the
8 federal poverty level. Premiums due for foster parents with gross
9 family income between two hundred percent and three hundred percent of
10 the federal poverty level shall not exceed one hundred dollars per
11 month.

12 (c) To determine the periodic premiums due the administrator from
13 nonsubsidized enrollees. Premiums due from nonsubsidized enrollees
14 shall be in an amount equal to the cost charged by the managed health
15 care system provider to the state for the plan plus the administrative
16 cost of providing the plan to those enrollees and the premium tax under
17 RCW 48.14.0201.

18 (d) To determine the periodic premiums due the administrator from
19 health coverage tax credit eligible enrollees. Premiums due from
20 health coverage tax credit eligible enrollees must be in an amount
21 equal to the cost charged by the managed health care system provider to
22 the state for the plan, plus the administrative cost of providing the
23 plan to those enrollees and the premium tax under RCW 48.14.0201. The
24 administrator will consider the impact of eligibility determination by
25 the appropriate federal agency designated by the Trade Act of 2002
26 (P.L. 107-210) as well as the premium collection and remittance
27 activities by the United States internal revenue service when
28 determining the administrative cost charged for health coverage tax
29 credit eligible enrollees.

30 (e) An employer or other financial sponsor may, with the prior
31 approval of the administrator, pay the premium, rate, or any other
32 amount on behalf of a subsidized or nonsubsidized enrollee, by
33 arrangement with the enrollee and through a mechanism acceptable to the
34 administrator. The administrator shall establish a mechanism for
35 receiving premium payments from the United States internal revenue
36 service for health coverage tax credit eligible enrollees.

37 (f) To develop, as an offering by every health carrier providing

1 coverage identical to the basic health plan, as configured on January
2 1, 2001, a basic health plan model plan with uniformity in enrollee
3 cost-sharing requirements.

4 (3) To evaluate, with the cooperation of participating managed
5 health care system providers, the impact on the basic health plan of
6 enrolling health coverage tax credit eligible enrollees. The
7 administrator shall issue to the appropriate committees of the
8 legislature preliminary evaluations on June 1, 2005, and January 1,
9 2006, and a final evaluation by June 1, 2006. The evaluation shall
10 address the number of persons enrolled, the duration of their
11 enrollment, their utilization of covered services relative to other
12 basic health plan enrollees, and the extent to which their enrollment
13 contributed to any change in the cost of the basic health plan.

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

18 (5) To design and implement a structure of enrollee cost-sharing
19 due a managed health care system from subsidized, nonsubsidized, and
20 health coverage tax credit eligible enrollees. The structure shall
21 discourage inappropriate enrollee utilization of health care services,
22 and may utilize copayments, deductibles, and other cost-sharing
23 mechanisms, but shall not be so costly to enrollees as to constitute a
24 barrier to appropriate utilization of necessary health care services.

25 (6) To limit enrollment of persons who qualify for subsidies so as
26 to prevent an overexpenditure of appropriations for such purposes.
27 Whenever the administrator finds that there is danger of such an
28 overexpenditure, the administrator shall close enrollment until the
29 administrator finds the danger no longer exists. Such a closure does
30 not apply to health coverage tax credit eligible enrollees who receive
31 a premium subsidy from the United States internal revenue service as
32 long as the enrollees qualify for the health coverage tax credit
33 program. To prevent the risk of overexpenditure, the administrator may
34 disenroll persons receiving subsidies from the program based on
35 criteria adopted by the administrator. The criteria may include:
36 Length of continual enrollment on the program, income level, or
37 eligibility for other coverage. The administrator shall develop

1 criteria for persons disenrolled under this subsection to reapply for
2 the program.

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

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

11 (9) To solicit and accept applications from managed health care
12 systems, as defined in this chapter, for inclusion as eligible basic
13 health care providers under the plan for subsidized enrollees,
14 nonsubsidized enrollees, or health coverage tax credit eligible
15 enrollees. The administrator shall endeavor to assure that covered
16 basic health care services are available to any enrollee of the plan
17 from among a selection of two or more participating managed health care
18 systems. In adopting any rules or procedures applicable to managed
19 health care systems and in its dealings with such systems, the
20 administrator shall consider and make suitable allowance for the need
21 for health care services and the differences in local availability of
22 health care resources, along with other resources, within and among the
23 several areas of the state. Contracts with participating managed
24 health care systems shall ensure that basic health plan enrollees who
25 become eligible for medical assistance may, at their option, continue
26 to receive services from their existing providers within the managed
27 health care system if such providers have entered into provider
28 agreements with the department of social and health services.

29 (10) To receive periodic premiums from or on behalf of subsidized,
30 nonsubsidized, and health coverage tax credit eligible enrollees,
31 deposit them in the basic health plan operating account, keep records
32 of enrollee status, and authorize periodic payments to managed health
33 care systems on the basis of the number of enrollees participating in
34 the respective managed health care systems.

35 (11) To accept applications from individuals residing in areas
36 served by the plan, on behalf of themselves and their spouses and
37 dependent children, for enrollment in the Washington basic health plan
38 as subsidized, nonsubsidized, or health coverage tax credit eligible

1 enrollees, to give priority to members of the Washington national guard
2 and reserves who served in Operation Enduring Freedom, Operation Iraqi
3 Freedom, or Operation Noble Eagle, and their spouses and dependents,
4 for enrollment in the Washington basic health plan, to establish
5 appropriate minimum-enrollment periods for enrollees as may be
6 necessary, and to determine, upon application and on a reasonable
7 schedule defined by the authority, or at the request of any enrollee,
8 eligibility due to current gross family income for sliding scale
9 premiums. Funds received by a family as part of participation in the
10 adoption support program authorized under RCW 26.33.320 and 74.13.100
11 through 74.13.145 shall not be counted toward a family's current gross
12 family income for the purposes of this chapter. When an enrollee fails
13 to report income or income changes accurately, the administrator shall
14 have the authority either to bill the enrollee for the amounts overpaid
15 by the state or to impose civil penalties of up to two hundred percent
16 of the amount of subsidy overpaid due to the enrollee incorrectly
17 reporting income. The administrator shall adopt rules to define the
18 appropriate application of these sanctions and the processes to
19 implement the sanctions provided in this subsection, within available
20 resources. No subsidy may be paid with respect to any enrollee whose
21 current gross family income exceeds twice the federal poverty level or,
22 subject to RCW 70.47.110, who is a recipient of medical assistance or
23 medical care services under chapter 74.09 RCW. If a number of
24 enrollees drop their enrollment for no apparent good cause, the
25 administrator may establish appropriate rules or requirements that are
26 applicable to such individuals before they will be allowed to reenroll
27 in the plan.

28 (12) To accept applications from business owners on behalf of
29 themselves and their employees, spouses, and dependent children, as
30 subsidized or nonsubsidized enrollees, who reside in an area served by
31 the plan. The administrator may require all or the substantial
32 majority of the eligible employees of such businesses to enroll in the
33 plan and establish those procedures necessary to facilitate the orderly
34 enrollment of groups in the plan and into a managed health care system.
35 The administrator may require that a business owner pay at least an
36 amount equal to what the employee pays after the state pays its portion
37 of the subsidized premium cost of the plan on behalf of each employee
38 enrolled in the plan. Enrollment is limited to those not eligible for

1 medicare who wish to enroll in the plan and choose to obtain the basic
2 health care coverage and services from a managed care system
3 participating in the plan. The administrator shall adjust the amount
4 determined to be due on behalf of or from all such enrollees whenever
5 the amount negotiated by the administrator with the participating
6 managed health care system or systems is modified or the administrative
7 cost of providing the plan to such enrollees changes.

8 (13) To determine the rate to be paid to each participating managed
9 health care system in return for the provision of covered basic health
10 care services to enrollees in the system. Although the schedule of
11 covered basic health care services will be the same or actuarially
12 equivalent for similar enrollees, the rates negotiated with
13 participating managed health care systems may vary among the systems.
14 In negotiating rates with participating systems, the administrator
15 shall consider the characteristics of the populations served by the
16 respective systems, economic circumstances of the local area, the need
17 to conserve the resources of the basic health plan trust account, and
18 other factors the administrator finds relevant.

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

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

37 (16) To develop a program of proven preventive health measures and

1 to integrate it into the plan wherever possible and consistent with
2 this chapter.

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

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

8 (19) To administer the premium discounts provided under RCW
9 48.41.200(3)(a) (i) and (ii) pursuant to a contract with the Washington
10 state health insurance pool.

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

14 **Sec. 4.** RCW 70.47.100 and 2004 c 192 s 4 are each amended to read
15 as follows:

16 (1) A managed health care system participating in the plan shall do
17 so by contract with the administrator and shall provide, directly or by
18 contract with other health care providers, covered basic health care
19 services to each enrollee covered by its contract with the
20 administrator as long as payments from the administrator on behalf of
21 the enrollee are current. A participating managed health care system
22 may offer, without additional cost, health care benefits or services
23 not included in the schedule of covered services under the plan. A
24 participating managed health care system shall not give preference in
25 enrollment to enrollees who accept such additional health care benefits
26 or services. Managed health care systems participating in the plan
27 shall not discriminate against any potential or current enrollee based
28 upon health status, sex, race, ethnicity, or religion. The
29 administrator may receive and act upon complaints from enrollees
30 regarding failure to provide covered services or efforts to obtain
31 payment, other than authorized copayments, for covered services
32 directly from enrollees, but nothing in this chapter empowers the
33 administrator to impose any sanctions under Title 18 RCW or any other
34 professional or facility licensing statute.

35 (2) The plan shall allow, at least annually, an opportunity for
36 enrollees to transfer their enrollments among participating managed
37 health care systems serving their respective areas. The administrator

1 shall establish a period of at least twenty days in a given year when
2 this opportunity is afforded enrollees, and in those areas served by
3 more than one participating managed health care system the
4 administrator shall endeavor to establish a uniform period for such
5 opportunity. The plan shall allow enrollees to transfer their
6 enrollment to another participating managed health care system at any
7 time upon a showing of good cause for the transfer.

8 (3) Prior to negotiating with any managed health care system, the
9 administrator shall determine, on an actuarially sound basis, the
10 reasonable cost of providing the schedule of basic health care
11 services, expressed in terms of upper and lower limits, and recognizing
12 variations in the cost of providing the services through the various
13 systems and in different areas of the state.

14 (4) In negotiating with managed health care systems for
15 participation in the plan, the administrator shall adopt a uniform
16 procedure that includes at least the following:

17 (a) The administrator shall issue a request for proposals,
18 including standards regarding the quality of services to be provided;
19 financial integrity of the responding systems; and responsiveness to
20 the unmet health care needs of the local communities or populations
21 that may be served;

22 (b) The administrator shall then review responsive proposals and
23 may negotiate with respondents to the extent necessary to refine any
24 proposals;

25 (c) The administrator may then select one or more systems to
26 provide the covered services within a local area; and

27 (d) The administrator may adopt a policy that gives preference to
28 respondents, such as nonprofit community health clinics, that have a
29 history of providing quality health care services to low-income
30 persons.

31 (5) The administrator may contract with a managed health care
32 system to provide covered basic health care services to subsidized
33 enrollees, nonsubsidized enrollees, health coverage tax credit eligible
34 enrollees, or any combination thereof.

35 (6) The administrator may establish procedures and policies to
36 further negotiate and contract with managed health care systems
37 following completion of the request for proposal process in subsection

1 (4) of this section, upon a determination by the administrator that it
2 is necessary to provide access, as defined in the request for proposal
3 documents, to covered basic health care services for enrollees.

4 (7)~~((a))~~ The administrator ~~((shall))~~ may implement a self-funded
5 or self-insured method of providing insurance coverage to subsidized
6 enrollees, as provided under RCW 41.05.140~~((, if one of the following~~
7 ~~conditions is met:~~

8 ~~(i) The authority determines that no managed health care system~~
9 ~~other than the authority is willing and able to provide access, as~~
10 ~~defined in the request for proposal documents, to covered basic health~~
11 ~~care services for all subsidized enrollees in an area; or~~

12 ~~(ii) The authority determines that no other managed health care~~
13 ~~system is willing to provide access, as defined in the request for~~
14 ~~proposal documents, for one hundred thirty three percent of the~~
15 ~~statewide benchmark price or less, and the authority is able to offer~~
16 ~~such coverage at a price that is less than the lowest price at which~~
17 ~~any other managed health care system is willing to provide such access~~
18 ~~in an area.~~

19 ~~(b) The authority shall initiate steps to provide the coverage~~
20 ~~described in (a) of this subsection within ninety days of making its~~
21 ~~determination that the conditions for providing a self-funded or self-~~
22 ~~insured method of providing insurance have been met.~~

23 ~~(c) The administrator may not implement a self-funded or self-~~
24 ~~insured method of providing insurance in an area unless the~~
25 ~~administrator has received a certification from a member of the~~
26 ~~American academy of actuaries that the funding available in the basic~~
27 ~~health plan self-insurance reserve account is sufficient for the self-~~
28 ~~funded or self-insured risk assumed, or expected to be assumed, by the~~
29 ~~administrator)). Prior to implementing a self-funded or self-insured~~
30 ~~method, the administrator shall ensure that funding available in the~~
31 ~~basic health plan self-insurance reserve account is sufficient for the~~
32 ~~self-funded or self-insured risk assumed, or expected to be assumed, by~~
33 ~~the administrator. If implementing a self-funded or self-insured~~
34 ~~method, the administrator may request funds to be moved from the basic~~
35 ~~health plan trust account or the basic health plan subscription account~~
36 ~~to the basic health plan self-insurance reserve account established in~~
37 ~~RCW 41.05.140.~~

1 **Sec. 5.** RCW 74.09.053 and 2006 c 264 s 2 are each amended to read
2 as follows:

3 (1) The department of social and health services(~~(, in coordination~~
4 ~~with the health care authority,~~) shall by November 15th of each year
5 report to the legislature:

6 (a) The number of medical assistance recipients who: (i) Upon
7 enrollment or recertification had reported being employed, and
8 beginning with the 2008 report, the month and year they reported being
9 hired; or (ii) upon enrollment or recertification had reported being
10 the dependent of someone who was employed, and beginning with the 2008
11 report, the month and year they reported the employed person was hired.
12 For recipients identified under (a)(i) and (ii) of this subsection, the
13 department shall report the basis for their medical assistance
14 eligibility, including but not limited to family medical coverage,
15 transitional medical assistance, children's medical or aged or
16 ~~((disabled))~~ individuals with disabilities coverage; member months; and
17 the total cost to the state for these recipients, expressed as general
18 fund-state, health services account and general fund-federal dollars.
19 The information shall be reported by employer ~~((size))~~ size for
20 employers having more than fifty employees as recipients or with
21 dependents as recipients. This information shall be provided for the
22 preceding January and June of that year.

23 (b) The following aggregated information: (i) The number of
24 employees who are recipients or with dependents as recipients by
25 private and governmental employers; (ii) the number of employees who
26 are recipients or with dependents as recipients by employer size for
27 employers with fifty or fewer employees, fifty-one to one hundred
28 employees, one hundred one to one thousand employees, one thousand one
29 to five thousand employees and more than five thousand employees; and
30 (iii) the number of employees who are recipients or with dependents as
31 recipients by industry type.

32 ~~((2))~~ (2) For each aggregated classification, the report will
33 include the number of hours worked, the number of department of social
34 and health services covered lives, and the total cost to the state for
35 these recipients. This information shall be for each quarter of the
36 preceding year.

1 NEW SECTION. **Sec. 6.** RCW 70.47.170 (Annual reporting requirement)
2 and 2006 c 264 s 1 are each repealed.

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