CERTIFICATION OF ENROLLMENT

SUBSTITUTE HOUSE BILL 1312

Chapter 284, Laws of 2011

62nd Legislature
2011 Regular Session

STATE HEALTH CARE PROGRAMS--LOW-INCOME INDIVIDUALS--WAIVER

EFFECTIVE DATE: 07/22/11

Passed by the House April 5, 2011
Yeas 57 Nays 39

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate April 20, 2011
Yeas 48 Nays 0

BRAD OWEN

President of the Senate

Approved May 10, 2011, 3:23 p.m.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 1312** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BARBARA BAKER

Chief Clerk

FILED

May 11, 2011

Secretary of State
State of Washington

SUBSTITUTE HOUSE BILL 1312

Passed Legislature - 2011 Regular Session

State of Washington 62nd Legislature 2011 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Cody, Jinkins, Green, and Kenney)

READ FIRST TIME 02/25/11.

AN ACT Relating to statutory changes needed to implement a waiver to receive federal assistance for certain state purchased health care programs; amending RCW 70.47.060; and reenacting and amending RCW 70.47.020 and 74.09.035.

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

Sec. 1. RCW 70.47.020 and 2009 c 568 s 2 are each reenacted and amended to read as follows:

As used in this chapter:

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

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

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

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

(5) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children: (a) Who is not eligible for medicare; (b) who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator; (c) who is accepted for enrollment by the administrator as provided in RCW 48.43.018, either because the potential enrollee cannot be required to complete the standard health questionnaire under RCW 48.43.018, or, based upon the results of the standard health questionnaire, the potential enrollee would not qualify for coverage under the Washington state health insurance pool; (d) who resides in an area of the state served by a managed health care system participating in the plan; (e) who chooses to obtain basic health care coverage from a particular managed health care system; and (f) who pays or on whose behalf is paid the full costs for participation in the plan, without any subsidy from the plan.

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

(7) "Rate" means the amount, negotiated by the administrator with

and paid to a participating managed health care system, that is based upon the enrollment of subsidized, nonsubsidized, and health coverage tax credit eligible enrollees in the plan and in that system.

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

(9) "Subsidized enrollee" means:

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

(i) Who is not eligible for medicare;

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

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

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

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

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

(vii) Who is not receiving ((~~medical assistance administered by the department of social and health services~~)) <u>or has not been determined to be currently eligible for federally financed categorically needy or medically needy programs under chapter 74.09 RCW, except as provided under RCW 70.47.110</u>;

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

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

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

Sec. 2. RCW 70.47.060 and 2009 c 568 s 3 are each amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be necessary for basic health care. In addition, the administrator may, to the extent that funds are available, offer as basic health plan services chemical dependency services, mental health services, and organ transplant services. 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. The administrator shall encourage enrollees who have been continually enrolled on basic health for a period of one year or more to complete a health risk assessment and participate in programs approved by the administrator that may include wellness, smoking cessation, and chronic disease management programs. In approving programs, the administrator shall consider evidence that any such programs are proven to improve enrollee health status.

(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)~~)) (9)(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.

(g) To collect from all public employees a voluntary opt-in donation of varying amounts through a monthly or one-time payroll deduction as provided for in RCW 41.04.230. The donation must be deposited in the health services account established in RCW 43.72.900 to be used for the sole purpose of maintaining enrollment capacity in the basic health plan.

The administrator shall send an annual notice to state employees extending the opportunity to participate in the opt-in donation program for the purpose of saving enrollment slots for the basic health plan. The first such notice shall be sent to public employees no later than June 1, 2009.

The notice shall include monthly sponsorship levels of fifteen dollars per month, thirty dollars per month, fifty dollars per month, and any other amounts deemed reasonable by the administrator. The sponsorship levels shall be named "safety net contributor," "safety net

hero," and "safety net champion" respectively. The donation amounts provided shall be tied to the level of coverage the employee will be purchasing for a working poor individual without access to health care coverage.

The administrator shall ensure that employees are given an opportunity to establish a monthly standard deduction or a one-time deduction towards the basic health plan donation program. The basic health plan donation program shall be known as the "save the safety net program."

The donation permitted under this subsection may not be collected from any public employee who does not actively opt in to the donation program. Written notification of intent to discontinue participation in the donation program must be provided by the public employee at least fourteen days prior to the next standard deduction.

(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. To prevent the risk of overexpenditure, the administrator may disenroll persons receiving subsidies from the program based on criteria adopted by the administrator. The criteria may include: Length of continual enrollment on the program, income level, or eligibility for other coverage. The administrator shall ((~~first attempt to~~)) identify enrollees who are eligible for other coverage, and, working with the department of social and health service as provided in RCW 70.47.010(5)(d), transition enrollees currently eligible for ((~~medical assistance~~)) federally financed categorically needy or medically needy programs administered under chapter 74.09 RCW to that coverage. The administrator shall develop criteria for persons disenrolled under this subsection to reapply for the program.

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

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

(9) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan for subsidized enrollees, nonsubsidized enrollees, or health coverage tax credit eligible enrollees. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state. Contracts with participating managed

health care systems shall ensure that basic health plan enrollees who become eligible for medical assistance may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

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

(11) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan as subsidized, nonsubsidized, or health coverage tax credit eligible enrollees, to 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. The application is also considered an application for medical assistance under chapter 74.09 RCW and must include a social security number, if available, for each family member requesting coverage. 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~~)) 74.13A.005 through 74.13A.080 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.

Sec. 3. RCW 74.09.035 and 2010 1st sp.s. c 8 s 29 and 2010 c 94 s 22 are each reenacted and amended to read as follows:

(1) To the extent of available funds, medical care services may be provided to recipients of disability lifeline benefits, persons denied disability lifeline benefits under RCW 74.04.005(5)(b) or 74.04.655 who otherwise meet the requirements of RCW 74.04.005(5)(a), and recipients of alcohol and drug addiction services provided under chapter 74.50

RCW, in accordance with medical eligibility requirements established by the department. ((~~To the extent authorized in the operating budget,~~)) Enrollment in medical care services may not result in expenditures that exceed the amount that has been appropriated in the operating budget. If it appears that continued enrollment will result in expenditures exceeding the appropriated level for a particular fiscal year, the department may freeze new enrollment and establish a waiting list of eligible persons who may receive benefits only when sufficient funds are available. Upon implementation of a federal medicaid 1115 waiver providing federal matching funds for medical care services, ((~~these services also may be provided to persons who have been terminated from disability lifeline benefits under RCW 74.04.005(5)(h)~~)) persons subject to termination of disability lifeline benefits under RCW 74.04.005(5)(h) remain enrolled in medical care services and persons subject to denial of disability lifeline benefits under RCW 74.04.005(5)(h) remain eligible for medical care services.

(2) Determination of the amount, scope, and duration of medical care services shall be limited to coverage as defined by the department, except that adult dental, and routine foot care shall not be included unless there is a specific appropriation for these services.

(3) The department shall enter into performance-based contracts with one or more managed health care systems for the provision of medical care services to recipients of disability lifeline benefits. The contract must provide for integrated delivery of medical and mental health services.

(4) The department shall establish standards of assistance and resource and income exemptions, which may include deductibles and co-insurance provisions. In addition, the department may include a prohibition against the voluntary assignment of property or cash for the purpose of qualifying for assistance.

(5) Residents of skilled nursing homes, intermediate care facilities, and intermediate care facilities for persons with intellectual disabilities, as that term is described by federal law, who are eligible for medical care services shall be provided medical services to the same extent as provided to those persons eligible under the medical assistance program.

(6) ((~~Payments made by the department under this program shall be the limit of expenditures for medical care services solely from state funds.~~

~~(7)~~)) Eligibility for medical care services shall commence with the date of certification for disability lifeline benefits or the date of eligibility for alcohol and drug addiction services provided under chapter 74.50 RCW.

Passed by the House April 5, 2011.
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