S-2288.3

SENATE BILL 5894

State of Washington 63rd Legislature 2013 Regular Session

By Senator Becker

Read first time 04/03/13. Referred to Committee on Ways & Means.

1 AN ACT Relating to authorizing the medicaid expansion while
2 ensuring state financial protections, increasing consumer engagement
3 and choice, and establishing expectations for improved health outcomes;
4 amending RCW 74.09.055; reenacting and amending RCW 74.09.010,
5 74.09.510, 74.09.522, and 74.09.053; adding new sections to chapter
6 74.09 RCW; creating a new section; repealing RCW 74.09.035, 70.47.002,
7 70.47.005, 70.47.010, 70.47.015, 70.47.020, 70.47.030, 70.47.040,
8 70.47.050, 70.47.060, 70.47.0601, 70.47.070, 70.47.080, 70.47.090,
9 70.47.100, 70.47.110, 70.47.115, 70.47.120, 70.47.130, 70.47.140,
10 70.47.150, 70.47.160, 70.47.170, 70.47.200, 70.47.201, 70.47.210,
11 70.47.220, 70.47.230, 70.47.240, 70.47.250, 70.47.900, 70.47.901, and
12 70.47.902; and providing effective dates.

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

14 **PART I**
15 **INTENT**

16 NEW SECTION. **Sec. 101.** (1) The legislature finds that the
17 opportunity to implement medicaid expansion for adults with incomes
18 below one hundred and thirty-three percent of the federal poverty level

provides the nexus to streamline the medicaid program, improve the program efficiency, and maximize federal funding to save millions of dollars in the state budget while ensuring additional funding is available for the private health delivery system.

(2) Certain parameters must be established as a condition to implement the medicaid expansion defined in the social security act section 1902(a)(10)(A)(i)(VIII) including, but not limited to, the following: Development of a budget circuit breaker, implementation of personal responsibility for enrollees through cost-sharing and through individual incentives, implementation of enhanced program performance expectations, and elimination of an array of separate medical programs. The health care authority is also directed to make program improvements that ensure enrollees a choice of health plans, monitor crowd-out of employer coverage, and report on opportunities to integrate behavioral health services with the medical program.

PART II
CIRCUIT BREAKER

NEW SECTION. **Sec. 201.** A new section is added to chapter 74.09 RCW to read as follows:

(1) The authority is authorized to implement the medicaid expansion defined in the social security act, section 1902(a)(10)(A)(i)(VIII), consistent with budget authorization provided in the omnibus appropriations act, as long as the federal medical assistance percentages defined in the social security act, section 1905(y), remain at the levels outlined in law. A circuit breaker is provided to ensure the state budget is not adversely impacted by the federal government.

(2) If the federal medical assistance percentage for the expansion falls below ninety percent, the authority shall ensure that the state does not incur any additional costs above what would have been incurred had the federal authority remained at ninety percent. The director is authorized to make any necessary program adjustments to comply with this requirement, including adding or adjusting premiums, modifying benefits, or reducing optional programs.

(3) To the extent a waiver is needed to accomplish this, the director shall promptly apply for such waiver. If a waiver is not

approved, the expansion program shall be closed upon appropriate notification to the legislature and enrollees.

PART III
PROGRAM CONSOLIDATION AND ENROLLEE RESPONSIBILITY

Sec. 301. RCW 74.09.010 and 2011 1st sp.s. c 15 s 2 and 2011 c 316 s 2 are each reenacted and amended to read as follows:

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

(1) "Authority" means the Washington state health care authority.

(2) "Children's health program" means the health care services program provided to children under eighteen years of age and in households with incomes at or below the federal poverty level as annually defined by the federal department of health and human services as adjusted for family size, and who are not otherwise eligible for medical assistance or the limited casualty program for the medically needy.

(3) "Chronic care management" means the health care management within a health home of persons identified with, or at high risk for, one or more chronic conditions. Effective chronic care management:

(a) Actively assists patients to acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;

(b) Employs evidence-based clinical practices;

(c) Coordinates care across health care settings and providers, including tracking referrals;

(d) Provides ready access to behavioral health services that are, to the extent possible, integrated with primary care; and

(e) Uses appropriate community resources to support individual patients and families in managing chronic conditions.

(4) "Chronic condition" means a prolonged condition and includes, but is not limited to:

(a) A mental health condition;

(b) A substance use disorder;

(c) Asthma;

(d) Diabetes;

(e) Heart disease; and

1 (f) Being overweight, as evidenced by a body mass index over
2 twenty-five.
3 (5) "County" means the board of county commissioners, county
4 council, county executive, or tribal jurisdiction, or its designee.
5 (6) "Department" means the department of social and health
6 services.
7 (7) "Department of health" means the Washington state department of
8 health created pursuant to RCW 43.70.020.
9 (8) "Director" means the director of the Washington state health
10 care authority.
11 (9) "Full benefit dual eligible beneficiary" means an individual
12 who, for any month: Has coverage for the month under a medicare
13 prescription drug plan or medicare advantage plan with part D coverage;
14 and is determined eligible by the state for full medicaid benefits for
15 the month under any eligibility category in the state's medicaid plan
16 or a section 1115 demonstration waiver that provides pharmacy benefits.
17 (10) "Health home" or "primary care health home" means coordinated
18 health care provided by a licensed primary care provider coordinating
19 all medical care services, and a multidisciplinary health care team
20 comprised of clinical and nonclinical staff. The term "coordinating
21 all medical care services" shall not be construed to require prior
22 authorization by a primary care provider in order for a patient to
23 receive treatment for covered services by an optometrist licensed under
24 chapter 18.53 RCW. Primary care health home services shall include
25 those services defined as health home services in 42 U.S.C. Sec. 1396w-
26 4 and, in addition, may include, but are not limited to:
27 (a) Comprehensive care management including, but not limited to,
28 chronic care treatment and management;
29 (b) Extended hours of service;
30 (c) Multiple ways for patients to communicate with the team,
31 including electronically and by phone;
32 (d) Education of patients on self-care, prevention, and health
33 promotion, including the use of patient decision aids;
34 (e) Coordinating and assuring smooth transitions and follow-up from
35 inpatient to other settings;
36 (f) Individual and family support including authorized
37 representatives;

(g) The use of information technology to link services, track tests, generate patient registries, and provide clinical data; and

(h) Ongoing performance reporting and quality improvement.

(11) "Internal management" means the administration of medical assistance, medical care services, the children's health program, and the limited casualty program.

(12) "Limited casualty program" means the medical care program provided to medically needy persons as defined under Title XIX of the federal social security act, and to medically indigent persons who are without income or resources sufficient to secure necessary medical services.

(13) "Medical assistance" means the federal aid medical care program provided to categorically needy persons as defined under Title XIX of the federal social security act including the medicaid expansion authorized under section 1902(a)(10)(A)(i)(VIII), contingent upon state and federal funding.

(14) "Medical care services" means the limited scope of care financed by state funds and provided to disability lifeline benefits recipients, and recipients of alcohol and drug addiction services provided under chapter 74.50 RCW. The medical care services program authorized through the federal bridge waiver expires December 31, 2013, consistent with the terms of the waiver agreement.

(15) "Multidisciplinary health care team" means an interdisciplinary team of health professionals which may include, but is not limited to, medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers including substance use disorder prevention and treatment providers, doctors of chiropractic, physical therapists, licensed complementary and alternative medicine practitioners, home care and other long-term care providers, and physicians' assistants.

(16) "Nursing home" means nursing home as defined in RCW 18.51.010.

(17) "Poverty" means the federal poverty level determined annually by the United States department of health and human services, or successor agency.

(18) "Primary care provider" means a general practice physician, family practitioner, internist, pediatrician, osteopath, naturopath, physician assistant, osteopathic physician assistant, and advanced registered nurse practitioner licensed under Title 18 RCW.

1 (19) "Secretary" means the secretary of social and health services.

2 **Sec. 302.** RCW 74.09.055 and 2011 1st sp.s. c 15 s 6 are each
3 amended to read as follows:
4 (1) The authority is authorized to establish copayment, deductible,
5 or coinsurance, or other cost-sharing requirements for recipients of
6 any medical programs defined in RCW 74.09.010, except that premiums
7 shall not be imposed on children in households at or below ((~~two~~
8 ~~hundred~~)) one hundred thirty-eight percent of the federal poverty
9 level.
10 (2) The authority must seek a waiver to implement cost-sharing
11 levels similar to the cost-sharing applied to the basic health
12 population in the bridge waiver, for those with similar incomes.

13 **Sec. 303.** RCW 74.09.510 and 2011 1st sp.s. c 36 s 9 and 2011 1st
14 sp.s. c 15 s 25 are each reenacted and amended to read as follows:
15 Medical assistance may be provided in accordance with eligibility
16 requirements established by the authority, as defined in the social
17 security Title XIX state plan ((~~for mandatory categorically needy~~
18 ~~persons~~)) and:
19 (1) Individuals who would be eligible for cash assistance except
20 for their institutional status;
21 (2) Individuals who are under twenty-one years of age, who would be
22 eligible for medicaid, but do not qualify as dependent children and who
23 are in (a) foster care, (b) subsidized adoption, (c) a nursing facility
24 or an intermediate care facility for persons with intellectual
25 disabilities, or (d) inpatient psychiatric facilities;
26 (3) Individuals who:
27 (a) Are under twenty-one years of age;
28 (b) On or after July 22, 2007, were in foster care under the legal
29 responsibility of the department or a federally recognized tribe
30 located within the state; and
31 (c) On their eighteenth birthday, were in foster care under the
32 legal responsibility of the department or a federally recognized tribe
33 located within the state;
34 (4) Persons who are aged, blind, or disabled who: (a) Receive only
35 a state supplement, or (b) would not be eligible for cash assistance if
36 they were not institutionalized;

(5) Categorically eligible individuals ((~~who meet the income and resource requirements of the cash assistance programs~~)) as defined in the social security act;

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

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

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

(9) Other individuals eligible for medical services under ((~~RCW 74.09.035 based on age, blindness, or disability and income and resources standards for medical care services and~~)) RCW 74.09.700 for whom federal financial participation is available under Title XIX of the social security act;

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

(11) Women who: (a) Are under sixty-five years of age; (b) have been screened for breast and cervical cancer under the national breast and cervical cancer early detection program administered by the department of health or tribal entity and have been identified as needing treatment for breast or cervical cancer; and (c) are not otherwise covered by health insurance. Medical assistance provided under this subsection is limited to the period during which the woman requires treatment for breast or cervical cancer, and is subject to any conditions or limitations specified in the omnibus appropriations act. The program is closed to new enrollees after December 31, 2013, but enrollees receiving treatment may complete treatment or transfer to more comprehensive coverage available through the medicaid expansion.

Sec. 304. RCW 74.09.522 and 2011 1st sp.s. c 15 s 29, 2011 1st sp.s. c 9 s 2, and 2011 c 316 s 4 are each reenacted and amended to read as follows:

(1) For the purposes of this section:

(a) "Managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, health insuring organizations, or any combination thereof, that provides directly or by contract health care services covered under this chapter and rendered by licensed providers, on a prepaid capitated basis and that meets the requirements of section 1903(m)(1)(A) of Title XIX of the federal social security act or federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act;

(b) "Nonparticipating provider" means a person, health care provider, practitioner, facility, or entity, acting within their scope of practice, that does not have a written contract to participate in a managed health care system's provider network, but provides health care services to enrollees of programs authorized under this chapter whose health care services are provided by the managed health care system.

(2) The authority shall enter into agreements with managed health care systems to provide health care services to ((~~recipients of temporary assistance for needy families~~)) medical assistance enrollees under the following conditions:

(a) ((~~Agreements shall be made for at least thirty thousand recipients statewide;~~

~~(b) Agreements in at least one county shall include enrollment of all recipients of temporary assistance for needy families;~~

~~(c)~~)) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act or federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act, recipients shall have a choice of systems in which to enroll and shall have the right to terminate their enrollment in a system: PROVIDED, That the authority may limit recipient termination of enrollment without cause to the first month of a period of enrollment, which period shall not exceed twelve months: AND PROVIDED FURTHER, That the authority shall not restrict a recipient's right to terminate enrollment in a system for good cause as established by the authority by rule;

((~~(d)~~)) (b) By January 1, 2015, enrollees in the medicaid expansion defined in the social security act, section 1902(a)(1)(A)(i)(VIII), must be provided a choice of plan consistent with the enrollment

practices offered other enrollees processed by the health benefit exchange: PROVIDED, That the authority report to the legislature on adverse impacts that may necessitate program modification;

(c) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act, participating managed health care systems shall not enroll a disproportionate number of medical assistance recipients within the total numbers of persons served by the managed health care systems, except as authorized by the authority under federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act;

((~~(c)~~)) (d)(i) In negotiating with managed health care systems the authority shall adopt a uniform procedure to enter into contractual arrangements, to be included in contracts issued or renewed on or after January 1, 2012, including:

(A) Standards regarding the quality of services to be provided;

(B) The financial integrity of the responding system;

(C) Provider reimbursement methods that incentivize chronic care management within health homes;

(D) Provider reimbursement methods that reward health homes that, by using chronic care management, reduce emergency department and inpatient use; and

(E) Promoting provider participation in the program of training and technical assistance regarding care of people with chronic conditions described in RCW 43.70.533, including allocation of funds to support provider participation in the training, unless the managed care system is an integrated health delivery system that has programs in place for chronic care management.

(ii)(A) Health home services contracted for under this subsection may be prioritized to enrollees with complex, high cost, or multiple chronic conditions.

(B) Contracts that include the items in ((~~(c)~~)) (d)(i)(C) through (E) of this subsection must not exceed the rates that would be paid in the absence of these provisions;

((~~(f)~~)) (e) The authority shall seek waivers from federal requirements as necessary to implement this chapter;

((~~(g)~~)) (f) The authority shall, wherever possible, enter into prepaid capitation contracts that include inpatient care. However, if

this is not possible or feasible, the authority may enter into prepaid capitation contracts that do not include inpatient care;

((~~(h)~~)) <u>(g)</u> The authority shall define those circumstances under which a managed health care system is responsible for out-of-plan services and assure that recipients shall not be charged for such services;

((~~(i)~~)) <u>(h)</u> Nothing in this section prevents the authority from entering into similar agreements for other groups of people eligible to receive services under this chapter; and

((~~(j)~~)) <u>(i)</u> The ((~~department~~)) <u>authority</u> must consult with the federal center for medicare and medicaid innovation and seek funding opportunities to support health homes.

(3)<u>(a) Contracts must incorporate accountability measures that monitor patient health and improved health outcomes, and may include an expectation that each patient receive a wellness examination that documents the baseline health status and allows for monitoring of health improvements and outcome measures.</u>

<u>(b) Contracts may allow plans to offer small incentives for enrollees to participate in prevention and wellness activities.</u>

<u>(4)</u> The authority shall ensure that publicly supported community health centers and providers in rural areas, who show serious intent and apparent capability to participate as managed health care systems are seriously considered as contractors. The authority shall coordinate its managed care activities with activities under chapter 70.47 RCW.

((~~(4)~~)) <u>(5)</u> The authority shall work jointly with the state of Oregon and other states in this geographical region in order to develop recommendations to be presented to the appropriate federal agencies and the United States congress for improving health care of the poor, while controlling related costs.

((~~(5)~~)) <u>(6)</u> The legislature finds that competition in the managed health care marketplace is enhanced, in the long term, by the existence of a large number of managed health care system options for medicaid clients. In a managed care delivery system, whose goal is to focus on prevention, primary care, and improved enrollee health status, continuity in care relationships is of substantial importance, and disruption to clients and health care providers should be minimized.

1 To help ensure these goals are met, the following principles shall
2 guide the authority in its healthy options managed health care
3 purchasing efforts:
4 (a) All managed health care systems should have an opportunity to
5 contract with the authority to the extent that minimum contracting
6 requirements defined by the authority are met, at payment rates that
7 enable the authority to operate as far below appropriated spending
8 levels as possible, consistent with the principles established in this
9 section.
10 (b) Managed health care systems should compete for the award of
11 contracts and assignment of medicaid beneficiaries who do not
12 voluntarily select a contracting system, based upon:
13 (i) Demonstrated commitment to or experience in serving low-income
14 populations;
15 (ii) Quality of services provided to enrollees;
16 (iii) Accessibility, including appropriate utilization, of services
17 offered to enrollees;
18 (iv) Demonstrated capability to perform contracted services,
19 including ability to supply an adequate provider network;
20 (v) Payment rates; and
21 (vi) The ability to meet other specifically defined contract
22 requirements established by the authority, including consideration of
23 past and current performance and participation in other state or
24 federal health programs as a contractor.
25 (c) Consideration should be given to using multiple year
26 contracting periods.
27 (d) Quality, accessibility, and demonstrated commitment to serving
28 low-income populations shall be given significant weight in the
29 contracting, evaluation, and assignment process.
30 (e) All contractors that are regulated health carriers must meet
31 state minimum net worth requirements as defined in applicable state
32 laws. The authority shall adopt rules establishing the minimum net
33 worth requirements for contractors that are not regulated health
34 carriers. This subsection does not limit the authority of the
35 Washington state health care authority to take action under a contract
36 upon finding that a contractor's financial status seriously jeopardizes
37 the contractor's ability to meet its contract obligations.

(f) Procedures for resolution of disputes between the authority and contract bidders or the authority and contracting carriers related to the award of, or failure to award, a managed care contract must be clearly set out in the procurement document.

((~~(6)~~)) (7) The authority may apply the principles set forth in subsection ((~~(5)~~)) (6) of this section to its managed health care purchasing efforts on behalf of clients receiving supplemental security income benefits to the extent appropriate.

((~~(7)~~)) (8) A managed health care system shall pay a nonparticipating provider that provides a service covered under this chapter to the system's enrollee no more than the lowest amount paid for that service under the managed health care system's contracts with similar providers in the state.

((~~(8)~~)) (9) For services covered under this chapter to medical assistance or medical care services enrollees and provided on or after August 24, 2011, nonparticipating providers must accept as payment in full the amount paid by the managed health care system under subsection ((~~(7)~~)) (8) of this section in addition to any deductible, coinsurance, or copayment that is due from the enrollee for the service provided. An enrollee is not liable to any nonparticipating provider for covered services, except for amounts due for any deductible, coinsurance, or copayment under the terms and conditions set forth in the managed health care system contract to provide services under this section.

((~~(9)~~)) (10) Pursuant to federal managed care access standards, 42 C.F.R. Sec. 438, managed health care systems must maintain a network of appropriate providers that is supported by written agreements sufficient to provide adequate access to all services covered under the contract with the ((~~department~~)) authority, including hospital-based physician services. The ((~~department~~)) authority will monitor and periodically report on the proportion of services provided by contracted providers and nonparticipating providers, by county, for each managed health care system to ensure that managed health care systems are meeting network adequacy requirements. No later than January 1st of each year, the ((~~department~~)) authority will review and report its findings to the appropriate policy and fiscal committees of the legislature for the preceding state fiscal year.

((~~(10)~~)) (11) Subsections ((~~(7)~~)) (8) through ((~~(9)~~)) (10) of this section expire July 1, 2016.

(12) The authority must develop contract performance measures that demonstrate meaningful measurement of enrollee health status and wellness, efforts by the managed care plan to increase enrollee participation in meaningful activities including a wellness visit, and application of evidence-based practices. The performance measures shall assist the authority and the legislature in monitoring managed care plan accountability and monitoring for limited access to appropriate care or fraud.

NEW SECTION. **Sec. 305.** A new section is added to chapter 74.09 RCW to read as follows:

(1) The authority, in cooperation with the department, must complete a study on the integration of the behavioral health system into the medical purchasing. The medicaid expansion and the implementation of mental health parity in the medical benefits provide the natural opportunity to redesign the medical package and align the delivery systems to ensure enrollees can access the full scope of medical care, including mental health services and chemical dependency services, as part of their comprehensive medical package.

(2) The integration of the behavioral health services may include contracting with the regional support networks as providers within the managed care contracts, or other community-based delivery strategies that ensure the full range of care is available to enrollees, while providing an accountable contract to monitor performance and manage costs efficiently and effectively.

(3) The study must identify the pathway to integration with a focus on administrative efficiency, seamless delivery of care for enrollees, and critical connectivity with social support systems, crisis intervention systems, and criminal justice systems.

(4) The study must be submitted to the governor and the legislature by October 1, 2014, and must be submitted with recommendations for the necessary statutory changes and the budget transition.

PART IV
MONITORING CROWD-OUT

Sec. 401. RCW 74.09.053 and 2009 c 568 s 6 and 2009 c 479 s 62 are each reenacted and amended to read as follows:

(1) Beginning in November 2012, the department of social and health services, in coordination with the health care authority, shall by November 15th of each year report to the legislature:

(a) The number of medical assistance recipients who: (i) Upon enrollment or recertification had reported being employed, and beginning with the 2008 report, the month and year they reported being hired; or (ii) upon enrollment or recertification had reported being the dependent of someone who was employed, and beginning with the 2008 report, the month and year they reported the employed person was hired. For recipients identified under (a)(i) and (ii) of this subsection, the department shall report the basis for their medical assistance eligibility, including but not limited to family medical coverage, transitional medical assistance, children's medical coverage, aged coverage, or coverage for persons with disabilities; member months; and the total cost to the state for these recipients, expressed as general fund-state and general fund-federal dollars. The information shall be reported by employer size for employers having more than fifty employees as recipients or with dependents as recipients. This information shall be provided for the preceding January and June of that year.

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

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

<u>(3) Beginning in November 2015, reports must include information on the medicaid enrollees that may have dropped employer coverage. Data must be gathered to monitor any crowd-out of employer coverage related to the expansion of medicaid coverage.</u>

(4) Crowd-out data should be shared with the Washington state institute for public policy for monitoring and inclusion in their grant research on medicaid, and the agency must work with the United States health and human services department to explore alternatives that may allow an efficient method of providing premium assistance and help enrollees retain their employer coverage or other private coverage if cost-effective for the state.

PART V
REPEALERS

NEW SECTION. **Sec. 501.** The following acts or parts of acts are each repealed, effective December 31, 2013:

(1) RCW 74.09.035 (Medical care services--Eligibility, standards--Limits) and 2011 1st sp.s. c 36 s 6, 2011 1st sp.s. c 15 s 3, & 2011 c 284 s 3;

(2) RCW 70.47.002 (Intent--2002 c 2) and 2002 c 2 s 1;

(3) RCW 70.47.005 (Transfer power, duties, and functions to Washington state health care authority) and 1993 c 492 s 201;

(4) RCW 70.47.010 (Legislative findings--Purpose--Director to coordinate eligibility) and 2011 1st sp.s. c 15 s 82, 2009 c 568 s 1, 2000 c 79 s 42, 1993 c 492 s 208, & 1987 1st ex.s. c 5 s 3;

(5) RCW 70.47.015 (Enrollment--Findings--Intent--Enrollee premium share--Expedited application and enrollment process--Commission for insurance producers) and 2009 c 479 s 49, 2008 c 217 s 99, 1997 c 337 s 1, & 1995 c 265 s 1;

(6) RCW 70.47.020 (Definitions) and 2011 1st sp.s. c 15 s 83, 2011 1st sp.s. c 9 s 3, 2011 c 284 s 1, 2011 c 205 s 1, 2009 c 568 s 2, 2007 c 259 s 35, 2005 c 188 s 2, 2004 c 192 s 1, 2000 c 79 s 43, 1997 c 335 s 1, & 1997 c 245 s 5;

(7) RCW 70.47.030 (Basic health plan trust account--Basic health plan subscription account) and 2004 c 192 s 2, 1995 2nd sp.s. c 18 s 913, 1993 c 492 s 210, & 1992 c 232 s 907;

(8) RCW 70.47.040 (Basic health plan--Health care authority head to be administrator--Joint operations) and 2010 1st sp.s. c 7 s 7, 1993 c 492 s 211, & 1987 1st ex.s. c 5 s 6;

(9) RCW 70.47.050 (Rules) and 1987 1st ex.s. c 5 s 7;

1 (10) RCW 70.47.060 (Powers and duties of administrator--Schedule of
2 services--Premiums, copayments, subsidies--Enrollment) and 2011 c 284
3 s 2, 2009 c 568 s 3, 2007 c 259 s 36, 2006 c 343 s 9, 2004 c 192 s 3,
4 2001 c 196 s 13, & 2000 c 79 s 34;
5 (11) RCW 70.47.0601 (Income determination--Unemployment
6 compensation) and 2011 c 4 s 18;
7 (12) RCW 70.47.070 (Benefits from other coverages not reduced) and
8 2009 c 568 s 4 & 1987 1st ex.s. c 5 s 9;
9 (13) RCW 70.47.080 (Enrollment of applicants--Participation
10 limitations) and 1993 c 492 s 213 & 1987 1st ex.s. c 5 s 10;
11 (14) RCW 70.47.090 (Removal of enrollees) and 1987 1st ex.s. c 5 s
12 11;
13 (15) RCW 70.47.100 (Participation by a managed health care system--
14 Expiration of subsections) and 2011 1st sp.s. c 9 s 4, 2011 c 316 s 5,
15 2009 c 568 s 5, 2004 c 192 s 4, 2000 c 79 s 35, & 1987 1st ex.s. c 5 s
16 12;
17 (16) RCW 70.47.110 (Enrollment of medical assistance recipients)
18 and 2011 1st sp.s. c 15 s 84, 1991 sp.s. c 4 s 3, & 1987 1st ex.s. c 5
19 s 13;
20 (17) RCW 70.47.115 (Enrollment of persons in timber impact areas)
21 and 1992 c 21 s 7 & 1991 c 315 s 22;
22 (18) RCW 70.47.120 (Administrator--Contracts for services) and 1997
23 c 337 s 7 & 1987 1st ex.s. c 5 s 14;
24 (19) RCW 70.47.130 (Exemption from insurance code) and 2009 c 298
25 s 4, 2004 c 115 s 2, 2000 c 5 s 21, 1997 c 337 s 8, 1994 c 309 s 6, &
26 1987 1st ex.s. c 5 s 15;
27 (20) RCW 70.47.140 (Reservation of legislative power) and 1987 1st
28 ex.s. c 5 s 2;
29 (21) RCW 70.47.150 (Confidentiality) and 2005 c 274 s 336 & 1990 c
30 54 s 1;
31 (22) RCW 70.47.160 (Right of individuals to receive services--Right
32 of providers, carriers, and facilities to refuse to participate in or
33 pay for services for reason of conscience or religion--Requirements)
34 and 1995 c 266 s 3;
35 (23) RCW 70.47.170 (Annual reporting requirement) and 2009 c 568 s
36 7 & 2006 c 264 s 1;
37 (24) RCW 70.47.200 (Mental health services--Definition--Coverage
38 required, when) and 2005 c 6 s 6;

(25) RCW 70.47.201 (Mental health services--Rules) and 2005 c 6 s 11;

(26) RCW 70.47.210 (Prostate cancer screening) and 2006 c 367 s 7;

(27) RCW 70.47.220 (Increase in reimbursement rates not applicable) and 2010 1st sp.s. c 30 s 15;

(28) RCW 70.47.230 (Payments to nonparticipating providers) and 2011 1st sp.s. c 9 s 5;

(29) RCW 70.47.240 (Discontinuation of health coverage--Preexisting condition) and 2012 c 64 s 3;

(30) RCW 70.47.250 (Federal basic health option--Report to legislature--Certification--Director's findings--Program's guiding principles) and 2012 c 87 s 15;

(31) RCW 70.47.900 (Short title) and 1987 1st ex.s. c 5 s 1;

(32) RCW 70.47.901 (Severability--1987 1st ex.s. c 5) and 1987 1st ex.s. c 5 s 26; and

(33) RCW 70.47.902 (Construction--Chapter applicable to state registered domestic partnerships--2009 c 521) and 2009 c 521 s 151.

NEW SECTION. **Sec. 502.** Section 303 of this act takes effect December 31, 2013.

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