H-2765.1

**HOUSE BILL 2476**

**State of Washington 68th Legislature 2024 Regular Session**

**By** Representatives Macri, Riccelli, Ramel, and Thai

Read first time 01/25/24. Referred to Committee on Appropriations.

1 AN ACT Relating to creating a covered lives assessment
2 professional services rate account; adding a new section to chapter
3 48.02 RCW; adding a new chapter to Title 74 RCW; creating a new
4 section; and providing contingent expiration dates.

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

6 NEW SECTION. **Sec. 1.** (1) Beginning January 1, 2026, and
7 annually thereafter, the authority shall determine the number of
8 covered persons per calendar year as described in RCW 71.24.064.
9 (2)(a) For assessments collected in calendar year 2026, the
10 authority shall assess a per member per month assessment of no more
11 than $18.00 per covered life for medicaid managed care organizations.
12 (b) For assessments collected in calendar year 2027 and annually
13 thereafter, the authority shall set the assessment at the minimum
14 rate necessary to fund the professional services rate increases in
15 section 3(3) of this act.
16 (3) The assessments as applied in subsection (2) of this section
17 are limited to the first 3,000,000 member months on a per-carrier
18 basis.
19 (4) The covered lives assessment collected from each medicaid
20 managed care organization is that proportion of the total assessment
21 amount for the ensuing calendar year that is represented by the

medicaid managed care organization's proportion of covered lives in this state during the previous calendar year.

(5) An annual assessment is imposed as set forth in this subsection, which shall be paid in equal quarterly installments. For calendar year 2026, the first assessment notice must be sent on or before February 15th, and subsequent assessment notices must be sent on or before 45 calendar days prior to the end of each quarter. Medicaid managed care organizations shall pay their assessments within 30 calendar days of receiving any notice.

(6) Assessments and penalties collected under this section must be deposited in the covered lives assessment professional services rate account and spent according to section 3 of this act.

(7) If an assessment against a medicaid managed care organization is prohibited by court order, the assessment for the remaining medicaid managed care organizations may be adjusted to ensure that the net assessment amount calculated in subsection (2) of this section will be collected.

(8) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Covered lives" means all persons residing in Washington state who are either:

(i) Covered under a fully insured individual or group health plan issued or delivered in Washington state; or

(ii) Covered under medicaid managed care organizations.

(b) "Covered lives assessment" means the fees imposed by this section.

(c) "Health carrier" means every health care service contractor, as defined in RCW 48.44.010, every health maintenance organization, as defined in RCW 48.46.020, and every insurer that issues disability insurance regulated in chapter 48.20 or 48.21 RCW registered to do business in this state.

(d) "Health plan" has the same meaning as defined in RCW 48.43.005 and does not include medicare advantage plans established under medicare part C or outpatient prescription drug plans established under medicare part D.

(e) "Medicaid managed care organization" means a managed health care system under contract with the state of Washington to provide services to medicaid enrollees under RCW 74.09.522.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.02 RCW to read as follows:

(1) Beginning January 1, 2026, and annually thereafter, the commissioner shall determine the number of covered persons per calendar year as described in RCW 71.24.064.

(2)(a) For assessments collected in calendar year 2026, the commissioner shall assess a per member per month assessment of no more than $0.50 per covered life for health carriers.

(b) For assessments collected in calendar year 2027 and annually thereafter, the commissioner shall set the assessment at the minimum rate necessary to fund the professional services rate increases in section 3(3) of this act.

(3) The assessments as applied in subsection (2) of this section are limited to the first 3,000,000 member months on a per-carrier basis.

(4) The covered lives assessment collected from each health carrier is that proportion of the total assessment amount for the ensuing calendar year that is represented by the health carrier's proportion of covered lives in this state during the previous calendar year.

(5) An annual assessment is imposed as set forth in this subsection, which shall be paid in equal quarterly installments. For calendar year 2026, the first assessment notice shall be sent on or before February 15th, and subsequent assessment notices must be sent on or before 45 calendar days prior to the end of each quarter. Health carriers shall pay their assessments within 30 calendar days of receiving any notice.

(6) Assessments and penalties collected under this section must be deposited in the covered lives assessment professional services rate account and spent according to section 3 of this act.

(7) If an assessment against a health carrier is prohibited by court order, the assessment for the remaining health carriers may be adjusted to ensure that the net assessment amount calculated in subsection (2) of this section will be collected.

(8) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Covered lives" means all persons residing in Washington state who are either:

(i) Covered under a fully insured individual or group health plan issued or delivered in Washington state; or

(ii) Covered under medicaid managed care organizations.

(b) "Covered lives assessment" means the fees imposed by this section.

(c) "Health carrier" means every health care service contractor, as defined in RCW 48.44.010, every health maintenance organization, as defined in RCW 48.46.020, and every insurer that issues disability insurance regulated in chapter 48.20 or 48.21 RCW registered to do business in this state.

(d) "Health plan" has the same meaning as defined in RCW 48.43.005 and does not include medicare advantage plans established under medicare part C or outpatient prescription drug plans established under medicare part D.

NEW SECTION. **Sec. 3.** (1) The covered lives assessment professional services rate account is created in the state treasury. All receipts from the assessments, interest, and penalties collected by the authority and commissioner as outlined in sections 1 and 2 of this act must be deposited into the account. Moneys in the account may be spent only after appropriation. Expenditures from the account may be used only as outlined in this chapter. The purpose and use of the account shall be to receive and disburse funds, together with accrued interest, in accordance with this chapter. Moneys in the account, including interest earned, shall not be used or disbursed for any purposes other than those specified in this chapter. Any amounts expended from the account that are later recouped by the authority on audit or otherwise shall be returned to the account.

(a) Any unexpended balance in the account at the end of a fiscal year shall carry over into the following fiscal year or that fiscal year and the following fiscal year and shall be applied to reduce the amount of the assessment under sections 1 and 2 of this act.

(b) If the program is discontinued, any amounts remaining in the account shall be refunded to health carriers and medicaid managed care organizations, pro rata according to the amount paid by the health carriers and medicaid managed care organizations since January 1, 2025, subject to the limitations of federal law.

(2) Disbursements from the account are conditioned upon appropriation and the continued availability of other funds sufficient to maintain professional services payment rates covered by medicaid, including fee-for-service and managed care, effective January 1, 2026, to no less than the corresponding medicare rates for

1 those services on October 1, 2023. Rates for subsequent years shall 2 be annually adjusted based on the inflation factor. The professional 3 services included under this act shall be determined by the authority 4 through rule making to be completed by July 1, 2025, and shall apply 5 to all covered professional services that are delivered by 6 physicians, physician assistants, and advanced registered nurse 7 practitioners.

8 (3) Disbursements from the account may be made only:

9 (a) To make payments to health care providers and managed care 10 organizations as specified in this chapter;

11 (b) To medicaid managed care organizations for funding the 12 nonfederal share of increased capitation payments based on their 13 projected assessment obligation pursuant to this chapter;

14 (c) To refund erroneous or excessive payments made by health 15 carriers and medicaid managed care organizations pursuant to this 16 chapter; and

17 (d) To repay the federal government for any excess payments made 18 to health care providers from the account if the assessments or 19 payment increases set forth in this chapter are deemed out of 20 compliance with federal statutes and regulations in a final 21 determination by a court of competent jurisdiction with all appeals 22 exhausted. In such a case, the authority may require health care 23 providers receiving excess payments to refund the payments in 24 question to the account. The state in turn shall return funds to the 25 federal government in the same proportion as the original financing. 26 If a health care provider is unable to refund payments, the state 27 shall develop either a payment plan, or deduct moneys from future 28 medicaid payments, or both.

29 NEW SECTION. **Sec. 4.** (1) Beginning on the later of January 1, 30 2026, or 30 calendar days after satisfaction of the conditions in 31 section 5(1) of this act and subsection (2) of this section, and for 32 each subsequent calendar year so long as none of the conditions 33 stated in section 9 of this act have occurred, the authority shall 34 make quarterly payments to medicaid managed care organizations as 35 specified in this section in a manner consistent with federal 36 contracting requirements. The authority shall direct payments from 37 managed care organizations to health care providers.

38 (2) Before making such payments, the authority shall modify its 39 contracts with managed care organizations or otherwise require:

1 (a) Payment of the entire amount payable to health care providers
2 as directed by the authority under subsection (3) of this section,
3 less an allowance for premium taxes the organization is required to
4 pay under Title 48 RCW and for funding the nonfederal share of
5 increased capitation payments based on their projected assessment
6 pursuant to this chapter;
7 (b) That payments to health care providers be made as part of the
8 contracted reimbursement process;
9 (c) That any delegation or attempted delegation of an
10 organization's obligations under agreements with the authority does
11 not relieve the organization of its obligations under this section
12 and related contract provisions; and
13 (d) That if funds cannot be paid to health care providers, the
14 managed care organization shall return the funds to the authority,
15 which shall return them to the covered lives assessment professional
16 services rate account.
17 (3) If federal restrictions prevent the full amount of payments
18 under this section from being delivered to any class or classes of
19 health care provider, the authority, in consultation with the
20 Washington state medical association, will alter payment rates for
21 medicaid professional services.
22 (4) If a managed care organization is legally obligated to repay
23 the state or federal government amounts distributed to health care
24 providers under this section, it may recoup the amount it is
25 obligated to repay from individual health care providers under the
26 medicaid program by not more than the amount of overpayment each
27 health care provider received from that managed care organization.
28 (5) No health care provider, health carrier, or managed care
29 organization may use the payments under this section to gain
30 advantage in negotiations.

31 NEW SECTION. **Sec. 5.** The assessment, collection, and
32 disbursement of funds under this chapter shall be conditional upon:
33 (1) Final approval by the centers for medicare and medicaid
34 services in order to implement the applicable sections of this
35 chapter including, if necessary, waiver of the broad-based or
36 uniformity requirements as specified under section 1903(w)(3)(E) of
37 the federal social security act and 42 C.F.R. 433.68(e);

(2) To the extent necessary, amendment of contracts between the authority and managed care organizations in order to implement this chapter; and

(3) Certification by the office of financial management that appropriations have been adopted that fully support the rates established in this chapter for the upcoming calendar year.

NEW SECTION. **Sec. 6.** (1) The authority, in cooperation with the office of financial management, shall develop rules for determining the amount to be assessed to individual managed care organizations, notifying individual managed care organizations of the assessed amount, and collecting the amounts due. Such rule making shall specifically include provisions for:

(a) Transmittal of notices of assessment by the authority to each managed care organization informing the managed care organization of its total covered lives and the assessment amount due and payable;

(b) Interest on delinquent assessments at the rate specified in RCW 82.32.050; and

(c) Adjustment of the assessment amounts must be applied to include an inflation factor using the medicare economic index.

(2) For any managed care organizations failing to make an assessment payment within 60 calendar days of its due date, the authority shall offset an amount from payments scheduled to be made by the authority to the managed care organizations, reflecting the assessment payments owed by the managed care organizations plus any interest. The authority shall deposit these offset funds into the dedicated covered lives assessment professional services rate account.

(3) The assessment described in this section shall be considered a special purpose obligation or assessment in connection with coverage described in this section for the purpose of funding the operations of the exchange and may not be applied by issuers to vary premium rates at the plan level.

NEW SECTION. **Sec. 7.** (1) The commissioner, in cooperation with the office of financial management, shall develop rules for determining the amount to be assessed to health carriers, notifying health carriers of the assessed amount, and collecting the amounts due. Such rule making shall specifically include provisions for:

(a) Transmittal of notices of assessment by the commissioner to each health carrier informing the health carrier of its total covered lives and the assessment amount due and payable;

(b) Interest on delinquent assessments at the rate specified in RCW 82.32.050; and

(c) Adjustment of the assessment amounts must be applied to include an inflation factor using the medicare economic index.

(2) For any health carrier failing to make an assessment payment within 60 days of its due date, the commissioner may impose supplemental fees to fully and properly charge the carrier. Any carrier failing to pay the surcharges must pay the same penalties as the penalties for failure to pay taxes when due under RCW 48.14.060. The surcharges required by this section are in addition to all other taxes and fees now imposed or that may be subsequently imposed. The commissioner shall deposit these offset funds into the covered lives assessment professional services rate account.

(3) The assessment described in this section shall be considered a special purpose obligation or assessment in connection with coverage described in this section for the purpose of funding the operations of the exchange and may not be applied by issuers to vary premium rates at the plan level.

NEW SECTION. **Sec. 8.** (1) The provisions of this chapter are not severable. If the conditions in section 5(1) of this act are not satisfied or if any of the circumstances in section 9(1) of this act should occur, this entire chapter shall have no effect from that point forward.

(2) In the event that any portion of this chapter shall have been validly implemented and the entire chapter is later rendered ineffective under this section, prior assessments and payments under the validly implemented portions shall not be affected.

(3) The authority shall provide written notice of the expiration date of sections 1, 3 through 6, and 8 of this act to affected parties, the chief clerk of the house of representatives, the secretary of the senate, the office of the code reviser, and others as deemed appropriate by the authority.

NEW SECTION. **Sec. 9.** (1) This chapter does not take effect or ceases to be imposed, and any moneys remaining in the account shall be refunded to health carriers and managed care organizations in

1 proportion to the amounts paid by such entities, if and to the extent
2 that any of the following conditions occur:
3 (a) The federal department of health and human services and a
4 court of competent jurisdiction makes a final determination, with all
5 appeals exhausted, that any element of this chapter cannot be validly
6 implemented; or
7 (b) Funds generated by the assessment for payments to health care
8 providers or managed care organizations are determined to be not
9 eligible for federal matching funds in addition to those federal
10 funds that would be received without the assessment, or the federal
11 government replaces medicaid matching funds with a block grant or
12 grants.
13 (2) The authority shall provide written notice of the expiration
14 date of sections 1, 3 through 6, and 8 of this act to affected
15 parties, the chief clerk of the house of representatives, the
16 secretary of the senate, the office of the code reviser, and others
17 as deemed appropriate by the authority.

18 NEW SECTION. **Sec. 10.** Sections 1, 3 through 6, 8, and 9 of this
19 act constitute a new chapter in Title 74 RCW.

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