
SUBSTITUTE SENATE BILL 5148

State of Washington

62nd Legislature

2011 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Keiser, Becker, and Conway)

READ FIRST TIME 02/08/11.

1 AN ACT Relating to statutory changes needed to implement a waiver
2 to receive federal assistance for certain state purchased health care
3 programs; amending RCW 70.47.060; and reenacting and amending RCW
4 70.47.020 and 74.09.035.

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

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

8 As used in this chapter:

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

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

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

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

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

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

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

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

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

10 (9) "Subsidized enrollee" means:

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

13 (i) Who is not eligible for medicare;

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

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

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

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

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

28 (vii) Who is not receiving medical assistance administered by the
29 department of social and health services and has not been determined
30 currently eligible for federally financed categorically needy or
31 medically needy programs administered under chapter 74.09 RCW, except
32 as provided under RCW 70.47.110;

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

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

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

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

15 The administrator has the following powers and duties:

16 (1) To design and from time to time revise a schedule of covered
17 basic health care services, including physician services, inpatient and
18 outpatient hospital services, prescription drugs and medications, and
19 other services that may be necessary for basic health care. In
20 addition, the administrator may, to the extent that funds are
21 available, offer as basic health plan services chemical dependency
22 services, mental health services, and organ transplant services. All
23 subsidized and nonsubsidized enrollees in any participating managed
24 health care system under the Washington basic health plan shall be
25 entitled to receive covered basic health care services in return for
26 premium payments to the plan. The schedule of services shall emphasize
27 proven preventive and primary health care and shall include all
28 services necessary for prenatal, postnatal, and well-child care.
29 However, with respect to coverage for subsidized enrollees who are
30 eligible to receive prenatal and postnatal services through the medical
31 assistance program under chapter 74.09 RCW, the administrator shall not
32 contract for such services except to the extent that such services are
33 necessary over not more than a one-month period in order to maintain
34 continuity of care after diagnosis of pregnancy by the managed care
35 provider. The schedule of services shall also include a separate
36 schedule of basic health care services for children, eighteen years of
37 age and younger, for those subsidized or nonsubsidized enrollees who

1 choose to secure basic coverage through the plan only for their
2 dependent children. In designing and revising the schedule of
3 services, the administrator shall consider the guidelines for assessing
4 health services under the mandated benefits act of 1984, RCW 48.47.030,
5 and such other factors as the administrator deems appropriate. The
6 administrator shall encourage enrollees who have been continually
7 enrolled on basic health for a period of one year or more to complete
8 a health risk assessment and participate in programs approved by the
9 administrator that may include wellness, smoking cessation, and chronic
10 disease management programs. In approving programs, the administrator
11 shall consider evidence that any such programs are proven to improve
12 enrollee health status.

13 (2)(a) To design and implement a structure of periodic premiums due
14 the administrator from subsidized enrollees that is based upon gross
15 family income, giving appropriate consideration to family size and the
16 ages of all family members. The enrollment of children shall not
17 require the enrollment of their parent or parents who are eligible for
18 the plan. The structure of periodic premiums shall be applied to
19 subsidized enrollees entering the plan as individuals pursuant to
20 subsection (11) of this section and to the share of the cost of the
21 plan due from subsidized enrollees entering the plan as employees
22 pursuant to subsection (12) of this section.

23 (b) To determine the periodic premiums due the administrator from
24 subsidized enrollees under RCW 70.47.020(~~(+6)~~) (9)(b). Premiums due
25 for foster parents with gross family income up to two hundred percent
26 of the federal poverty level shall be set at the minimum premium amount
27 charged to enrollees with income below sixty-five percent of the
28 federal poverty level. Premiums due for foster parents with gross
29 family income between two hundred percent and three hundred percent of
30 the federal poverty level shall not exceed one hundred dollars per
31 month.

32 (c) To determine the periodic premiums due the administrator from
33 nonsubsidized enrollees. Premiums due from nonsubsidized enrollees
34 shall be in an amount equal to the cost charged by the managed health
35 care system provider to the state for the plan plus the administrative
36 cost of providing the plan to those enrollees and the premium tax under
37 RCW 48.14.0201.

1 (d) To determine the periodic premiums due the administrator from
2 health coverage tax credit eligible enrollees. Premiums due from
3 health coverage tax credit eligible enrollees must be in an amount
4 equal to the cost charged by the managed health care system provider to
5 the state for the plan, plus the administrative cost of providing the
6 plan to those enrollees and the premium tax under RCW 48.14.0201. The
7 administrator will consider the impact of eligibility determination by
8 the appropriate federal agency designated by the Trade Act of 2002
9 (P.L. 107-210) as well as the premium collection and remittance
10 activities by the United States internal revenue service when
11 determining the administrative cost charged for health coverage tax
12 credit eligible enrollees.

13 (e) An employer or other financial sponsor may, with the prior
14 approval of the administrator, pay the premium, rate, or any other
15 amount on behalf of a subsidized or nonsubsidized enrollee, by
16 arrangement with the enrollee and through a mechanism acceptable to the
17 administrator. The administrator shall establish a mechanism for
18 receiving premium payments from the United States internal revenue
19 service for health coverage tax credit eligible enrollees.

20 (f) To develop, as an offering by every health carrier providing
21 coverage identical to the basic health plan, as configured on January
22 1, 2001, a basic health plan model plan with uniformity in enrollee
23 cost-sharing requirements.

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

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

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

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

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

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

15 (3) To evaluate, with the cooperation of participating managed
16 health care system providers, the impact on the basic health plan of
17 enrolling health coverage tax credit eligible enrollees. The
18 administrator shall issue to the appropriate committees of the
19 legislature preliminary evaluations on June 1, 2005, and January 1,
20 2006, and a final evaluation by June 1, 2006. The evaluation shall
21 address the number of persons enrolled, the duration of their
22 enrollment, their utilization of covered services relative to other
23 basic health plan enrollees, and the extent to which their enrollment
24 contributed to any change in the cost of the basic health plan.

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

29 (5) To design and implement a structure of enrollee cost-sharing
30 due a managed health care system from subsidized, nonsubsidized, and
31 health coverage tax credit eligible enrollees. The structure shall
32 discourage inappropriate enrollee utilization of health care services,
33 and may utilize copayments, deductibles, and other cost-sharing
34 mechanisms, but shall not be so costly to enrollees as to constitute a
35 barrier to appropriate utilization of necessary health care services.

36 (6) To limit enrollment of persons who qualify for subsidies so as
37 to prevent an overexpenditure of appropriations for such purposes.
38 Whenever the administrator finds that there is danger of such an

1 overexpenditure, the administrator shall close enrollment until the
2 administrator finds the danger no longer exists. Such a closure does
3 not apply to health coverage tax credit eligible enrollees who receive
4 a premium subsidy from the United States internal revenue service as
5 long as the enrollees qualify for the health coverage tax credit
6 program. To prevent the risk of overexpenditure, the administrator may
7 disenroll persons receiving subsidies from the program based on
8 criteria adopted by the administrator. The criteria may include:
9 Length of continual enrollment on the program, income level, or
10 eligibility for other coverage. The administrator shall (~~first~~
11 ~~attempt to~~) identify enrollees who are eligible for other coverage,
12 and, working with the department of social and health service as
13 provided in RCW 70.47.010(5)(d), transition enrollees currently
14 eligible for (~~medical assistance~~) federally financed categorically
15 needy or medically needy programs administered under chapter 74.09 RCW
16 to that coverage. The administrator shall develop criteria for persons
17 disenrolled under this subsection to reapply for the program.

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

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

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

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

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

12 (11) To accept applications from individuals residing in areas
13 served by the plan, on behalf of themselves and their spouses and
14 dependent children, for enrollment in the Washington basic health plan
15 as subsidized, nonsubsidized, or health coverage tax credit eligible
16 enrollees, to give priority to members of the Washington national guard
17 and reserves who served in Operation Enduring Freedom, Operation Iraqi
18 Freedom, or Operation Noble Eagle, and their spouses and dependents,
19 for enrollment in the Washington basic health plan, to establish
20 appropriate minimum-enrollment periods for enrollees as may be
21 necessary, and to determine, upon application and on a reasonable
22 schedule defined by the authority, or at the request of any enrollee,
23 eligibility due to current gross family income for sliding scale
24 premiums. The application is also considered an application for
25 medical assistance under chapter 74.09 RCW and must include a social
26 security number, if available, for each family member requesting
27 coverage. Funds received by a family as part of participation in the
28 adoption support program authorized under RCW 26.33.320 and (~~74.13.100~~
29 ~~through 74.13.145~~) 74.13A.005 through 74.13A.080 shall not be counted
30 toward a family's current gross family income for the purposes of this
31 chapter. When an enrollee fails to report income or income changes
32 accurately, the administrator shall have the authority either to bill
33 the enrollee for the amounts overpaid by the state or to impose civil
34 penalties of up to two hundred percent of the amount of subsidy
35 overpaid due to the enrollee incorrectly reporting income. The
36 administrator shall adopt rules to define the appropriate application
37 of these sanctions and the processes to implement the sanctions
38 provided in this subsection, within available resources. No subsidy

1 may be paid with respect to any enrollee whose current gross family
2 income exceeds twice the federal poverty level or, subject to RCW
3 70.47.110, who is a recipient of medical assistance or medical care
4 services under chapter 74.09 RCW. If a number of enrollees drop their
5 enrollment for no apparent good cause, the administrator may establish
6 appropriate rules or requirements that are applicable to such
7 individuals before they will be allowed to reenroll in the plan.

8 (12) To accept applications from business owners on behalf of
9 themselves and their employees, spouses, and dependent children, as
10 subsidized or nonsubsidized enrollees, who reside in an area served by
11 the plan. The administrator may require all or the substantial
12 majority of the eligible employees of such businesses to enroll in the
13 plan and establish those procedures necessary to facilitate the orderly
14 enrollment of groups in the plan and into a managed health care system.
15 The administrator may require that a business owner pay at least an
16 amount equal to what the employee pays after the state pays its portion
17 of the subsidized premium cost of the plan on behalf of each employee
18 enrolled in the plan. Enrollment is limited to those not eligible for
19 medicare who wish to enroll in the plan and choose to obtain the basic
20 health care coverage and services from a managed care system
21 participating in the plan. The administrator shall adjust the amount
22 determined to be due on behalf of or from all such enrollees whenever
23 the amount negotiated by the administrator with the participating
24 managed health care system or systems is modified or the administrative
25 cost of providing the plan to such enrollees changes.

26 (13) To determine the rate to be paid to each participating managed
27 health care system in return for the provision of covered basic health
28 care services to enrollees in the system. Although the schedule of
29 covered basic health care services will be the same or actuarially
30 equivalent for similar enrollees, the rates negotiated with
31 participating managed health care systems may vary among the systems.
32 In negotiating rates with participating systems, the administrator
33 shall consider the characteristics of the populations served by the
34 respective systems, economic circumstances of the local area, the need
35 to conserve the resources of the basic health plan trust account, and
36 other factors the administrator finds relevant.

37 (14) To monitor the provision of covered services to enrollees by
38 participating managed health care systems in order to assure enrollee

1 access to good quality basic health care, to require periodic data
2 reports concerning the utilization of health care services rendered to
3 enrollees in order to provide adequate information for evaluation, and
4 to inspect the books and records of participating managed health care
5 systems to assure compliance with the purposes of this chapter. In
6 requiring reports from participating managed health care systems,
7 including data on services rendered enrollees, the administrator shall
8 endeavor to minimize costs, both to the managed health care systems and
9 to the plan. The administrator shall coordinate any such reporting
10 requirements with other state agencies, such as the insurance
11 commissioner and the department of health, to minimize duplication of
12 effort.

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

17 (16) To develop a program of proven preventive health measures and
18 to integrate it into the plan wherever possible and consistent with
19 this chapter.

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

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

25 (19) To administer the premium discounts provided under RCW
26 48.41.200(3)(a) (i) and (ii) pursuant to a contract with the Washington
27 state health insurance pool.

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

31 **Sec. 3.** RCW 74.09.035 and 2010 1st sp.s. c 8 s 29 and 2010 c 94 s
32 22 are each reenacted and amended to read as follows:

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

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

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

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

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

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

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

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

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