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SENATE BILL 6603

State of Washington 60th Legislature 2008 Regular Session

By Senators Fairley, Kohl-Welles, and Fraser; by request of Insurance Commissioner

Read first time 01/18/08. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to providing preventative and catastrophic health coverage through a guaranteed health benefit program for permanent residents of this state; amending RCW 70.47.020; reenacting and amending RCW 43.79A.040; adding a new section to chapter 42.56 RCW; adding a new chapter to Title 70 RCW; and providing for submission of this act to a vote of the people.

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

NEW SECTION. **Sec. 1.** It is the intent of the legislature to protect residents of this state from catastrophic health costs and ensure access to meaningful preventive health care. The program established by this chapter establishes a program that provides such care to all residents of this state not enrolled in medicare, veterans' benefits, TRICARE, CHAMPUS, FEHBP, or other federal government programs, or who are confined or reside in a government-operated institution.

The legislature finds that such a program will help ensure the financial security of all residents of this state by providing broad pooling of catastrophic health care costs.

The legislature finds that lack of preventive and catastrophic coverage can adversely affect the health of residents of Washington.

The legislature further finds that a significant percentage of the population of this state does not have reasonably available insurance or other coverage for the costs of necessary preventive and catastrophic health care. This lack of health care is detrimental to the health of individuals lacking coverage and to the public welfare, and results in substantial expenditures for emergency and remedial health care, often at the expense of health care providers, health care facilities, and all purchasers of health care, including the state.

NEW SECTION. **Sec. 2.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Allowed charges" means those expenses incurred by covered persons for medically necessary expenses based on the terms and conditions of the program, as defined by the board.

(2) "Assessment" means that amount due and payable from employers and employees to fund the program.

(3) "Authority" means the state health care authority established in chapter 41.05 RCW.

(4) "Board" means the guaranteed health benefits board created in section 7 of this act.

(5) "Carrier" or "participating carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020. Carrier also includes any self-funded program that may be created by the authority under this chapter and any entity that offers to participate in the program even if that entity is not otherwise subject to regulation under Title 48 RCW.

(6) "CHAMPUS" means the civilian health and medical program of the uniformed services.

(7) "Code" means the internal revenue code, as codified in Title 26 U.S.C., as amended.

(8) "Commissioner" means the Washington state insurance commissioner.

(9) "Competitive bid process" means a documented formal process providing an equal and open opportunity to qualified carriers and

culminating in a selection based on criteria that may include such factors as the carrier's fees or costs, ability, capacity, experience, reputation, responsiveness to time limitations, responsiveness to solicitation requirements, quality of previous performance, or compliance with statutes and rules relating to contracts or services.

(10) "Coverage year" means a calendar year, unless the authority adopts a different twelve-month period.

(11) "Creditable coverage" means the period an individual was covered under a group or individual health plan or insurance in another state or through an otherwise excluded plan of health care coverage that provided benefits similar to or more comprehensive than those offered by the program for at least three months without a break in coverage of more than sixty-three days.

(12) "Employee" includes common law employees and leased employees of an employer.

(13) "Employer" or "business entity" means any business having employees that are permanent residents of this state who are subject to medicare tax. Employer includes all of the following forms of business: Partnerships, subchapter "c" and "s" corporations, nonprofit organizations, governmental entities, limited liability corporations or partnerships, and sole proprietorships.

(14) "FEHBP" means the federal employees health benefits program.

(15) "Medical assistance" or "medicaid" means coverage under Title XIX of the federal social security act (42 U.S.C. Sec. 1396 et seq., as amended) and chapter 74.09 RCW.

(16) "Medicare" means coverage under Title XVIII of the social security act (42 U.S.C. Sec. 1395 et seq., as amended).

(17) "Permanent residence" means the place where a person lives with the intent to make it a fixed and permanent home. For purposes of this chapter, it has the same meaning as "domicile."

(18) "Permanent resident" means a person who permanently resides in Washington. Persons with homes in more than one state are considered permanent residents of this state if they intend to make Washington their permanent home and reside in this state for at least six months each year. A person is not a permanent resident if he or she remains away from this state for more than six consecutive months and does not intend to make Washington his or her permanent home.

(19) "Preexisting condition" means any medical condition, illness, or injury that existed prior to the effective date of coverage.

(20) "Program" means the guaranteed health benefit program created in this chapter.

(21) "Resident" means a person living in a particular locality in the state of Washington. Confinement of a person in a nursing home, hospital, or other institution by itself is not sufficient to qualify a person as a resident.

(22) "Wages" means wages subject to medicare tax.

(23) "Wellness program" or "wellness activity" means a bona fide, explicit program of an activity, such as but not limited to smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, or nutrition education for the purpose of improving enrollee health status and reducing health service costs.

NEW SECTION. **Sec. 3.** The guaranteed health benefit program is created.

(1) On the effective date of this section, and except as set forth in this section, every person who has permanently resided in Washington state for at least six months, and all children born in this state on or after the effective date of this section who live with an eligible resident parent or legal guardian, are enrolled in the program.

(2)(a) Persons moving to this state after the effective date of this section who provide satisfactory evidence of permanent residency in this state to the authority must be enrolled into the program.

(b) Any person moving to this state after the effective date of this section who cannot provide evidence of creditable coverage is eligible for the program, upon satisfactory evidence of permanent residency, after six months of permanent residency. However, no preexisting condition will be covered until the person has permanently resided in Washington for twelve months.

(3) Persons enrolled in the state's medicaid managed-care program are eligible for the program. However, persons enrolled in the state's medicaid fee-for-service program are not eligible.

(4) Persons not eligible for the program include persons who are:

(a) Enrolled in both parts A and B of medicare;

(b) Enrolled in federal government programs such as but not limited to medicare, veterans' administration benefits, TRICARE, CHAMPUS, and FEHBP; or

(c) Confined or reside in a government-operated institution.

(5) Persons who disenroll from federal health care programs or who cease to reside in a government-operated institution must be registered with a participating carrier based on rules adopted by the authority.

(6) Each person must be covered as an individual.

(7) Coverage continues in force as long as the person permanently resides in this state.

(8) Participating carriers shall accept every eligible person immediately upon receipt of a completed registration form, subject to reasonable verification of eligibility, as established by the authority by rule.

(9) The authority shall adopt standards for implementing this section by rule, including evidence of permanent residency and creditable coverage and procedures for registering with participating carriers.

NEW SECTION. **Sec. 4.** (1) Except as provided in this section, all participating carriers must accept any eligible person that registers for coverage with the carrier as long as the person resides in the area in which the carrier is contracted to offer coverage.

(2) If a person chooses a different carrier during an open enrollment period for the following coverage year, the prior carrier must cooperate with the new carrier and the eligible person during transition of coverage.

(3) Upon request of a covered person during an open enrollment period, a participating carrier must continue coverage for a covered person:

(a) Unless the covered person commits a fraud against the program or the carrier;

(b) Unless the covered person no longer resides in the participating carrier's contracted area;

(c) Unless the covered person is no longer eligible to participate in the program, such as if the person establishes permanent residency in another state; or

(d) For other conditions as the authority may adopt by rule.

NEW SECTION. **Sec. 5.** (1) With respect to coverage for persons eligible for the program on the effective date of this section and who become eligible thereafter, there is no limitation or exclusion of benefits relating to a preexisting condition because the condition was present or expected before the date of eligibility for coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

(2) Benefits for persons moving to Washington after the effective date of this section may not be excluded or limited for any preexisting condition that occurred more than twelve months prior to the date the person first establishes permanent residency in this state.

NEW SECTION. **Sec. 6.** The program shall be funded by assessments as provided for in this section.

(1)(a) Every employer operating in Washington is required to pay an assessment to finance the program.

(b) The employer assessment is calculated as follows:

(i) Three percent up to five hundred thousand dollars of wages;

(ii) Four percent over five hundred thousand dollars of wages and up to one million dollars of wages; and

(iii) Five percent over one million dollars of wages.

(2) Employees shall pay a flat assessment equal to one percent of their wages subject to medicare tax.

(3) Washington residents earning wages in another state shall pay a flat assessment equal to two percent of such wages subject to medicare tax.

(4) Assessments must be collected by the department of revenue and deposited in the guaranteed benefit program trust account established in section 22 of this act.

(a) Moneys in the account must be used to pay participating carriers at a rate determined annually by the board after conclusion of a competitive bidding process and to pay the necessary and appropriate expenses associated with administration of the program.

(b) Assessments also may be used to establish such reserves as are deemed necessary or appropriate by the board for any self-funded plan that may be established by the board.

(5) The board may not incur any liabilities or obligations beyond the extent to which funds have been allocated by the legislature.

(a) If the board determines that the assessment will not generate sufficient funds to pay for the program's benefits, the board must present options to the legislature to raise revenue, lower costs, or both.

(b) In presenting options to the legislature, the board must consider reducing covered benefits, increasing the attachment point, changing the residency requirement for persons moving into the state, or implementing cost-saving measures in order to administer the program within the allocated budget. However, universal eligibility for the program for permanent residents as provided for by this chapter may not be abridged.

NEW SECTION. **Sec. 7.** The guaranteed health benefits board is established to govern the program as set forth in this section.

(1) The governor shall appoint nine members to the board who shall represent: The general public; health care providers, including health care facilities; carriers; business, both large and small business entities; and labor.

(2)(a) The original members of the board must be appointed for intervals of one to three years. Thereafter, all board members serve a term of three years.

(b) Appointed members of the board are eligible for reappointment.

(c) Board members serve without compensation, except that they may be reimbursed for travel expenses pursuant to RCW 43.03.050 and 43.03.060.

(d) The board must adopt a plan of operation, bylaws, and other governing documents as may be necessary to ensure the fair, reasonable, and equitable operation of the board.

(e) Meetings of the board are subject to the open public meetings act, chapter 42.30 RCW.

NEW SECTION. **Sec. 8.** The board shall determine the schedule of benefits for the program and establish a schedule of allowed charges for any self-funded arrangement, including a list of expenses that are covered or excluded under the program.

(1) Preventive benefits. Scheduled benefits for preventive care must include annual examinations, cancer screenings, immunizations, and

other benefits the board determines to cover, taking into account recommendations of the United States preventive services task force, and must include at least one annual dental care visit.

(2) Catastrophic benefits. Catastrophic coverage must include coverage for medically necessary care after a covered person incurs allowed charges, as determined by the board, in excess ten thousand dollars during a coverage year.

(3) Mandated benefits, services, included providers, and patient bill of rights protections. The schedule of benefits adopted by the board must include all mandated benefits and mandated offerings in force as of the effective date of this section, as well as all state statutes and rules regarding patient rights and carrier contracting with categories of providers, including the state's grievance and appeals requirements and a person's right to request an independent review of medical necessity decisions made by a carrier, as provided in RCW 43.70.235, 48.43.500 through 48.43.535, 48.43.545, 48.43.550, 70.02.045, 70.02.110, and 70.02.900.

NEW SECTION. **Sec. 9.** The authority shall administer, supervise, and manage the program.

(1) The authority shall adopt administrative cost savings plans and incentives designed to reduce the administrative burdens of carriers, providers, and the program.

(2) The authority shall develop a plan for contracting with participating carriers that:

(a) Rewards health outcomes rather than simply paying for particular procedures;

(b) Pays for health care that reflects patient preference and is of proven value; and

(c) Calls for the use of evidence-based standards of care where available.

(3) The authority may appoint technical or advisory committees whose members serve without compensation for their services but may be reimbursed for their travel expenses, as provided in RCW 43.03.050 and 43.03.060.

(4) The authority may adopt rules to administer the program, including but not limited to rules that establish procedures for appeals of eligibility decisions, establish appeals procedures for

enforcement actions and other purposes the authority determines are necessary for the efficient and effective administration of the program, and ensure that all covered persons receive quality health care and that all covered services are medically necessary and efficacious, cost-effective, and reasonable in relation to the services delivered.

(5) The authority may appoint a medical director and other staff the authority determines are necessary or appropriate to fulfill the responsibilities and duties necessary for the administration of the program.

(6)(a) The authority may contract with private entities or enter into interagency agreements with public agencies to provide technical or professional assistance or assist in the administration of the program.

(b) Any such contractor is prohibited from releasing, publishing, or otherwise using any information made available to it under its contractual responsibility without specific permission of the authority.

(7) The authority may apply for, receive, and accept grants, gifts, and other payments, including property and service, from any governmental or other public or private entity or person and may make arrangements for the use of these receipts, including the undertaking of special studies and other projects relating to health care costs or access to health care.

(8) The authority shall develop and implement a plan to publicize the existence of the program and maintain public awareness of the program and shall publicize open enrollment options for eligible persons.

(9) The authority shall review all publications of carriers related to the program for compliance with applicable state and federal requirements.

(10) The authority shall report to the board on all operations of the program, prepare an annual budget, and manage the administrative expenses of the program.

NEW SECTION. **Sec. 10.** By July 1, 2010, the authority shall establish a program for accepting enrollment registration forms for

receipt of services from participating carriers, with the intent that the first coverage year begin January 1, 2011.

(1) Eligible persons may register with any participating carrier that offers program coverage where the person resides.

(2) Eligible persons who do not register with a carrier before the first day of a coverage year must be assigned to a participating carrier through a rotational system to be established and managed by the authority.

(3) Registration with a participating carrier must be for the entire coverage year except as may be established by the authority by rule.

(4) Parents or legal guardians may register their dependents.

(5) Students attending school in another state may continue program coverage under rules adopted by the authority.

(6) Eligibility for the program ceases the first day of the month following establishment of permanent residency in another state.

NEW SECTION. **Sec. 11.** Benefits must be provided by carriers selected by the authority after completion of a competitive bid process through one or more contracts with carriers.

(1) All participating carriers must be in good standing with the office of insurance commissioner.

(2) The rates charged by carriers must be negotiated by the authority and approved by the board. Rates may not change more frequently than annually.

(3) Payment to participating carriers must be by a capitated arrangement.

NEW SECTION. **Sec. 12.** In order to ensure availability of program coverage throughout the entire state and choice for program enrollees, one or more self-funded arrangements may be offered in areas of the state if the authority determines that fewer than two options for enrollment will be available to eligible enrollees in any coverage year.

NEW SECTION. **Sec. 13.** Rates for program benefits shall be based on a single community-rated risk pool. Rates paid to participating carriers, including any self-funded arrangement, must be risk adjusted

annually based on experience during the most recent prior year for which statistics related to rates and risk are available and applied to the rates charged by a participating carrier for the next succeeding coverage year.

(1) Every carrier that participates in the program must submit to the authority, or to a third party at the direction of the authority, all information deemed necessary for risk assessment and adjustment calculations, including demographic and claims data.

(2) Carriers that do not participate in the program in later years shall provide all necessary data to the authority, or to a third party at the direction of the authority, for the carrier's years of participation in the program.

(3) All claims data related to the program are the property of the state.

(4) The authority shall adopt rules to establish and manage risk adjustment.

NEW SECTION. **Sec. 14.** (1) The authority shall conduct an annual open enrollment period for the program of no fewer than thirty days each twelve-month period during which any person may choose to change participating carriers for the following coverage year.

(2) The authority shall establish by rule standards by which a person may change participating carriers at times other than during the annual open enrollment period.

(a) A person may not be registered with more than one participating carrier at the same time.

(b) When changing carriers, there must be no overlap and no gap in an enrollee's coverage.

NEW SECTION. **Sec. 15.** It is the express intent of this chapter that the program be secondary to all amounts paid or payable through any worker's compensation coverage, automobile medical payment, or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any federal law or program.

NEW SECTION. **Sec. 16.** Participating carriers shall file reports

with the authority in a format, manner, and time designated by the authority by rule.

NEW SECTION. **Sec. 17.** The insurance commissioner has authority over the solvency of participating carriers.

NEW SECTION. **Sec. 18.** The privacy protections of chapters 48.43 and 70.02 RCW and the federal health insurance portability and accountability act (45 C.F.R. 160 et seq.) apply to all contracts issued to participating carriers and all actions of the board, the authority, the commissioner, and the secretary of the department of social and health services.

NEW SECTION. **Sec. 19.** The legislature recognizes that every individual possesses a fundamental right to exercise his or her religious beliefs and conscience. The legislature further recognizes that in developing public policy, conflicting religious and moral beliefs must be respected. The state also recognizes the right of individuals enrolled in the program to receive the full range of services covered under the program. Therefore:

(1) No person may be required by law or contract to participate in the provision of or payment for a specific service if the person objects to doing so for reason of conscience or religion.

(2) The authority shall establish a mechanism to recognize the right to exercise conscience while ensuring enrollees have timely access to services and ensuring prompt payment to service providers.

NEW SECTION. **Sec. 20.** (1) All persons appointed by participating carriers to assist in the choosing of and registering with a carrier, other than persons providing only ministerial duties and employees of any agency of the state, must be appropriately licensed by the commissioner as producers and must comply with the requirements of chapter 48.17 RCW.

(2) When an eligible person is assisted in choosing and registering with a participating carrier by a licensed producer, the carrier chosen by the enrollee must pay the producer a commission.

(a) The amount of the commission must be set forth in a rule adopted by the authority.

(b) When establishing the amount of the commission, the authority must consider the rates of commission paid to producers by carriers for health plans other than this program.

(c) Preference in commission rates may be given to producers who assist with enrollment of eligible persons who reside in rural or underserved areas of the state.

NEW SECTION. **Sec. 21.** Employers must make information developed by the authority about the program and open enrollment available to their employees.

NEW SECTION. **Sec. 22.** (1) The guaranteed benefit program trust account is established in the custody of the state treasurer. All receipts from the deposit of assessments, reserves, dividends, and refunds must be deposited into the account. Expenditures from the account may be used only for payment of premiums to participating carriers and operating expenses of the program.

(a) Expenditures from the account must be disbursed by the state treasurer by warrants on vouchers authorized by the authority.

(b) Moneys in the account, including unanticipated revenues under RCW 43.79.270, may be spent only after allocation.

(2) The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

(3) The authority must keep full and adequate records and accounts of the assets, obligations, transactions, and affairs of the program created under this chapter.

(4) The state investment board shall act as the investor for the funds and, except as provided in RCW 43.33A.160 and 43.84.160, one hundred percent of all earnings from these investments must accrue directly to the fund.

NEW SECTION. **Sec. 23.** (1) The guaranteed benefit program reserve trust account is created in the custody of the state treasurer. All receipts from reserves established for self-funded benefits, if any, must be deposited into the account. Expenditures from the account may only be used for the establishment of appropriate reserves, payment of benefits for eligible enrollees, and operating expenses of any self-

funded program. Only the authority may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

(2) The account is subject to the examination requirements of chapter 48.03 RCW as if the program were a domestic insurer. In conducting this examination, the commissioner is authorized to determine the adequacy of the reserves established for the program.

(3) The authority shall file periodic statements of the financial condition, transactions, and affairs of any self-funded option established under the program established under this section in a form and manner prescribed by the commissioner. A copy of the annual statement must be filed with the speaker of the house of representatives and the president of the senate within four months after the end of the coverage year.

Sec. 24. RCW 43.79A.040 and 2007 c 523 s 5, 2007 c 357 s 21, and 2007 c 214 s 14 are each reenacted and amended to read as follows:

(1) Money in the treasurer's trust fund may be deposited, invested, and reinvested by the state treasurer in accordance with RCW 43.84.080 in the same manner and to the same extent as if the money were in the state treasury.

(2) All income received from investment of the treasurer's trust fund shall be set aside in an account in the treasury trust fund to be known as the investment income account.

(3) The investment income account may be utilized for the payment of purchased banking services on behalf of treasurer's trust funds including, but not limited to, depository, safekeeping, and disbursement functions for the state treasurer or affected state agencies. The investment income account is subject in all respects to chapter 43.88 RCW, but no appropriation is required for payments to financial institutions. Payments shall occur prior to distribution of earnings set forth in subsection (4) of this section.

(4)(a) Monthly, the state treasurer shall distribute the earnings credited to the investment income account to the state general fund except under (b) and (c) of this subsection.

(b) The following accounts and funds shall receive their proportionate share of earnings based upon each account's or fund's average daily balance for the period: The Washington promise

scholarship account, the college savings program account, the Washington advanced college tuition payment program account, the agricultural local fund, the American Indian scholarship endowment fund, the foster care scholarship endowment fund, the foster care endowed scholarship trust fund, the students with dependents grant account, the basic health plan self-insurance reserve account, the contract harvesting revolving account, the Washington state combined fund drive account, the commemorative works account, the Washington international exchange scholarship endowment fund, the developmental disabilities endowment trust fund, the energy account, the fair fund, the family leave insurance account, the fruit and vegetable inspection account, the future teachers conditional scholarship account, the game farm alternative account, the GET ready for math and science scholarship account, the grain inspection revolving fund, the guaranteed benefit program reserve trust account, the guaranteed benefit program trust account, the juvenile accountability incentive account, the law enforcement officers' and firefighters' plan 2 expense fund, the local tourism promotion account, the produce railcar pool account, the regional transportation investment district account, the rural rehabilitation account, the stadium and exhibition center account, the youth athletic facility account, the self-insurance revolving fund, the sulfur dioxide abatement account, the children's trust fund, the Washington horse racing commission Washington bred owners' bonus fund account, the Washington horse racing commission class C purse fund account, the individual development account program account, the Washington horse racing commission operating account (earnings from the Washington horse racing commission operating account must be credited to the Washington horse racing commission class C purse fund account), the life sciences discovery fund, the Washington state heritage center account, and the reading achievement account. However, the earnings to be distributed shall first be reduced by the allocation to the state treasurer's service fund pursuant to RCW 43.08.190.

(c) The following accounts and funds shall receive eighty percent of their proportionate share of earnings based upon each account's or fund's average daily balance for the period: The advanced right-of-way revolving fund, the advanced environmental mitigation revolving account, the city and county advance right-of-way revolving fund, the

federal narcotics asset forfeitures account, the high occupancy vehicle account, the local rail service assistance account, and the miscellaneous transportation programs account.

(5) In conformance with Article II, section 37 of the state Constitution, no trust accounts or funds shall be allocated earnings without the specific affirmative directive of this section.

NEW SECTION. **Sec. 25.** The state auditor shall examine the records of the program every second year, or more frequently upon request of the board, and may recommend methods of accounting and the rendering of periodic reports of projects undertaken by the board.

NEW SECTION. **Sec. 26.** A new section is added to chapter 42.56 RCW to read as follows:

(1) The following information is exempt from disclosure under this chapter:

(a) Records obtained by or on file with any carrier or the authority containing information concerning the medical history or treatment of any person, a person's financial information, and a person's social security number;

(b) Actuarial formula, statistics, and assumptions submitted in support of or in response to a request for proposals as part of a competitive bid or submitted to or at the request of the authority; and

(c) Actuarial formulas, statistics, cost and utilization data, or other proprietary information submitted upon request of the authority may be withheld at any time from public inspection when necessary to preserve trade secrets or prevent unfair competition.

(2) When soliciting proposals for the purpose of awarding contracts for goods or services related to the program, the authority, upon written request of the bidder, shall exempt from public inspection and copying such proprietary data, trade secrets, or other information contained in the bidder's proposal that relate to the bidder's unique methods of conducting business or of determining prices or premium rates to be charged for services under terms of the proposal.

(3) The definitions in section 2 of this act apply throughout this section unless the context clearly requires otherwise.

NEW SECTION. **Sec. 27.** (1) The secretary of the department of social and health services shall seek all necessary waivers or amendments needed for full implementation of the program and shall seek to obtain federal reimbursements for all eligible persons who enroll in the program.

(2) The secretary of the department of social and health services shall report to the governor, the legislature, the commissioner, and the authority on the status of federal reimbursement and requests for waivers or amendments. This includes any waiver requested or granted by the federal department of health and human services under section 1115 of the social security act or such other waivers or amendments as the secretary may determine are necessary.

(3) The secretary of the department of social and health services shall consult with the board and other interested parties prior to submission of waivers and amendments to the federal department of health and human services.

(4) Rules adopted under the authority of this chapter must meet federal requirements that are a necessary condition to the receipt of federal funds by the state.

NEW SECTION. **Sec. 28.** If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. Rules adopted under this act must meet federal requirements that are a necessary condition to the receipt of federal funds by the state.

NEW SECTION. **Sec. 29.** (1) The commissioner shall study and report on whether to retain, eliminate, or change the Washington state health insurance pool, created in chapter 48.41 RCW, after full implementation of this program. The final report must be submitted to the governor and appropriate committees of the legislature by December 1st of a year that is no later than two years after the first registration occurs.

(2) The report must consider the following:

(a) The economic impact to the pool of implementing the program;

(b) The potential impact to residents of eliminating or changing the pool;

(c) Alternatives for coverage for existing members of the pool and persons who might require access to the pool for coverage to supplement the program if the pool were eliminated;

(d) The potential for cost savings to the state, residents, providers, and facilities, and carriers by eliminating or changing the pool;

(e) Alternative approaches to changing or winding down the pool; and

(f) Any other factors the commissioner determines are relevant to the question of whether the Washington state health insurance pool should be retained, eliminated, or changed.

(3) In preparation of the report, the commissioner shall consult with relevant parties, such as but not limited to the board and the authority, the state office of financial management, the Washington state health insurance pool board, carriers, providers (including facilities), consumers, business, and labor.

NEW SECTION. **Sec. 30.** The authority shall report to the governor and to the legislature on the effects of the program no later than December 1st of a year that is no later than five years after full implementation of the program and every odd-numbered year thereafter.

NEW SECTION. **Sec. 31.** The commissioner, the authority, and the secretary of the department of social and health services may adopt such rules as are necessary or desirable to implement this act.

Sec. 32. RCW 70.47.020 and 2007 c 259 s 35 are each amended to read as follows:

As used in this chapter:

(1) "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.

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

(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) "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.

(5) "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).

(6) "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~~)) 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

(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

(b) An individual who meets the requirements in (a)(i) through (iv) and (vi) 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) and (vi) 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~~)).

(7) "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.

(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) "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.

(10) "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.

NEW SECTION. **Sec. 33.** This chapter may be known and cited as the guaranteed health benefit program act.

NEW SECTION. **Sec. 34.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 35.** Sections 1 through 23, 25, 27 through 31, 33, and 34 of this act constitute a new chapter in Title 70 RCW.

NEW SECTION. **Sec. 36.** The secretary of state shall submit this act to the people for their adoption and ratification, or rejection, at the next general election to be held in this state, in accordance with Article II, section 1 of the state Constitution and the laws adopted to facilitate its operation.

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