H-0905.2

HOUSE BILL 1262

State of Washington **54th Legislature** **1995 Regular Session**

By Representatives Dyer, Backlund, Hymes, Casada and Cooke

Read first time 01/19/95. Referred to Committee on Health Care.

1 AN ACT Relating to health care reform; adding new sections to
2 chapter 48.43 RCW; adding a new section to chapter 41.05 RCW; adding a
3 new section to chapter 44.44 RCW; adding a new section to chapter 48.20
4 RCW; adding a new section to chapter 48.21 RCW; adding a new section to
5 chapter 48.36A RCW; adding a new section to chapter 48.44 RCW; adding
6 a new section to chapter 48.46 RCW; adding a new section to chapter
7 48.41 RCW; adding new sections to chapter 48.70 RCW; adding new
8 sections to chapter 48.85 RCW; adding a new section to chapter 70.47
9 RCW; creating new sections; and repealing RCW 43.72.020.

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

11 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43 RCW
12 to read as follows:
13 (1) The legislature intends that state government policy stabilize
14 health services costs, reform the health insurance market, actively
15 address the health care needs of all citizens of the state, improve the
16 public's health, and reduce unwarranted health services costs to
17 preserve the viability of nonhealth care businesses.
18 (2) The legislature intends that:

1 (a) State residents be enrolled in the health care plan of their
2 choice that meets state standards regarding affordability,
3 accessibility, cost-effectiveness, and clinical quality;
4 (b) State residents be able to choose health services from the full
5 range of health care providers, in a manner consistent with good health
6 services management, quality assurance, and cost-effectiveness;
7 (c) Individuals and businesses have the option to purchase any
8 health services they may choose in addition to those included in the
9 standard benefits package;
10 (d) These goals be accomplished within a reformed system using
11 health service providers and facilities in a way that allows consumers
12 to choose among competing plans operating within regulations that
13 promote the public good; and
14 (e) A policy of coordinating the delivery, purchase, and provision
15 of health services among the federal, state, local, and tribal
16 governments be encouraged and accomplished by chapter 492, Laws of
17 1993, as amended.

18 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW
19 to read as follows:
20 HEALTH REFORM IMPROVEMENT. The legislature finds that our health
21 and financial security are at risk as a result of certain aspects of
22 our health insurance and health service delivery system. Correcting
23 these problems can only be accomplished successfully through
24 incremental changes that provide access to essential health care
25 services, freedom of choice of providers and insurance plans, and
26 choice of affordable financing mechanisms for individual and group
27 purchasers. This must be accomplished within a reformed and efficient
28 system acceptable to individual purchasers, employers, insurance, and
29 providers of health care.
30 The legislature finds that encouraging the individual and small
31 group insurance market, maintaining effective price competition,
32 creating provider incentives for cost reductions, and pooling small
33 businesses and individuals through purchasing arrangements where prices
34 can be negotiated are effective means for making health insurance more
35 available and affordable for small businesses and individuals.

36 NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43 RCW
37 to read as follows:

In this chapter, unless the context otherwise requires:

(1) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, fraternal benefit societies regulated under chapter 48.36A RCW, a health care service contractor as defined in RCW 48.44.010 or a health maintenance organization as defined in RCW 48.46.020.

(2) "Standardized rate" means the rating method used to establish the premium for the standard benefits package adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and employer use of wellness programs as determined by the commissioner under section 16 of this act.

(3) "Continuous quality improvement and total quality management" means a continuous process to improve health services while reducing costs.

(4) "Employee" means a resident who is in the employment of an employer, as defined by chapter 50.04 RCW.

(5) "Enrollee" means any person who is a Washington resident enrolled with a health carrier.

(6) "Enrollee point of service cost-sharing" means amounts paid to a health carrier directly providing services, health care providers, or health care facilities by enrollees for receipt of specific standard benefits package services, and may include copayments, coinsurance, or deductibles.

(7) "Enrollee premium sharing" means that portion of the premium that is paid by enrollees or their family members.

(8) "Federal poverty level" means the federal poverty guidelines determined annually by the United States department of health and human services or successor agency.

(9) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if

owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations, but does not include Christian Science sanatoriums operated, listed, or certified by the First Church of Christ Scientist, Boston, Massachusetts.

(10) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW and chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(11) "Subscriber-purchasing group" means a member-owned and governed nonprofit organization certified in accordance with chapter 48.43 RCW.

(12) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease including but not limited to medical, surgical, chiropractic, physical therapy, speech and hearing services, speech pathology, audiology, mental health, dental, hospital, and vision care.

(13) "Health plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage unless workers' compensation coverage is provided under an employer's election permitted by chapter 51.16 RCW;

(g) Accident only coverage; and

(h) Specified disease, hospital confinement indemnity, or limited benefit health insurance, where such policies are not offered or

1 marketed to groups or individuals who are covered by a standard
2 benefits package.

3 (14) "Long-term care" means institutional, residential, outpatient,
4 or community-based services that meet the individual needs of persons
5 of all ages who are limited in their functional capacities or have
6 disabilities and require assistance with performing two or more
7 activities of daily living for an extended or indefinite period of
8 time. These services include case management, protective supervision,
9 in-home care, nursing services, convalescent, custodial, chronic, and
10 terminally ill care.

11 (15) "Premium" means all sums charged, received, or deposited by a
12 health carrier as consideration for a health plan or the continuance of
13 a health plan. Any assessment or any "membership," "policy,"
14 "contract," "service," or similar fee or charge made by a health
15 carrier in consideration for a health plan is deemed part of the
16 premium. "Premium" shall not include amounts paid as enrollee point of
17 service cost-sharing.

18 (16) "Standard benefits package" or "package" means those health
19 services determined under section 13 of this act.

20 (17) "Wellness program" means an explicit program of activity
21 consistent with department of health guidelines, such as smoking
22 cessation, injury and accident prevention, reduction of alcohol misuse,
23 appropriate weight reduction, exercise, automobile and motorcycle
24 safety, blood cholesterol reduction, and nutrition education for the
25 purpose of improving enrollee health status and reducing health service
26 costs.

27 NEW SECTION. **Sec. 4.** WASHINGTON HEALTH SERVICES COMMISSION--
28 TRANSFERRED POWERS AND DUTIES. The Washington health services
29 commission is terminated on January 1, 1996. The commission's powers
30 and duties are transferred pursuant to sections 5 through 8 of this
31 act. The powers and duties of the Washington health services
32 commission not repealed by chapter . . ., Laws of 1995 (this act), are
33 transferred as follows:

34 (1) To the Washington health care authority:

35 (a) Standard benefits package provisions, under section 13 of this
36 act;

37 (b) Standard point-of-service cost-sharing provisions.

38 (2) To the department of health:

(a) Health data provisions;
(b) Quality assurance provisions;
(c) Credentialing provisions;
(d) Conflict of interest by health care providers provisions;
(e) Provision relating to funding of medical research and health professions training activities;
(f) Duty to evaluate the effect of reforms under chapter . . ., Laws of 1995 (this act) on access to appropriate care in rural areas.
(3) To the office of insurance commissioner:
(a) Health carrier provisions and related insurance provisions;
(b) Antitrust provisions;
(c) Standardized rating provisions.
(4) To the joint committee on health systems oversight:
(a) Provisions relating to the general oversight of the implementation of chapter . . ., Laws of 1995 (this act);
(b) Provisions relating to monitoring the actual growth in total annual health services costs.

NEW SECTION. **Sec. 5.** TRANSFER OF RECORDS, EQUIPMENT, FUNDS. All reports, documents, surveys, books, records, files, papers, or written material in the possession of the Washington health services commission shall be allocated in a manner prescribed by the office of financial management. All cabinets, furniture, office equipment, motor vehicles, and other tangible property used by the Washington health services commission shall be allocated in a manner prescribed by the office of financial management. All funds, credits, or other assets held by the Washington health services commission shall be allocated in a manner prescribed by the office of financial management.

Any appropriations made to the Washington health services commission shall, on the effective date of this section, be allocated in a manner prescribed by the legislature.

Whenever any question arises as to the transfer of any personnel, funds, books, documents, records, papers, files, equipment, or other tangible property used or held in the exercise of the powers and the performance of the duties and functions transferred, the director of financial management shall make a determination as to the proper allocation and certify the same to the state agencies concerned.

1 NEW SECTION. **Sec. 6.** TRANSFER OF EMPLOYEES. All employees of the
2 Washington health services commission are transferred in the manner
3 prescribed by the office of financial management.

4 NEW SECTION. **Sec. 7.** RULES AND BUSINESS. All rules and all
5 pending business before the Washington health services commission shall
6 be continued consistent with the authority transferred. All existing
7 contracts and obligations shall remain in full force and shall be
8 performed by the agency to which the related authority was transferred.

9 NEW SECTION. **Sec. 8.** VALIDITY OF PRIOR ACTS. The transfer of the
10 powers, duties, functions, and personnel of the Washington health
11 services commission shall not affect the validity of any act performed
12 prior to the effective date of this section.

13 NEW SECTION. **Sec. 9.** A new section is added to chapter 41.05 RCW
14 to read as follows:
15 The administrator of the health care authority shall appoint a
16 seasonal employment advisory committee composed of equal numbers of
17 seasonal employee and employer representatives to assist the
18 administrator in development of mechanisms to facilitate coverage for
19 seasonal employees.
20 Members of the committee shall serve without compensation for their
21 services but shall be reimbursed for their expenses while attending
22 meetings on behalf of the administrator in accordance with RCW
23 43.03.050 and 43.03.060.

24 NEW SECTION. **Sec. 10.** A new section is added to chapter 44.44 RCW
25 to read as follows:
26 JOINT COMMITTEE ON HEALTH SYSTEMS OVERSIGHT--MEMBERSHIP, TERMS,
27 LEADERSHIP. (1) There is hereby created a joint committee on health
28 systems oversight. The committee shall consist of: (a) Four members
29 of the senate appointed by the president of the senate, two of whom
30 shall be members of the majority party and two of whom shall be members
31 of the minority party; and (b) four members of the house of
32 representatives appointed by the speaker of the house of
33 representatives, two of whom shall be members of the majority party and
34 two of whom shall be members of the minority party. Members of the

committee shall be appointed before the close of each regular session during an odd-numbered year.

(2) Each member's term of office shall run from the close of the session in which the member was appointed until the close of the next regular session held in an odd-numbered year. If a successor is not appointed during a session, the member's term shall continue until the member is reappointed or a successor is appointed. The term of office for a committee member who does not continue as a member of the senate or house of representatives shall cease upon the convening of the next session of the legislature during an odd-numbered year after the member's appointment, or upon the member's resignation, whichever is earlier. Vacancies on the committee shall be filled by appointment in the same manner as described in subsection (1) of this section. All such vacancies shall be filled from the same political party and from the same house as the member whose seat was vacated.

(3) The committee shall elect a chair and a vice-chair. The chair shall be a member of the senate in even-numbered years and a member of the house of representatives in odd-numbered years.

(4) The committee shall have the following powers and duties:

(a) Oversee the implementation of chapter . . ., Laws of 1995 (this act) and related chapters of the Revised Code of Washington;

(b) Periodically make recommendations to the appropriate committees of the legislature and the governor regarding the standard benefits package;

(c) Comply with other specified provisions of chapter . . ., Laws of 1995 (this act);

(d) Consistent with funds appropriated from the health services account established by RCW 43.72.902: Hire staff, who shall have extensive experience in health reform activities in Washington state; conduct or cause to be conducted appropriate studies and review; and make necessary recommendations to the legislature;

(e) Administer oaths, issue subpoenas, and compel the attendance of witnesses and the production of materials relevant to the committee's duties; and

(f) Review rules prepared by the insurance commissioner, health care authority, and department of health where appropriate to ensure consistency with the policies of this act.

(5) In January 1998 the legislative budget committee shall commence a study of the necessity of the existence of the committee and report

its recommendation to the appropriate committee of the legislature by December 1, 1998.

NEW SECTION. **Sec. 11.** A new section is added to chapter 48.43 RCW to read as follows:

On and after January 1, 1996, every health carrier offering health plans must offer the standard benefits package to residents of this state as the minimum level of coverage.

NEW SECTION. **Sec. 12.** A new section is added to chapter 48.43 RCW to read as follows:

Beginning January 1, 1996, a health carrier offering health plans shall:

(1) Provide the benefits included in the standard benefits package to enrolled Washington residents on a standardized rate basis;

(2) Accept for enrollment any state resident within the carrier's service area and provide or assure the provision of all services within the standard benefits package regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The insurance commissioner may grant a temporary exemption from this subsection, if, upon application by a health carrier, the commissioner finds that continued enrollment of additional, eligible individuals would exceed the clinical, financial, or administrative capacity of the carrier;

(3) If the health carrier provides benefits through contracts with, ownership of, or management of health care facilities and contracts with or employs health care providers, demonstrate to the satisfaction of the insurance commissioner in consultation with the department of health that its facilities and personnel are adequate to provide the benefits prescribed in the health plans to enrolled Washington residents, and that it is financially capable of providing such residents with, or has made adequate contractual arrangements with health care providers and facilities to provide enrollees with such benefits;

(4) Provide all enrollees with standardized and uniform instructions and informational materials, designed by the department of health by January 1, 1996, to increase individual and family awareness of injury and illness prevention; encourage assumption of personal

1 responsibility for protecting personal health; and stimulate discussion
2 about the use and limits of medical care in improving the health of
3 individuals and communities;
4 (5) Disclose to enrollees the charity care requirements under
5 chapter 70.170 RCW;
6 (6) Include in all of its contracts with health care providers and
7 health care facilities a provision prohibiting such providers and
8 facilities from billing enrollees for any amounts in excess of
9 applicable enrollee point of service cost-sharing obligations for
10 services covered by the carrier;
11 (7) Include in all of its contracts issued for health plans
12 coverage a subrogation provision that allows the health carrier to
13 recover the costs of health plans services incurred to care for an
14 enrollee injured by a negligent third party. The costs recovered shall
15 be limited to:
16 (a) If the health carrier has not intervened in the action by an
17 injured enrollee against a negligent third party, then the amount of
18 costs the health carrier can recover shall be limited to the excess
19 remaining after the enrollee has been fully compensated for his or her
20 loss minus a proportionate share of the enrollee's costs and fees in
21 bringing the action. The proportionate share shall be determined by:
22 (i) The fees and costs approved by the court in which the action
23 was initiated; or
24 (ii) The written agreement between the attorney and client that
25 established fees and costs when fees and costs are not addressed by the
26 court.
27 When fees and costs have been approved by a court, after notice to
28 the health carrier, the health carrier shall have the right to be heard
29 on the matter of attorneys' fees and costs or its proportionate share;
30 (b) If the health carrier has intervened in the action by an
31 injured enrollee against a negligent third party, then the amount of
32 costs the health carrier can recover shall be the excess remaining
33 after the enrollee has been fully compensated for his or her loss or
34 the amount of the carrier's incurred costs, whichever is less;
35 (8) Establish and maintain a grievance procedure approved by the
36 commissioner, to provide a reasonable and effective resolution of
37 complaints initiated by enrollees concerning any matter relating to the
38 provision of benefits under the health plans, access to health care
39 services, and quality of services. Each health carrier shall respond

to complaints filed with the insurance commissioner within fifteen working days. The insurance commissioner shall establish standards for resolution of grievances;

(9) Comply with the provisions of chapter 48.30 RCW prohibiting unfair and deceptive acts and practices to the extent such provisions are not specifically modified or superseded by the provisions of chapter 492, Laws of 1993, as amended and be prohibited from offering or supplying incentives that would have the effect of avoiding the requirements of subsection (2) of this section;

(10) Have standardized and uniform culturally sensitive health promotion programs, designed by the department of health by January 1, 1996, that include approaches to accommodate different cultural value systems, gender, and age;

(11) Permit every category of health care provider to provide health services or care for conditions included in the standard benefits package to the extent that:

(a) The provision of such health services or care is within the health care providers' permitted scope of practice; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of health services;

(ii) Management and administrative procedures; and

(iii) Provision of cost-effective and clinically efficacious health services;

(12) Establish the geographic areas in which they will obligate themselves to deliver the services required under the standard benefits package. The commissioner shall review such areas and may disapprove those that have been clearly designed to be exclusionary;

(13) Annually report the names and addresses of all officers, directors, or trustees of the health carrier during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals;

(14) Annually report the number of residents enrolled and terminated during the previous year. Additional information regarding the enrollment and termination pattern for a health carrier may be required by the commissioner to determine compliance with the open enrollment and free access requirements of chapter 492, Laws of 1993, as amended; and

1 (15) Disclose any financial interests held by officers and
2 directors in any facilities associated with or operated by the health
3 carrier.

4 NEW SECTION. **Sec. 13.** A new section is added to chapter 48.43 RCW
5 to read as follows:
6 STANDARD BENEFITS PACKAGE DESIGN. (1) The standard benefits
7 package shall be the same as the basic health plan, pursuant to chapter
8 70.47 RCW, and may be modified only by an act of law.
9 (2) Point-of-service cost-sharing shall include deductibles,
10 copayments, or coinsurance. Deductibles shall be limited to four
11 thousand dollars per person, per year. There shall be no point-of-
12 service cost-sharing for preventive services provided in the standard
13 benefits package. The administrator of the health care authority shall
14 establish a model standard benefits package with uniform point-of-
15 service cost-sharing requirements, which all carriers shall offer to
16 provide consumers information to compare plans.
17 (3) A health carrier that offers the standard benefit package with
18 deductibles shall offer the standard benefits package with at least two
19 of the following set of deductible options, using the appropriate
20 copayment amounts as applied by the basic health plan as of July 1,
21 1994, and revised annually to account for inflation using the consumer
22 price index and rounded to the nearest whole dollar:
23 (a) Zero deductible;
24 (b) Two hundred fifty dollars deductible for individuals, seven
25 hundred fifty dollars deductible for families;
26 (c) Five hundred dollars deductible for individuals, one thousand
27 dollars deductible for families;
28 (d) One thousand dollars deductible for individuals, two thousand
29 dollars deductible for families;
30 (e) Two thousand dollars deductible for individuals, four thousand
31 dollars deductible for families.

32 NEW SECTION. **Sec. 14.** A new section is added to chapter 48.43 RCW
33 to read as follows:
34 (1) The insurance commissioner shall appoint representatives from
35 health insurers, health service contractors, and health maintenance
36 organizations and participate with them in their work to:

1 (a) Using the contract developed under section 36(1) of this act,
2 prepare various versions of the benefits contract to reflect each of
3 the various point-of-service cost-sharing options. The representatives
4 may prepare separate contract forms for each of the different types of
5 health carriers, such as health insurers, health service contractors,
6 and health maintenance organizations as the representatives deem
7 necessary. The benefits contract with its various point-of-service
8 cost-sharing options are to be submitted to the commissioner not later
9 than October 1, 1996;
10 (b) Prepare a brochure for the standard benefits plan which will be
11 used by all health carriers to describe the coverage provided by the
12 standard benefits plan to potential enrollees. The brochure shall
13 describe the various point-of-service cost-sharing options. The
14 representatives may prepare separate brochures for each of the
15 different types of health carriers, such as health insurers, health
16 service organizations, and health maintenance contractors as the
17 representatives deem necessary. The brochure is to be submitted to the
18 commissioner not later than November 1, 1996;
19 (c) Prepare a claim form for the standard benefits plan which will
20 be used by all health carriers for enrollees to report claims. The
21 representative shall consult with the department of health in the
22 design of the claim form to maximize, to the greatest extent possible,
23 the inclusion of data collection elements required by the department of
24 health. The representatives may prepare separate claim forms for each
25 of the different types of health carriers, such as health insurers,
26 health service contractors, and health maintenance organizations as the
27 representatives deem necessary. The claim form is to be submitted to
28 the commissioner not later than December 1, 1996.
29 (2) If the representatives appointed in subsection (1) of this
30 section fail to submit the required documents within the time periods
31 required by subsection (1) of this section, or if the commissioner
32 finds the documents submitted by the representatives are inadequate to
33 meet the requirements of chapter . . ., Laws of 1995 (this act), the
34 commissioner shall either make revisions to the documents submitted by
35 the representatives or redraft the documents required by subsection (1)
36 of this section. If the commissioner either makes revisions or
37 redrafts any of the documents, the commissioner shall, within ten days
38 of initiating such action, notify the speaker of the house of
39 representatives, the majority leader of the senate, and each of the

members of the joint committee on health systems oversight of his or her decision to exercise this option and the reasons for exercising this option.

NEW SECTION. **Sec. 15.** A new section is added to chapter 48.43 RCW to read as follows:

No standard benefits package may be offered, delivered, or issued for delivery to any person in this state unless it otherwise complies with chapter 492, Laws of 1993, as amended, and complies with the following:

(1) Each health carrier shall submit its contracts and brochures for the standard benefits plan to the commissioner for approval.

(a) Each carrier is encouraged to use the standard contract and brochure prepared pursuant to section 14 of this act and the use of such contract and brochure by a carrier shall be deemed approved in form when submitted.

(b) Any health carrier may develop its own contract and brochure for the standard benefits plan and submit it for approval to the commissioner. The commissioner shall adopt minimum standards that define the terms, conditions, limitations, and exclusions. These terms, conditions, limitations, and exclusions shall not add to or delete services from the standard benefits plan. No form or document may be issued, delivered, or issued for delivery unless it has been filed with and approved by the commissioner.

(2) Every filing of forms or documents shall be made not less than thirty days in advance of any such issuance, delivery, or use. At the expiration of such thirty days the form or document filed shall be deemed approved unless affirmatively approved or disapproved by the commissioner within the thirty-day period. The commissioner may extend by not more than an additional fifteen days the period within which the commissioner may review such filing, by notifying the plan of the extension before expiration of the initial thirty-day period. At the expiration of any extension period and in the absence of prior affirmative approval or disapproval, any such form or document shall be deemed approved. The commissioner may withdraw approval at any time for cause. By approval of any filing for immediate use, the commissioner may waive any unexpired portion of the initial thirty-day waiting period.

(3) Whenever the commissioner disapproves a filing or withdraws a previous approval, the commissioner shall state the grounds for disapproval and cite the statute or rule used as grounds for disapproval.

(4) The commissioner may exempt from the requirements of this section any plan document or form that, in the commissioner's opinion, may not practicably be applied to, or the filing and approval of which are, in the commissioner's opinion, not desirable or necessary for the protection of the public.

(5) The commissioner shall disapprove any form or document or shall withdraw any previous approval, only:

(a) If it is in any respect in violation of or does not comply with Title 48 RCW, Title 284 WAC, and this chapter, or any applicable order of the commissioner;

(b) If it does not comply with any controlling filing previously made and approved;

(c) If it contains or incorporates by reference any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions that unreasonably or deceptively affect the health services purported to be offered or provided;

(d) If it has any title, heading, or other indication of its provisions that is misleading;

(e) If purchase of health services under the form or document is being solicited by deceptive advertising; or

(f) If the health service benefits provided in the form or document are unreasonable in relation to the premium charged.

NEW SECTION. **Sec. 16.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Premium rates for health plans shall not be excessive or inadequate, and shall not discriminate in a manner prohibited by section 12(2) of this act. Premium rates for health plans shall be developed on a standardized rate basis as determined by the commissioner.

(2) Prior to using, every health carrier shall file with the commissioner its enrollee point-of-service cost-sharing amounts, enrollee financial participation amounts, rates, its rating plan, and any other information used to determine the specific premium to be charged any enrollee and every modification of any of the foregoing.

(3) Every such filing shall indicate the type and extent of the health services contemplated and must be accompanied by sufficient information to permit the commissioner to determine whether it meets the requirements of this chapter. A carrier shall offer in support of any filing:

(a) Any historical data and actuarial projections used to establish the rate filed;

(b) An exhibit detailing the major elements of operating expense for the types of health services affected by the filing;

(c) An explanation of how investment income has been taken into account in the proposed rates;

(d) Any other information that the carrier deems relevant; and

(e) Any other information that the commissioner requires by rule.

(4) If a carrier has insufficient loss experience to support its proposed rates, it may submit loss experience for similar exposures of other carriers within the state.

(5) Every health carrier shall use standardized rating, set forth as follows:

(a) Adjustments to the rates for a health plan permitted for age shall not result in a rate per enrollee of more than four hundred percent of the lowest rate for any enrollee in 1996, three hundred percent in 1997, and two hundred percent thereafter. Such age adjustments shall not use age brackets smaller than five-year increments, and shall begin with age thirty and end with age sixty-five.

(b) Adjustments to the rates for a health plan permitted for wellness programs shall be limited to plus or minus twenty percent.

(c) The premium charged for a health plan may not be adjusted more frequently than annually except for rate decreases and, except that rates may be changed to reflect enrollment changes, changes in family composition of the enrollee, or benefit changes to the health plan requested by the employer or enrollee.

(d) A health plan that restricts an enrollee to use of a defined provider network may vary in rate from a plan that does not contain such a restriction, provided that the restriction of benefits of network providers results in appropriate reductions in claim costs.

(e) Adjustment to the rates are permitted for coverage of one child.

(6) Every filing shall state its proposed effective date.

(7) Actuarial formulas, statistics, and assumptions submitted in support of a rate or form filing by a carrier or submitted to the commissioner at the commissioner's request shall be withheld from public inspection in order to preserve trade secrets or prevent unfair competition.

(8) No carrier may make or issue a benefits package except in accordance with its filing then in effect.

(9) The commissioner shall review a filing as soon as reasonably possible after made, to determine whether it meets the requirements of this section. The commissioner shall ensure that differences in rates charged for health plans by health carriers are reasonable and reflect objective differences in plan design or coverage. The commissioner may establish rules that prescribe the manner in which geographic areas may be used by carriers to prevent unfair risk selection.

(10)(a) Except for (d) of this subsection, no filing may become effective within thirty days after the date of filing with the commissioner, which period may be extended by the commissioner for an additional period not to exceed fifteen days if the commissioner gives notice within such waiting period to the carrier that the commissioner needs additional time to consider the filing.

(b) A filing shall be deemed to meet the requirements of this section unless disapproved by the commissioner within the waiting period or any extension period.

(c) If within the waiting or any extension period, the commissioner finds that a filing does not meet the requirements of this section, the commissioner shall disapprove the filing, shall notify the carrier of the grounds for disapproval, and shall prohibit the use of the disapproved filing.

(d) A rate filing shall be deemed approved upon filing if the purpose of the filing is to increase rates by no more than the latest annual consumer price index increase for Washington state as determined by the office of financial management, provided the rate meets the other requirements of this section.

(11) If at any time after the applicable review period provided in this section, the commissioner finds that a filing does not meet the requirements of this section, the commissioner shall, after notice and hearing, issue an order specifying in what respect the commissioner finds that such filing fails to meet the requirements of this section,

and stating when, within a reasonable period thereafter, the filings shall be deemed no longer effective.

The order shall not affect any benefits package made or issued prior to the expiration of the period set forth in the order.

NEW SECTION. **Sec. 17.** A new section is added to chapter 48.43 RCW to read as follows:

(1) To meet the health needs of the residents of Washington state, it is critical to finance and provide long-term care and support services through an integrated, comprehensive system that promotes human dignity and recognizes the individuality of all functionally disabled persons. This system shall be available, accessible, and responsive to all residents based upon an assessment of their functional disabilities. The governor and the legislature recognize that families, volunteers, and community organizations are essential for the delivery of effective and efficient long-term care and support services, and that this private and public service infrastructure should be supported and strengthened. Further, it is important to provide benefits without requiring family or program beneficiary impoverishment for service eligibility.

(2) To realize the need for a strong long-term care system and to carry out the November 30, 1992, final recommendations of the Washington health care cost control and access commission, established under House Concurrent Resolution No. 4443 adopted by the legislature in 1990, related to long-term care, the joint committee on health systems oversight shall include in its planning process consideration of the scope of services to be covered, the cost of and financing of such coverage, the means through which existing long-term care programs and delivery systems can be coordinated and integrated, and the means through which family members can be supported in their role as informal caregivers for their parents, spouses, or other relatives.

(3) The committee shall submit recommendations concerning any necessary statutory changes or modifications of public policy to the governor and the legislature by January 1, 1997.

(4) The departments of health, retirement systems, revenue, social and health services, and veterans' affairs, the offices of financial management and state actuary, along with the health care authority, shall participate in the review of the long-term care needs enumerated

1 in this section and provide necessary supporting documentation and
2 staff expertise as requested by the committee.
3 (5) The committee shall include in its planning process, the
4 development of two social health maintenance organization long-term
5 care pilot projects. The two pilot projects shall be referred to as
6 the Washington life care pilot projects. Each life care pilot program
7 shall be a single-entry system administered by an individual
8 organization that is responsible for bringing together a full range of
9 medical and long-term care services. The Washington life care benefits
10 package shall include, but not be limited to, the following long-term
11 care services: Case management, intake and assessment, nursing home
12 care, adult family home care, home health and home health aide care,
13 hospice, chore services/homemaker/personal care, adult day care,
14 respite care, and appropriate social services. The pilot project shall
15 develop assessment and case management protocol that emphasize home and
16 community-based care long-term care options.
17 (a) In designing the pilot projects, the committee shall address
18 the following issues: Costs for the long-term care benefits, a
19 projected case-mix based upon disability, the required federal waiver
20 package, reimbursement, capitation methodology, marketing and
21 enrollment, management information systems, identification of the most
22 appropriate case management models, and provider contracts. The
23 committee shall also be responsible for establishing the size of the
24 two membership pools.
25 (b) Each program shall enroll applicants based on their level of
26 functional disability and personal care needs. The distribution of
27 these functional level categories and ethnicity within the enrolled
28 program population shall be representative of their distribution within
29 the community, using the best available data to estimate the community
30 distributions.
31 (c) The two sites selected for the Washington life care pilot
32 programs shall be drawn from the largest urban areas and include one
33 site in the eastern part of the state and one site in the western part
34 of the state. The two organizations selected to manage and coordinate
35 the life care services shall have the proven ability to provide
36 ambulatory care, personal care/chore services, dental care, case
37 management and referral services, must be accredited and licensed to
38 provide long-term care for home health services, and may be licensed to
39 provide nursing home care.

(d) The report on the development and establishment date of the two social health maintenance organizations shall be submitted to the governor and appropriate committees of the legislature by September 16, 1994. If the necessary federal waivers cannot be secured by January 1, 1997, the committee may elect to not establish the two pilot programs.

NEW SECTION. **Sec. 18.** A new section is added to chapter 48.43 RCW to read as follows:

(1) The commissioner shall determine the state and federal laws that would need to be repealed, amended, or waived to implement chapter 492, Laws of 1993, as amended, and report its recommendations, with proposed revisions to the Revised Code of Washington, to the governor, and appropriate committees of the legislature by July 1, 1994.

(2) The governor, in consultation with the commissioner, shall take the following steps in an effort to receive waivers or exemptions from federal statutes necessary to fully implement chapter 492, Laws of 1993, as amended to include, but not be limited to:

(a) Negotiate with the United States congress and the federal department of health and human services, health care financing administration to obtain a statutory or regulatory waiver of the provisions of the medical assistance statute, Title XIX of the federal social security act that constitute barriers to allowing payments for long-term care services even if care or services are provided by family members or friends;

(b) Negotiate with the United States congress and the federal department of health and human services, health care financing administration to obtain a statutory or regulatory waiver of provisions of the medical assistance statute, Title XIX of the federal social security act that currently constitute barriers to full implementation of provisions of chapter 492, Laws of 1993, as amended related to access to health services for low-income residents of Washington state. Such waivers shall include any waiver needed to require that: (i) Medical assistance recipients enroll in managed care systems, as defined in chapter 492, Laws of 1993, as amended; and (ii) enrollee point of service, cost-sharing levels adopted pursuant to section 13 of this act be applied to medical assistance recipients. Waived provisions may include and are not limited to: Categorical eligibility restrictions related to age, disability, blindness, or family structure; income and resource limitations tied to financial

eligibility requirements of the federal aid to families with dependent children and supplemental security income programs; administrative requirements regarding single state agencies, choice of providers, and fee for service reimbursement; and other limitations on health services provider payment methods;

(c) Request that the United States congress amend the internal revenue code to treat employee contributions to employee insurance coverage, such as the basic health plan or the standard benefits package offered through a health carrier, as fully deductible from adjusted gross income.

(3) On or before December 1, 1995, the commissioner shall report the status of its efforts to obtain the waivers provided in subsection (2) of this section.

NEW SECTION. **Sec. 19.** A new section is added to chapter 48.43 RCW to read as follows:

The legislative budget committee shall evaluate the implementation of the provisions of chapter . . ., Laws of 1995 (this act). The study shall determine to what extent chapter 492, Laws of 1993, as amended has been implemented consistent with the principles and elements set forth in chapter . . ., Laws of 1995 (this act) and shall report its findings to the governor and appropriate committees of the legislature by July 1, 2003.

NEW SECTION. **Sec. 20.** A new section is added to chapter 48.43 RCW to read as follows:

Beginning January 1, 1997, the insurance commissioner shall report annually to the appropriate committees in the legislature on the implementation of chapter 492, Laws of 1993, as amended.

NEW SECTION. **Sec. 21.** A new section is added to chapter 48.20 RCW to read as follows:

All disability insurance policies that are health plans as defined in chapter 48.43 RCW, and insurers who provide such policies, shall comply with the requirements of chapter 48.43 RCW. If there is any conflict between this chapter and chapter 48.43 RCW, chapter 48.43 RCW shall govern. The insurance commissioner shall advise the appropriate committees of the legislature and may issue bulletins or make rules to clarify conflicts between this chapter and chapter 48.43 RCW.

NEW SECTION. **Sec. 22.** A new section is added to chapter 48.21 RCW to read as follows:

All group disability insurance policies that are health plans as defined in chapter 48.43 RCW, and insurers who provide such policies, shall comply with the requirements of chapter 48.43 RCW. If there is any conflict between this chapter and chapter 48.43 RCW, chapter 48.43 RCW shall govern. The insurance commissioner shall advise the appropriate committees of the legislature and may issue bulletins or make rules to clarify conflicts between this chapter and chapter 48.43 RCW.

NEW SECTION. **Sec. 23.** A new section is added to chapter 48.36A RCW to read as follows:

All contractual benefits that are health plans as defined in chapter 48.43 RCW, and the society that provides such benefits, shall comply with the requirements of chapter 48.43 RCW. If there is any conflict between this chapter and chapter 48.43 RCW, chapter 48.43 RCW shall govern. The insurance commissioner shall advise the appropriate committees of the legislature and may issue bulletins or make rules to clarify conflicts between this chapter and chapter 48.43 RCW.

NEW SECTION. **Sec. 24.** A new section is added to chapter 48.44 RCW to read as follows:

All health care services that are health plans as defined in chapter 48.43 RCW, and the health care service contractor that provides such benefits, shall comply with the requirements of chapter 48.43 RCW. If there is any conflict between this chapter and chapter 48.43 RCW, chapter 48.43 RCW shall govern. The insurance commissioner shall advise the appropriate committees of the legislature and may issue bulletins or make rules to clarify conflicts between this chapter and chapter 48.43 RCW.

NEW SECTION. **Sec. 25.** A new section is added to chapter 48.46 RCW to read as follows:

All health care services that are health plans as defined in chapter 48.43 RCW, and the health maintenance organization that provides such benefits, shall comply with the requirements of chapter 48.43 RCW. If there is any conflict between this chapter and chapter 48.43 RCW, chapter 48.43 RCW shall govern. The insurance commissioner

1 shall advise the appropriate committees of the legislature and may
2 issue bulletins or make rules to clarify conflicts between this chapter
3 and chapter 48.43 RCW.

4 NEW SECTION. **Sec. 26.** A new section is added to chapter 48.41 RCW
5 to read as follows:
6 (1) The administrator shall prepare a brochure outlining the
7 benefits and exclusions of the pool policy in plain language. After
8 approval by the board of directors, such brochure shall be made
9 reasonably available to participants or potential participants. The
10 health insurance policy issued by the pool shall pay only usual,
11 customary, and reasonable charges for medically necessary eligible
12 health care services rendered or furnished for the diagnosis or
13 treatment of illnesses, injuries, and conditions which are not
14 otherwise limited or excluded. Eligible expenses are the usual,
15 customary, and reasonable charges for the health care services and
16 items for which benefits are extended under the pool policy. Such
17 benefits shall at minimum include the standard benefits package as
18 defined in chapter 48.43 RCW.
19 (2) The board shall design and employ cost containment measures and
20 requirements such as, but not limited to, preadmission certification
21 and concurrent inpatient review which may make the pool more cost-
22 effective.
23 (3) The pool benefit policy may contain benefit limitations,
24 exceptions, and reductions that are generally included in health
25 insurance plans and are approved by the insurance commissioner;
26 however, no limitation, exception, or reduction may be approved that
27 would exclude coverage for any disease, illness, or injury.
28 (4) The insurance commissioner and the administrator for the health
29 care authority shall develop procedures for transferring enrollees in
30 the health insurance pool provided by this chapter, to other health
31 care plans or to the basic health plan by January 1, 1997. The pool
32 shall discontinue providing health care coverage on December 31, 1996.
33 All enrollees in the pool on December 31, 1996, shall be transferred to
34 the coverage provided by the health care authority on December 31,
35 1996.

36 NEW SECTION. **Sec. 27.** A new section is added to chapter 48.43 RCW
37 to read as follows:

1 (1) Balancing the need for health care reform and the need to
2 protect health care providers, as a class and as individual providers,
3 from improper exclusion presents a problem that can be satisfied with
4 the creation of a process to ensure fair consideration of the inclusion
5 of health care providers in health care systems operated by health
6 carriers. It is therefore the intent of the legislature that the
7 commissioner in developing rules in accordance with this section and
8 the attorney general in monitoring the level of competition in the
9 various geographic markets, balance the need for cost-effective and
10 quality delivery of health services with the need for inclusion of both
11 individual health care providers and categories of health care
12 providers in health care programs developed by health carriers.
13 (2) All licensed health care providers licensed by the state,
14 irrespective of the type or kind of practice, should be afforded the
15 opportunity for inclusion by health carriers consistent with the goals
16 of health care reform.
17 The commissioner shall adopt rules requiring health carriers to
18 publish general criteria for the plan's selection or termination of
19 health care providers. Such rules shall not require the disclosure of
20 criteria deemed by the plan to be of a proprietary or competitive
21 nature that would hurt the plan's ability to compete or to manage
22 health services. Disclosure of criteria is proprietary or
23 anticompetitive if revealing the criteria would have the tendency to
24 cause health care providers to alter their practice pattern in a manner
25 that would harm efforts to contain health care costs and is proprietary
26 if revealing the criteria would cause the plan's competitors to obtain
27 valuable business information.
28 If a health carrier uses unpublished criteria to judge the quality
29 and cost-effectiveness of a health care provider's practice under any
30 specific program within the plan, the plan may not reject or terminate
31 the provider participating in that program based upon such criteria
32 until the provider has been informed of the criteria that his or her
33 practice fails to meet and is given a reasonable opportunity to conform
34 to such criteria.
35 (3)(a) Whenever a determination is made under (b) of this
36 subsection that a plan's share of the market reaches a point where the
37 plan's exclusion of health care providers from a program of the plan
38 would result in the substantial inability of providers to continue
39 their practice thereby unreasonably restricting consumer access to

needed health services, the health carrier must allow all providers within the affected market to participate in the programs of the health carrier. All such providers must meet the published criteria and requirements of the programs.

(b) The attorney general with the assistance of the insurance commissioner shall periodically analyze the market power of health carriers to determine when the market share of any program of a health carrier reaches a point where the plan's exclusion of health service providers from a program of the plan would result in the substantial inability of providers to continue their practice thereby unreasonably restricting consumer access to needed health services. In analyzing the market power of a health carrier, the attorney general shall consider:

(i) The ease with which providers may obtain contracts with other plans;

(ii) The amount of the private pay and government employer business that is controlled by the health carrier taking into account the selling of its provider network to self-insured employer plans;

(iii) The difficulty in establishing new competing plans in the relevant geographic market; and

(iv) The sufficiency of the number or type of providers under contract with the plan available to meet the needs of plan enrollees.

Notwithstanding the provisions of this subsection, if the health carrier demonstrates to the satisfaction of the attorney general and the commissioner that health service utilization data and similar information shows that the inclusion of additional health service providers would substantially lessen the plan's ability to control health care costs and that the plan's procedures for selection of providers are not improperly exclusive of providers, the plan need not include additional providers within the plan's program.

(4) The commissioner shall adopt rules for the resolution of disputes between providers and health carriers including disputes regarding the decision of a plan not to include the services of a provider.

(5) Nothing contained in this section shall be construed to require a plan to allow or continue the participation of a provider if the plan is a federally qualified health maintenance organization and the participation of the provider or providers would prevent the health

maintenance organization from operating as a health maintenance organization in accordance with 42 U.S.C. Sec. 300e.

NEW SECTION. **Sec. 28.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Utilization review processes employed or contracted for by health carriers shall, among other things, do the following:

(a) Be based on written policies and procedures on all review activities, both delegated and nondelegated, for covered services, especially regarding adverse review decisions, an appeals procedure, clinical review criteria, handling emergencies, data collection, confidentiality, and timeframes for making decisions;

(b) Use provider peers in making review decisions on the necessity and appropriateness of the health care services being reviewed;

(c) Provide an appeals process for adverse decisions, using provider peers other than those peers involved in the original decision;

(d) Issue utilization review decisions in a timely manner; and

(e) Document adverse review decisions, and make this documentation, including the specific clinical or other reason for the adverse decision, available to the covered person and affected provider or facility.

(2) As used in this section, the following definitions apply unless the context clearly requires otherwise:

(a) "Adverse review decision" or "adverse decision" means a determination that an admission, continued stay, or other health care service being reviewed does not meet the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness.

(b) "Appeals procedure" means a formal process whereby a covered person, attending physician, health care provider, or facility can appeal an adverse decision.

(c) "Clinical review criteria" means the screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health plan to determine necessity and appropriateness of health care services.

(d) "Provider peer" means a health care provider who is qualified to render a professional opinion on the medical condition, procedure, or treatment under review.

(e) "Utilization review process" means a system or set of formal techniques designed to monitor and evaluate the clinical necessity, appropriateness, and efficiency of health care services. Techniques may include ambulatory review, prospective review, second opinions, concurrent review, case management, discharge planning, and retrospective review.

(3) The commissioner may adopt necessary rules, standards, and guidelines regarding utilization review processes.

NEW SECTION. **Sec. 29.** A new section is added to chapter 48.70 RCW to read as follows:

(1) By July 1, 1983, the commissioner shall adopt all rules necessary to ensure that specified disease policies provide a reasonable level of benefits to policyholders, and that purchasers and potential purchasers of such policies are fully informed of the level of benefits provided.

(2) The commissioner shall adopt rules prohibiting the offering of specified disease policies to individuals who are not covered by a standard benefits package as defined in chapter 48.43 RCW.

NEW SECTION. **Sec. 30.** A new section is added to chapter 48.70 RCW to read as follows:

This chapter shall apply to all policies issued on or after July 1, 1983.

NEW SECTION. **Sec. 31.** A new section is added to chapter 48.85 RCW to read as follows:

The department of social and health services shall, in conjunction with the office of the insurance commissioner, coordinate a long-term care insurance program entitled the Washington long-term care partnership, whereby private insurance and medicaid funds shall be used to finance long-term care. For individuals purchasing a long-term care insurance policy or contract governed by chapter 48.84 RCW and meeting the criteria prescribed in this chapter, and any other terms as specified by the office of the insurance commissioner and the department of social and health services, this program shall allow for the exclusion of some or all of the individual's assets in determination of medicaid eligibility as approved by the federal health care financing administration.

1 NEW SECTION. **Sec. 32.** A new section is added to chapter 48.85 RCW
2 to read as follows:
3 The department of social and health services shall seek approval
4 and a waiver of appropriate federal medicaid regulations to allow the
5 protection of an individual's assets as provided in this chapter. The
6 department shall adopt all rules necessary to implement the Washington
7 long-term care partnership program, which rules shall permit the
8 exclusion of all or some of an individual's assets in a manner
9 specified by the office of the insurance commissioner and the
10 department of social and health services in a determination of medicaid
11 eligibility to the extent that private long-term care insurance
12 provides payment or benefits for services.

13 NEW SECTION. **Sec. 33.** A new section is added to chapter 48.85 RCW
14 to read as follows:
15 (1) The insurance commissioner shall adopt rules defining the
16 criteria that long-term care insurance policies must meet to satisfy
17 the requirements of this chapter. The rules shall provide that all
18 long-term care insurance policies purchased for the purposes of this
19 chapter:
20 (a) Be guaranteed renewable;
21 (b) Provide coverage for nursing home care;
22 (c) Provide optional coverage for home and community-based
23 services;
24 (d) Provide automatic compounded inflation protection or similar
25 coverage to protect the policyholder from future increases in the cost
26 of long-term care;
27 (e) Not require prior hospitalization or confinement in a nursing
28 home as a prerequisite to receiving long-term care benefits; and
29 (f) Contain at least a six-month grace period that permits
30 reinstatement of the policy or contract retroactive to the date of
31 termination if the policy or contract holder's nonpayment of premiums
32 arose as a result of a cognitive impairment suffered by the policy or
33 contract holder as certified by a physician.
34 (2) Insurers offering long-term care policies for the purposes of
35 this chapter shall demonstrate to the satisfaction of the insurance
36 commissioner that they:
37 (a) Have procedures to provide notice to each purchaser of the
38 long-term care consumer education program;

1 (b) Offer case management services;
2 (c) Have procedures that provide for the keeping of individual
3 policy records and procedures for the explanation of coverage and
4 benefits identifying those payments or services available under the
5 policy that meet the purposes of this chapter;
6 (d) Agree to provide the insurance commissioner, on or before
7 September 1 of each year, an annual report containing information
8 derived from the long-term care partnership long-term care insurance
9 uniform data set as specified by the office of the insurance
10 commissioner.

11 NEW SECTION. **Sec. 34.** A new section is added to chapter 48.85 RCW
12 to read as follows:
13 The insurance commissioner, in conjunction with the department of
14 social and health services and members of the long-term care insurance
15 industry, shall develop a consumer education program designed to
16 educate consumers as to the need for long-term care, methods for
17 financing long-term care, the availability of long-term care insurance,
18 and the availability and eligibility requirements of the asset
19 protection program provided under this chapter.

20 NEW SECTION. **Sec. 35.** A new section is added to chapter 48.85 RCW
21 to read as follows:
22 By January 1 of each year until 1998, the insurance commissioner,
23 in conjunction with the department of social and health services, shall
24 report to the legislature on the progress of the asset protection
25 program. The report shall include:
26 (1) The success of the agencies in implementing the program;
27 (2) The number of insurers offering long-term care policies meeting
28 the criteria for asset protection;
29 (3) The number, age, and financial circumstances of individuals
30 purchasing long-term care policies meeting the criteria for asset
31 protection;
32 (4) The number of individuals seeking consumer information
33 services;
34 (5) The extent and type of benefits paid by insurers offering
35 policies meeting the criteria for asset protection;
36 (6) Estimates of the impact of the program on present and future
37 medicaid expenditures;

1 (7) The cost-effectiveness of the program; and
2 (8) A determination regarding the appropriateness of continuing the
3 program.

4 NEW SECTION. **Sec. 36.** A new section is added to chapter 70.47 RCW
5 to read as follows:
6 The administrator has the following powers and duties:
7 (1)(a) To administer a schedule of covered health services entitled
8 the basic health plan, which shall be the physician services, inpatient
9 and outpatient hospital services, and prescription drugs and
10 medications that were covered by the basic health plan as of July 1,
11 1994, with the following additional services: Limited chemical
12 dependency services and limited mental health services. After the
13 administrator has made the modifications to the basic health plan that
14 are necessary to include chemical dependency services and mental health
15 services, the basic health plan may not be further modified except by
16 an act of law.
17 (b) All subsidized and nonsubsidized enrollees in any participating
18 health care system under the Washington basic health plan shall be
19 entitled to receive services under the basic health plan in return for
20 premium payments to the plan. The schedule of services shall emphasize
21 proven preventive and primary health care and shall include all
22 services necessary for prenatal, postnatal, and well-child care.
23 However, with respect to coverage for groups of subsidized enrollees
24 who are eligible to receive prenatal and postnatal services through the
25 medical assistance program under chapter 74.09 RCW, the administrator
26 shall not contract for such services except to the extent that such
27 services are necessary over not more than a one-month period in order
28 to maintain continuity of care after diagnosis of pregnancy by the
29 provider. The schedule of services shall also include a separate
30 schedule of basic health care services for children, eighteen years of
31 age and younger, for those subsidized or nonsubsidized enrollees who
32 choose to secure basic coverage through the plan only for their
33 dependent children;
34 (2)(a) To design and implement a structure of periodic premiums due
35 the administrator from subsidized enrollees that is based upon gross
36 family income, giving appropriate consideration to family size and the
37 ages of all family members. The enrollment of children shall not
38 require the enrollment of their parent or parents who are eligible for

1 the plan. The structure of periodic premiums shall be applied to
2 subsidized enrollees entering the plan as individuals pursuant to
3 subsection (9) of this section and to the share of the cost of the plan
4 due from subsidized enrollees entering the plan as employees pursuant
5 to subsection (10) of this section.

6 (b) To determine the periodic premiums due the administrator from
7 nonsubsidized enrollees. Premiums due from nonsubsidized enrollees
8 shall be in an amount equal to the cost charged by the health care
9 system provider to the state for the plan plus the administrative cost
10 of providing the plan to those enrollees and the premium tax under RCW
11 48.14.0201.

12 (c) An employer or other financial sponsor may, with the prior
13 approval of the administrator, pay the premium, rate, or any other
14 amount on behalf of a subsidized or nonsubsidized enrollee, by
15 arrangement with the enrollee and through a mechanism acceptable to the
16 administrator, but in no case shall the payment made on behalf of the
17 enrollee exceed the total premiums due from the enrollee;

18 (3) To design and implement a structure of copayments due a health
19 care system from subsidized and nonsubsidized enrollees. The structure
20 shall discourage inappropriate enrollee utilization of health care
21 services, but shall not be so costly to enrollees as to constitute a
22 barrier to appropriate utilization of necessary health care services;

23 (4) To limit enrollment of persons who qualify for subsidies so as
24 to prevent an overexpenditure of appropriations for such purposes.
25 Whenever the administrator finds that there is danger of such an
26 overexpenditure, the administrator shall close enrollment until the
27 administrator finds the danger no longer exists;

28 (5) To limit the payment of subsidies to subsidized enrollees, as
29 defined in RCW 70.47.020;

30 (6) To adopt a schedule for the orderly development of the delivery
31 of services and availability of the plan to residents of the state,
32 subject to the limitations contained in RCW 70.47.080 or any act
33 appropriating funds for the plan;

34 (7) To solicit and accept applications from health care systems, as
35 defined in this chapter, for inclusion as eligible basic health care
36 providers under the plan. The administrator shall endeavor to assure
37 that covered basic health care services are available to any enrollee
38 of the plan from among a selection of two or more participating health
39 care systems. In adopting any rules or procedures applicable to health

1 care systems and in its dealings with such systems, the administrator
2 shall consider and make suitable allowance for the need for health care
3 services and the differences in local availability of health care
4 resources, along with other resources, within and among the several
5 areas of the state. Contracts with participating health care systems
6 shall ensure that basic health plan enrollees who become eligible for
7 medical assistance may, at their option, continue to receive services
8 from their existing providers within the health care system if such
9 providers have entered into provider agreements with the department of
10 social and health services;

11 (8) To receive periodic premiums from or on behalf of subsidized
12 and nonsubsidized enrollees, deposit them in the basic health plan
13 operating account, keep records of enrollee status, and authorize
14 periodic payments to health care systems on the basis of the number of
15 enrollees participating in the respective health care systems;

16 (9) To accept applications from individuals residing in areas
17 served by the plan, on behalf of themselves and their spouses and
18 dependent children, for enrollment in the Washington basic health plan
19 as subsidized or nonsubsidized enrollees, to establish appropriate
20 minimum-enrollment periods for enrollees as may be necessary, and to
21 determine, upon application and at least semiannually thereafter, or at
22 the request of any enrollee, eligibility due to current gross family
23 income for sliding scale premiums. No subsidy may be paid with respect
24 to any enrollee whose current gross family income exceeds twice the
25 federal poverty level or, subject to RCW 70.47.110, who is a recipient
26 of medical assistance or medical care services under chapter 74.09 RCW.
27 If, as a result of an eligibility review, the administrator determines
28 that a subsidized enrollee's income exceeds twice the federal poverty
29 level and that the enrollee knowingly failed to inform the plan of such
30 increase in income, the administrator may bill the enrollee for the
31 subsidy paid on the enrollee's behalf during the period of time that
32 the enrollee's income exceeded twice the federal poverty level. If a
33 number of enrollees drop their enrollment for no apparent good cause,
34 the administrator may establish appropriate rules or requirements that
35 are applicable to such individuals before they will be allowed to re-
36 enroll in the plan. Enrollees whose income is less than one hundred
37 twenty-five percent of the federal poverty level shall not pay any
38 premium share;

1 (10) To accept applications from business owners on behalf of
2 themselves and their employees, spouses, and dependent children, as
3 subsidized or nonsubsidized enrollees, who reside in an area served by
4 the plan. The administrator may require all or the substantial
5 majority of the eligible employees of such businesses to enroll in the
6 plan and establish those procedures necessary to facilitate the orderly
7 enrollment of groups in the plan and into a health care system.
8 Enrollment is limited to those not eligible for medicare who wish to
9 enroll in the plan and choose to obtain the basic health care coverage
10 and services from a care system participating in the plan. The
11 administrator shall adjust the amount determined to be due on behalf of
12 or from all such enrollees whenever the amount negotiated by the
13 administrator with the participating health care system or systems is
14 modified or the administrative cost of providing the plan to such
15 enrollees changes;
16 (11) To determine the rate to be paid to each participating health
17 care system in return for the provision of covered basic health care
18 services to enrollees in the system. Although the schedule of covered
19 basic health care services will be the same for similar enrollees, the
20 rates negotiated with participating health care systems may vary among
21 the systems. In negotiating rates with participating systems, the
22 administrator shall consider the characteristics of the populations
23 served by the respective systems, economic circumstances of the local
24 area, the need to conserve the resources of the basic health plan trust
25 account, and other factors the administrator finds relevant;
26 (12) To monitor the provision of covered services to enrollees by
27 participating health care systems in order to assure enrollee access to
28 good quality basic health care, to require periodic data reports
29 concerning the utilization of health care services rendered to
30 enrollees in order to provide adequate information for evaluation, and
31 to inspect the books and records of participating health care systems
32 to assure compliance with the purposes of this chapter. In requiring
33 reports from participating health care systems, including data on
34 services rendered enrollees, the administrator shall endeavor to
35 minimize costs, both to the health care systems and to the plan. The
36 administrator shall coordinate any such reporting requirements with
37 other state agencies, such as the insurance commissioner and the
38 department of health, to minimize duplication of effort;

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

(14) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter;

(15) To provide, consistent with available funding, assistance for rural residents and underserved populations.

NEW SECTION. **Sec. 37.** The legislative budget committee shall conduct a feasibility study to determine the cost-effectiveness and logistics of contracting out the administration and delivery of all juvenile and adult inmate health care services and plan for the implementation of contracted services. The study shall be submitted to the appropriate committees of the legislature on or before December 12, 1995.

NEW SECTION. **Sec. 38.** Captions as used in this act constitute no part of the law.

NEW SECTION. **Sec. 39.** RCW 43.72.020 and 1994 c 154 s 311 & 1993 c 492 s 403 is repealed.

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