CERTIFICATION OF ENROLLMENT

HOUSE BILL 1891

Chapter 4, Laws of 1991

52nd Legislature
1991 Special Session

BASIC HEALTH PLAN--COORDINATION WITH MEDICAL ASSISTANCE

EFFECTIVE DATE: 7/1/91

Passed by the House June 28, 1991
Yeas 91 Nays 0

JOE KING
Speaker of the House of Representatives

Passed by the Senate June 29, 1991
Yeas 44 Nays 0

JOEL PRITCHARD
President of the Senate

Approved June 30, 1991

BOOTH GARDNER
Governor of the State of Washington

CERTIFICATE

I, Alan Thompson, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **HOUSE BILL 1891** as passed by the House of Representatives and the Senate on the dates hereon set forth.

ALAN THOMPSON
Chief Clerk

FILED

June 30, 1991 - 7:52 p.m.

Secretary of State
State of Washington

HOUSE BILL 1891

Passed Legislature - 1st Special Session

State of Washington 52nd Legislature 1991 Regular Session

By Representatives Braddock and Wineberry; by request of Washington Basic Health Plan and Office of Financial Management.Read first time February 13, 1991. Referred to Committee on Health Care\Appropriations.

AN ACT Relating to coordination of the basic health plan with medical assistance; amending RCW 70.47.030, 70.47.060, and 70.47.110; providing an effective date; and declaring an emergency.

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

Sec. 1. RCW 70.47.030 and 1987 1st ex.s. c 5 s 5 are each amended to read as follows:

The basic health plan trust account is hereby established in the state treasury. All nongeneral fund-state funds ((~~appropriated~~)) collected for this ((~~chapter~~)) program shall be deposited in the basic health plan trust account and may be expended without further appropriation. ((~~Disbursements from other moneys in the account shall be made pursuant to appropriation and upon warrants drawn by the Washington basic health plan administrator.~~)) Moneys in the account shall be used exclusively for the purposes of this chapter, including

payments to participating managed health care systems on behalf of enrollees in the plan and payment of costs of administering the plan. ((~~The earnings on any surplus balances in the basic health plan trust account shall be credited to the account, notwithstanding RCW 43.84.090.~~)) After ((~~January 1, 1988~~)) July 1, 1991, the administrator shall not expend or encumber for an ensuing fiscal period amounts exceeding ((~~ninety~~)) ninety-five percent of the amount((~~s~~)) anticipated to ((~~accrue in the account~~)) be spent for purchased services during the fiscal ((~~period~~)) year.

Sec. 2. RCW 70.47.060 and 1987 1st ex.s. c 5 s 8 are each amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, and other services that may be necessary for basic health care, which enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care, shall include all services necessary for prenatal, postnatal, and well-child care, and shall include a separate schedule of basic health care services for children, eighteen years of age and younger, for those enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.42.080, and such other factors as the administrator deems appropriate.

(2) To design and implement a structure of periodic premiums due the administrator from enrollees that is based upon gross family income, giving appropriate consideration to family size as well as the ages of all family members. The enrollment of children shall not require the enrollment of their parent or parents who are eligible for the plan.

(3) To design and implement a structure of nominal copayments due a managed health care system from enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(4) To design and implement, in concert with a sufficient number of potential providers in a discrete area, an enrollee financial participation structure, separate from that otherwise established under this chapter, that has the following characteristics:

(a) Nominal premiums that are based upon ability to pay, but not set at a level that would discourage enrollment;

(b) A modified fee-for-services payment schedule for providers;

(c) Coinsurance rates that are established based on specific service and procedure costs and the enrollee’s ability to pay for the care. However, coinsurance rates for families with incomes below one hundred twenty percent of the federal poverty level shall be nominal. No coinsurance shall be required for specific proven prevention programs, such as prenatal care. The coinsurance rate levels shall not have a measurable negative effect upon the enrollee’s health status; and

(d) A case management system that fosters a provider-enrollee relationship whereby, in an effort to control cost, maintain or improve the health status of the enrollee, and maximize patient involvement in her or his health care decision-making process, every effort is made by

the provider to inform the enrollee of the cost of the specific services and procedures and related health benefits.

The potential financial liability of the plan to any such providers shall not exceed in the aggregate an amount greater than that which might otherwise have been incurred by the plan on the basis of the number of enrollees multiplied by the average of the prepaid capitated rates negotiated with participating managed health care systems under RCW 70.47.100 and reduced by any sums charged enrollees on the basis of the coinsurance rates that are established under this subsection.

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

(6) To adopt a schedule for the orderly development of the delivery of services and availability of the plan to residents of the state, subject to the limitations contained in RCW 70.47.080.

In the selection of any area of the state for the initial operation of the plan, the administrator shall take into account the levels and rates of unemployment in different areas of the state, the need to provide basic health care coverage to a population reasonably representative of the portion of the state’s population that lacks such coverage, and the need for geographic, demographic, and economic diversity.

Before July 1, 1988, the administrator shall endeavor to secure participation contracts with managed health care systems in discrete geographic areas within at least five congressional districts.

(7) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan. The administrator shall endeavor

to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state.

(8) To receive periodic premiums from enrollees, deposit them in the basic health plan operating account, keep records of enrollee status, and authorize periodic payments to managed health care systems on the basis of the number of enrollees participating in the respective managed health care systems.

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and at least annually thereafter, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. An enrollee who remains current in payment of the sliding-scale premium, as determined under subsection (2) of this section, and whose gross family income has risen above twice the federal poverty level, may continue enrollment unless and until the enrollee's gross family income has remained above twice the poverty level for six consecutive months, by making payment at the unsubsidized rate required for the managed health care system in which he or she may be enrolled. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter

74.09 RCW. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to re-enroll in the plan.

(10) ((~~To require that prospective enrollees who may be eligible for categorically needy medical coverage under RCW 74.09.510 or whose income does not exceed the medically needy income level under RCW 74.09.700 apply for such coverage, but the administrator shall enroll the individuals in the plan pending the determination of eligibility under chapter 74.09 RCW.~~

~~(11)~~)) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the administrator shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant.

((~~(12)~~)) (11) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the

administrator shall endeavor to minimize costs, both to the managed health care systems and to the administrator. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the ((~~hospital commission~~)) department of health, to minimize duplication of effort.

((~~(13)~~)) (12) To monitor the access that state residents have to adequate and necessary health care services, determine the extent of any unmet needs for such services or lack of access that may exist from time to time, and make such reports and recommendations to the legislature as the administrator deems appropriate.

((~~(14)~~)) (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.

((~~(15)~~)) (14) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

((~~(16)~~)) (15) To provide, consistent with available resources, technical assistance for rural health activities that endeavor to develop needed health care services in rural parts of the state.

Sec. 3. RCW 70.47.110 and 1987 1st ex.s. c 5 s 13 are each amended to read as follows:

The department of social and health services ((~~shall~~)) may make ((~~periodic~~)) payments to the administrator ((~~as an agent for the~~)) or to participating managed health care systems on behalf of any enrollee who is a recipient of ((~~medical assistance, medical care--limited casualty program, or~~)) medical care ((~~services~~)) under chapter 74.09 RCW, at the maximum rate allowable for federal matching purposes under Title XIX of the social security act((~~, but not to exceed the rate~~

~~negotiated by the administrator with the participating managed health care system for the services covered by the plan, and no premium or copayment may be charged to such an enrollee~~)). Any enrollee on whose behalf the department of social and health services makes such payments ((~~to the administrator under this section and chapter 74.09 RCW~~)) may continue as an enrollee, making premium payments based on the enrollee's own income as determined under the sliding scale, after eligibility for coverage under chapter 74.09 RCW has ended, as long as the enrollee remains eligible under this chapter. Nothing in this section affects the right of any person eligible for coverage under chapter 74.09 RCW to receive the services offered to other persons under that chapter but not included in the schedule of basic health care services covered by the plan. The administrator shall seek to determine which enrollees or prospective enrollees may be eligible for medical care under chapter 74.09 RCW and may require these individuals to complete the eligibility determination process under chapter 74.09 RCW prior to enrollment or continued participation in the plan. The administrator and the department of social and health services shall cooperatively adopt procedures to facilitate the transition of plan enrollees and payments on their behalf between the plan and the programs established under chapter 74.09 RCW.

NEW SECTION. **Sec. 4.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect July 1, 1991.

Passed the House June 28, 1991.
Passed the Senate June 29, 1991.
Approved by the Governor June 30, 1991.
Filed in Office of Secretary of State June 30, 1991.