H-3965.1

HOUSE BILL 2555

State of Washington 59th Legislature 2006 Regular Session

By Representatives Hinkle, Condotta, Talcott, McDonald, Serben, Rodne and Holmquist

Read first time 01/10/2006. Referred to Committee on Health Care.

1 AN ACT Relating to health insurance; and amending RCW 48.21.045,
2 48.44.023, 48.46.066, and 70.47.060.

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

4 **Sec. 1.** RCW 48.21.045 and 2004 c 244 s 1 are each amended to read
5 as follows:
6 (1) Notwithstanding any other provision of this section, an insurer
7 offering any health benefit plan to a small employer may offer small
8 group health benefit plans that qualify as insurance coverage combined
9 with a health savings account as defined by the United States internal
10 revenue service.
11 (2)(a) An insurer offering any health benefit plan to a small
12 employer, either directly or through an association or member-governed
13 group formed specifically for the purpose of purchasing health care,
14 may offer and actively market to the small employer a health benefit
15 plan featuring a limited schedule of covered health care services.
16 Nothing in this subsection shall preclude an insurer from offering, or
17 a small employer from purchasing, other health benefit plans that may
18 have more comprehensive benefits than those included in the product

offered under this subsection. An insurer offering a health benefit plan under this subsection shall clearly disclose all covered benefits to the small employer in a brochure filed with the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240, 48.21.244, 48.21.250, 48.21.300, 48.21.310, or 48.21.320.

((~~(2)~~)) (3) Nothing in this section shall prohibit an insurer from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection ((~~(1)~~)) (2) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

((~~(3)~~)) (4) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The insurer shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The insurer shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection ((~~(3)~~)) (4).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups

on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs ((~~due to network provider reimbursement schedules or type of network~~)) for a plan. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, adjusted community rates established under this section shall pool the medical experience of all small groups purchasing coverage. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four percentage points from the overall adjustment of a carrier's entire small group pool, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected

weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal. A variation that is not denied within sixty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial within thirty days of the denial.

((~~(4)~~)) (5) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

((~~(5)~~)) (6)(a) Except as provided in this subsection, requirements used by an insurer in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) An insurer shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) An insurer may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

((~~(6)~~)) (7) An insurer must offer coverage to all eligible employees of a small employer and their dependents. An insurer may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. An insurer may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

1 ((~~(7)~~)) (8) As used in this section, "health benefit plan," "small
2 employer," "adjusted community rate," and "wellness activities" mean
3 the same as defined in RCW 48.43.005.

4 **Sec. 2.** RCW 48.44.023 and 2004 c 244 s 7 are each amended to read
5 as follows:
6 (1) Notwithstanding any other provision of this section, an insurer
7 offering any health benefit plan to a small employer may offer small
8 group health benefit plans that qualify as insurance coverage combined
9 with a health savings account as defined by the United States internal
10 revenue service.
11 (2)(a) A health care services contractor offering any health
12 benefit plan to a small employer, either directly or through an
13 association or member-governed group formed specifically for the
14 purpose of purchasing health care, may offer and actively market to the
15 small employer a health benefit plan featuring a limited schedule of
16 covered health care services. Nothing in this subsection shall
17 preclude a contractor from offering, or a small employer from
18 purchasing, other health benefit plans that may have more comprehensive
19 benefits than those included in the product offered under this
20 subsection. A contractor offering a health benefit plan under this
21 subsection shall clearly disclose all covered benefits to the small
22 employer in a brochure filed with the commissioner.
23 (b) A health benefit plan offered under this subsection shall
24 provide coverage for hospital expenses and services rendered by a
25 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
26 to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290,
27 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335,
28 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and
29 48.44.460.
30 ((~~(2)~~)) (3) Nothing in this section shall prohibit a health care
31 service contractor from offering, or a purchaser from seeking, health
32 benefit plans with benefits in excess of the health benefit plan
33 offered under subsection ((~~(1)~~)) (2) of this section. All forms,
34 policies, and contracts shall be submitted for approval to the
35 commissioner, and the rates of any plan offered under this section
36 shall be reasonable in relation to the benefits thereto.

1 ((~~(3)~~)) (4) Premium rates for health benefit plans for small
2 employers as defined in this section shall be subject to the following
3 provisions:
4 (a) The contractor shall develop its rates based on an adjusted
5 community rate and may only vary the adjusted community rate for:
6 (i) Geographic area;
7 (ii) Family size;
8 (iii) Age; and
9 (iv) Wellness activities.
10 (b) The adjustment for age in (a)(iii) of this subsection may not
11 use age brackets smaller than five-year increments, which shall begin
12 with age twenty and end with age sixty-five. Employees under the age
13 of twenty shall be treated as those age twenty.
14 (c) The contractor shall be permitted to develop separate rates for
15 individuals age sixty-five or older for coverage for which medicare is
16 the primary payer and coverage for which medicare is not the primary
17 payer. Both rates shall be subject to the requirements of this
18 subsection ((~~(3)~~)) (4).
19 (d) The permitted rates for any age group shall be no more than
20 four hundred twenty-five percent of the lowest rate for all age groups
21 on January 1, 1996, four hundred percent on January 1, 1997, and three
22 hundred seventy-five percent on January 1, 2000, and thereafter.
23 (e) A discount for wellness activities shall be permitted to
24 reflect actuarially justified differences in utilization or cost
25 attributed to such programs.
26 (f) The rate charged for a health benefit plan offered under this
27 section may not be adjusted more frequently than annually except that
28 the premium may be changed to reflect:
29 (i) Changes to the enrollment of the small employer;
30 (ii) Changes to the family composition of the employee;
31 (iii) Changes to the health benefit plan requested by the small
32 employer; or
33 (iv) Changes in government requirements affecting the health
34 benefit plan.
35 (g) Rating factors shall produce premiums for identical groups that
36 differ only by the amounts attributable to plan design, with the
37 exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs ((~~due to network provider reimbursement schedules or type of network~~)) for a plan. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four percentage points from the overall adjustment of a carrier's entire small group pool, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal. A variation that is not denied within sixty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial within thirty days of the denial.

((~~(4)~~)) (5) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

((~~(5)~~)) (6)(a) Except as provided in this subsection, requirements used by a contractor in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A contractor shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A contractor may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

((~~(6)~~)) <u>(7)</u> A contractor must offer coverage to all eligible employees of a small employer and their dependents. A contractor may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A contractor may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 3. RCW 48.46.066 and 2004 c 244 s 9 are each amended to read as follows:

(1) <u>Notwithstanding any other provision of this section, an insurer offering any health benefit plan to a small employer may offer small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service.</u>

<u>(2)</u>(a) A health maintenance organization offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer a health benefit plan featuring a limited schedule of covered health care services. Nothing in this subsection shall preclude a health maintenance organization from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A health maintenance organization offering a health

benefit plan under this subsection shall clearly disclose all the covered benefits to the small employer in a brochure filed with the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530.

((~~(2)~~)) (3) Nothing in this section shall prohibit a health maintenance organization from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection ((~~(1)~~)) (2) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

((~~(3)~~)) (4) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The health maintenance organization shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection ((~~(3)~~)) (4).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups

on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs ((~~due to network provider reimbursement schedules or type of network~~)) for a plan. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four percentage points from the overall adjustment of a carrier's entire small group pool, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected

1 weighted average of all small group benefit plans will have a revenue
2 neutral effect on the carrier's small group pool. Variations of
3 greater than four percentage points are subject to review by the
4 commissioner, and must be approved or denied within sixty days of
5 submittal. A variation that is not denied within sixty days shall be
6 deemed approved. The commissioner must provide to the carrier a
7 detailed actuarial justification for any denial within thirty days of
8 the denial.

9 ((~~(4)~~)) (5) Nothing in this section shall restrict the right of
10 employees to collectively bargain for insurance providing benefits in
11 excess of those provided herein.

12 ((~~(5)~~)) (6)(a) Except as provided in this subsection, requirements
13 used by a health maintenance organization in determining whether to
14 provide coverage to a small employer shall be applied uniformly among
15 all small employers applying for coverage or receiving coverage from
16 the carrier.

17 (b) A health maintenance organization shall not require a minimum
18 participation level greater than:

19 (i) One hundred percent of eligible employees working for groups
20 with three or less employees; and

21 (ii) Seventy-five percent of eligible employees working for groups
22 with more than three employees.

23 (c) In applying minimum participation requirements with respect to
24 a small employer, a small employer shall not consider employees or
25 dependents who have similar existing coverage in determining whether
26 the applicable percentage of participation is met.

27 (d) A health maintenance organization may not increase any
28 requirement for minimum employee participation or modify any
29 requirement for minimum employer contribution applicable to a small
30 employer at any time after the small employer has been accepted for
31 coverage.

32 ((~~(6)~~)) (7) A health maintenance organization must offer coverage
33 to all eligible employees of a small employer and their dependents. A
34 health maintenance organization may not offer coverage to only certain
35 individuals or dependents in a small employer group or to only part of
36 the group. A health maintenance organization may not modify a health
37 plan with respect to a small employer or any eligible employee or

1 dependent, through riders, endorsements or otherwise, to restrict or
2 exclude coverage or benefits for specific diseases, medical conditions,
3 or services otherwise covered by the plan.

4 **Sec. 4.** RCW 70.47.060 and 2004 c 192 s 3 are each amended to read
5 as follows:
6 The administrator has the following powers and duties:
7 (1) To design and from time to time revise a schedule of covered
8 basic health care services, including physician services, inpatient and
9 outpatient hospital services, prescription drugs and medications, and
10 other services that may be necessary for basic health care. In
11 addition, the administrator may, to the extent that funds are
12 available, offer as basic health plan services chemical dependency
13 services, mental health services and organ transplant services;
14 however, no one service or any combination of these three services
15 shall increase the actuarial value of the basic health plan benefits by
16 more than five percent excluding inflation, as determined by the office
17 of financial management. All subsidized and nonsubsidized enrollees in
18 any participating managed health care system under the Washington basic
19 health plan shall be entitled to receive covered basic health care
20 services in return for premium payments to the plan. The schedule of
21 services shall emphasize proven preventive and primary health care and
22 shall include all services necessary for prenatal, postnatal, and well-
23 child care. However, with respect to coverage for 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 managed care provider. The schedule of services shall also include a
30 separate schedule of basic health care services for children, eighteen
31 years of age and younger, for those subsidized or nonsubsidized
32 enrollees who choose to secure basic coverage through the plan only for
33 their dependent children. In designing and revising the schedule of
34 services, the administrator shall consider the guidelines for assessing
35 health services under the mandated benefits act of 1984, RCW 48.47.030,
36 and such other factors as the administrator deems appropriate.

(2)(a) To design and implement a structure of periodic premiums due the administrator from subsidized enrollees that is based upon gross family income, giving appropriate consideration to family size and 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. The structure of periodic premiums shall be applied to subsidized enrollees entering the plan as individuals pursuant to subsection (11) of this section and to the share of the cost of the plan due from subsidized enrollees entering the plan as employees pursuant to subsection (12) of this section.

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

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

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

(e) To develop, as an offering by every health carrier providing coverage identical to the basic health plan, as configured on January

1, 2001, a basic health plan model plan with uniformity in enrollee cost-sharing requirements.

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

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

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

(6) 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. Such a closure does not apply to health coverage tax credit eligible enrollees who receive a premium subsidy from the United States internal revenue service as long as the enrollees qualify for the health coverage tax credit program.

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

(8) To adopt a schedule for the orderly development of the delivery

1 of services and availability of the plan to residents of the state,
2 subject to the limitations contained in RCW 70.47.080 or any act
3 appropriating funds for the plan.

4 (9) To solicit and accept applications from managed health care
5 systems, as defined in this chapter, for inclusion as eligible basic
6 health care providers under the plan for subsidized enrollees,
7 nonsubsidized enrollees, or health coverage tax credit eligible
8 enrollees. The administrator shall endeavor to assure that covered
9 basic health care services are available to any enrollee of the plan
10 from among a selection of two or more participating managed health care
11 systems. In adopting any rules or procedures applicable to managed
12 health care systems and in its dealings with such systems, the
13 administrator shall consider and make suitable allowance for the need
14 for health care services and the differences in local availability of
15 health care resources, along with other resources, within and among the
16 several areas of the state. Contracts with participating managed
17 health care systems shall ensure that basic health plan enrollees who
18 become eligible for medical assistance may, at their option, continue
19 to receive services from their existing providers within the managed
20 health care system if such providers have entered into provider
21 agreements with the department of social and health services.

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

28 (11) To accept applications from individuals residing in areas
29 served by the plan, on behalf of themselves and their spouses and
30 dependent children, for enrollment in the Washington basic health plan
31 as subsidized, nonsubsidized, or health coverage tax credit eligible
32 enrollees, to establish appropriate minimum-enrollment periods for
33 enrollees as may be necessary, and to determine, upon application and
34 on a reasonable schedule defined by the authority, or at the request of
35 any enrollee, eligibility due to current gross family income for
36 sliding scale premiums. Funds received by a family as part of
37 participation in the adoption support program authorized under RCW
38 26.33.320 and 74.13.100 through 74.13.145 shall not be counted toward

1 a family's current gross family income for the purposes of this
2 chapter. When an enrollee fails to report income or income changes
3 accurately, the administrator shall have the authority either to bill
4 the enrollee for the amounts overpaid by the state or to impose civil
5 penalties of up to two hundred percent of the amount of subsidy
6 overpaid due to the enrollee incorrectly reporting income. The
7 administrator shall adopt rules to define the appropriate application
8 of these sanctions and the processes to implement the sanctions
9 provided in this subsection, within available resources. No subsidy
10 may be paid with respect to any enrollee whose current gross family
11 income exceeds twice the federal poverty level or, subject to RCW
12 70.47.110, who is a recipient of medical assistance or medical care
13 services under chapter 74.09 RCW. If a number of enrollees drop their
14 enrollment for no apparent good cause, the administrator may establish
15 appropriate rules or requirements that are applicable to such
16 individuals before they will be allowed to reenroll in the plan.

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

35 (13) <u>To design and implement a program to provide a subsidy for</u>
36 <u>low-income employees of a business of between two and fifty employees</u>
37 <u>who are eligible for coverage under the basic health plan and</u>
38 <u>participate in an employer sponsored high deductible health plan. The</u>

subsidy may only be deposited into a health savings account that conforms to section 223, Part VII of subchapter B of chapter 1 of the internal revenue code of 1986. The subsidy must be in an amount appropriated for this specific purpose in the omnibus operating appropriation bill or bills.

(14) 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 or actuarially equivalent 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.

(((14))) (15) 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 plan. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

(((15))) (16) 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.

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

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

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

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

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