# Chapter 70.47 RCW
# BASIC HEALTH PLAN—HEALTH CARE ACCESS ACT

**Sections**



**RCW 70.47.002 Intent—2002 c 2 (Initiative Measure No. 773).** It is the intent of the people to improve the health of low-income

children and adults by expanding access to basic health care and by reducing tobacco-related and other diseases and illnesses that disproportionately affect low-income persons. [2002 c 2 s 1 (Initiative Measure No. 773, approved November 6, 2001).]

**RCW 70.47.005 Transfer power, duties, and functions to Washington state health care authority.** The powers, duties, and functions of the Washington basic health plan are hereby transferred to the Washington state health care authority. All references to the *administrator of the Washington basic health plan in the Revised Code of Washington shall be construed to mean the *administrator of the Washington state health care authority. [1993 c 492 s 201.]

***Reviser's note:** The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**Findings—Intent—1993 c 492:** See notes following RCW 43.20.050.

**Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492:** See RCW 43.72.910 through 43.72.915.

**RCW 70.47.010 Legislative findings—Purpose—Director to coordinate eligibility.** (1)(a) The legislature finds that limitations on access to health care services for enrollees in the state, such as in rural and underserved areas, are particularly challenging for the basic health plan. Statutory restrictions have reduced the options available to the director to address the access needs of basic health plan enrollees. It is the intent of the legislature to authorize the director to develop alternative purchasing strategies to ensure access to basic health plan enrollees in all areas of the state, including: (i) The use of differential rating for managed health care systems based on geographic differences in costs; and (ii) limited use of self-insurance in areas where adequate access cannot be assured through other options.

(b) In developing alternative purchasing strategies to address health care access needs, the director shall consult with interested persons including health carriers, health care providers, and health facilities, and with other appropriate state agencies including the office of the insurance commissioner and the office of community and rural health. In pursuing such alternatives, the director shall continue to give priority to prepaid managed care as the preferred method of assuring access to basic health plan enrollees followed, in priority order, by preferred providers, fee-for-service, and self-funding.

(2) The legislature further finds that:

(a) A significant percentage of the population of this state does not have reasonably available insurance or other coverage of the costs of necessary basic health care services;

(b) This lack of basic health care coverage is detrimental to the health of the individuals lacking coverage and to the public welfare, and results in substantial expenditures for emergency and remedial health care, often at the expense of health care providers, health care facilities, and all purchasers of health care, including the state; and

(c) The use of managed health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state generally, and by low-income pregnant women, and at-risk children and adolescents who need greater access to managed health care.

(3) The purpose of this chapter is to provide or make more readily available necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization of necessary health care services. To that end, this chapter establishes a program to be made available to those residents not eligible for medicare who share in a portion of the cost or who pay the full cost of receiving basic health care services from a managed health care system.

(4) It is not the intent of this chapter to provide health care services for those persons who are presently covered through private employer-based health plans, nor to replace employer-based health plans. However, the legislature recognizes that cost-effective and affordable health plans may not always be available to small business employers. Further, it is the intent of the legislature to expand, wherever possible, the availability of private health care coverage and to discourage the decline of employer-based coverage.

(5)(a) It is the purpose of this chapter to acknowledge the initial success of this program that has (i) assisted thousands of families in their search for affordable health care; (ii) demonstrated that low-income, uninsured families are willing to pay for their own health care coverage to the extent of their ability to pay; and (iii) proved that local health care providers are willing to enter into a public-private partnership as a managed care system.

(b) As a consequence, the legislature intends to extend an option to enroll to certain citizens above two hundred percent of the federal poverty guidelines within the state who reside in communities where the plan is operational and who collectively or individually wish to exercise the opportunity to purchase health care coverage through the basic health plan if the purchase is done at no cost to the state. It is also the intent of the legislature to allow employers and other financial sponsors to financially assist such individuals to purchase health care through the program so long as such purchase does not result in a lower standard of coverage for employees.

(c) The legislature intends that, to the extent of available funds, the program be available throughout Washington state to subsidized and nonsubsidized enrollees. It is also the intent of the legislature to enroll subsidized enrollees first, to the maximum extent feasible.

(d) The legislature directs that the basic health plan director identify enrollees who are likely to be eligible for medical assistance and assist these individuals in applying for and receiving medical assistance. Enrollees receiving medical assistance are not eligible for the Washington basic health plan. [2011 1st sp.s. c 15 s 82; 2009 c 568 s 1; 2000 c 79 s 42; 1993 c 492 s 208; 1987 1st ex.s. c 5 s 3.]

**Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15:** See notes following RCW 74.09.010.

**Effective date—Severability—2000 c 79:** See notes following RCW 48.04.010.

**Findings—Intent—1993 c 492:** See notes following RCW 43.20.050.

**Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492:** See RCW 43.72.910 through 43.72.915.

**RCW 70.47.015 Enrollment—Findings—Intent—Enrollee premium share—Expedited application and enrollment process—Commission for insurance producers.** (1) The legislature finds that the basic health plan has been an effective program in providing health coverage for uninsured residents. Further, since 1993, substantial amounts of public funds have been allocated for subsidized basic health plan enrollment.

(2) Effective January 1, 1996, basic health plan enrollees whose income is less than one hundred twenty-five percent of the federal poverty level shall pay at least a ten-dollar premium share.

(3) No later than July 1, 1996, the *administrator shall implement procedures whereby hospitals licensed under chapters 70.41 and 71.12 RCW, health carrier, rural health care facilities regulated under chapter 70.175 RCW, and community and migrant health centers funded under RCW 41.05.220, may expeditiously assist patients and their families in applying for basic health plan or medical assistance coverage, and in submitting such applications directly to the health care authority or the department of social and health services. The health care authority and the department of social and health services shall make every effort to simplify and expedite the application and enrollment process.

(4) No later than July 1, 1996, the *administrator shall implement procedures whereby disability insurance producers, licensed under chapter 48.17 RCW, may expeditiously assist patients and their families in applying for basic health plan or medical assistance coverage, and in submitting such applications directly to the health care authority or the department of social and health services. Insurance producers may receive a commission for each individual sale of the basic health plan to anyone not signed up within the previous five years and a commission for each group sale of the basic health plan, if funding for this purpose is provided in a specific appropriation to the health care authority. No commission shall be provided upon a renewal. Commissions shall be determined based on the estimated annual cost of the basic health plan, however, commissions shall not result in a reduction in the premium amount paid to health carriers. For purposes of this section "health carrier" is as defined in RCW 48.43.005. The *administrator may establish: (a) Minimum educational requirements that must be completed by the insurance producers; (b) an appointment process for insurance producers marketing the basic health plan; or (c) standards for revocation of the appointment of an insurance producer to submit applications for cause, including untrustworthy or incompetent conduct or harm to the public. The health care authority and the department of social and health services shall make every effort to simplify and expedite the application and enrollment process. [2009 c 479 s 49; 2008 c 217 s 99; 1997 c 337 s 1; 1995 c 265 s 1.]

***Reviser's note:** The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**Effective date—2009 c 479:** See note following RCW 2.56.030.

**Severability—Effective date—2008 c 217:** See notes following RCW 48.03.020.

**Effective date—1997 c 337 ss 1 and 2:** "Sections 1 and 2 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect July 1, 1997." [1997 c 337 s 9.]

**Captions not law—1995 c 265:** "Captions as used in this act constitute no part of the law." [1995 c 265 s 29.]

**Effective date—1995 c 265:** "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, 1995, except that sections 13 through 18 of this act shall take effect January 1, 1996." [1995 c 265 s 30.]

**Savings—1995 c 265:** "This act shall not be construed as affecting any existing right acquired or liability or obligation incurred under the sections amended or repealed in this act or under any rule or order adopted under those sections, nor as affecting any proceeding instituted under those sections." [1995 c 265 s 31.]

**Severability—1995 c 265:** "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1995 c 265 s 32.]

**RCW 70.47.020 Definitions.** As used in this chapter:

(1) "Director" means the director of the Washington state health care authority.

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

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

(4) "Managed health care system" means: (a) Any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the director and rendered by duly

licensed providers, to a defined patient population enrolled in the plan and in the managed health care system; or (b) a self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100(9).

(5) "Nonparticipating provider" means a person, health care provider, practitioner, facility, or entity, acting within their authorized scope of practice or licensure, that does not have a written contract to participate in a managed health care system's provider network, but provides services to plan enrollees who receive coverage through the managed health care system.

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

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

(8) "Rate" means the amount, negotiated by the director with and paid to a participating managed health care system, that is based upon the enrollment of subsidized, nonsubsidized, and health coverage tax credit eligible enrollees in the plan and in that system.

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

(10) "Subsidized enrollee" means:

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

(i) Who is not eligible for medicare;

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

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

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

(v) Until March 1, 2011, whose gross family income at the time of enrollment does not exceed two hundred percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services;

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

(vii) Who is not receiving or has not been determined to be currently eligible for federally financed categorically needy or medically needy programs under chapter 74.09 RCW, except as provided under RCW 70.47.110; and

(viii) After February 28, 2011, who is in the basic health transition eligibles population under 1115 medicaid demonstration project number 11-W-00254/10;

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

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

(11) "Washington basic health plan" or "plan" means the system of enrollment and payment for basic health care services, administered by the plan director through participating managed health care systems, created by this chapter. [2023 c 470 s 1016. Prior: 2011 1st sp.s. c 15 s 83; 2011 1st sp.s. c 9 s 3; 2011 c 284 s 1; 2011 c 205 s 1; 2009 c 568 s 2; 2007 c 259 s 35; 2005 c 188 s 2; 2004 c 192 s 1; 2000 c 79 s 43; 1997 c 335 s 1; 1997 c 245 s 5; prior: 1995 c 266 s 2; 1995 c 2 s 3; 1994 c 309 s 4; 1993 c 492 s 209; 1987 1st ex.s. c 5 s 4.]

***Reviser's note:** RCW 48.43.018 was repealed by 2019 c 33 s 7.

**Explanatory statement—2023 c 470:** See note following RCW 10.99.030.

**Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15:** See notes following RCW 74.09.010.

**Findings—Intent—2011 1st sp.s. c 9:** "(1) The legislature finds that:

(a) There is an increasing level of dispute and uncertainty regarding the amount of payment nonparticipating providers may receive for health care services provided to enrollees of state purchased health care programs designed to serve low-income individuals and families, such as basic health and the medicaid managed care programs;

(b) The dispute has resulted in litigation, including a recent Washington superior court ruling that determined nonparticipating providers were entitled to receive billed charges from a managed health care system for services provided to medicaid and basic health plan enrollees. The decision would allow a nonparticipating provider to demand and receive payment in an amount exceeding the payment managed health care system network providers receive for the same

services. Similar provider lawsuits have now been filed in other jurisdictions in the state;

(c) In the biennial operating budget, the legislature has previously indicated its intent that payment to nonparticipating providers for services provided to medicaid managed care enrollees should be limited to amounts paid to medicaid fee-for-service providers. The duration of these provisions is limited to the period during which the operating budget is in effect. A more permanent resolution of these issues is needed; and

(d) Continued failure to resolve this dispute will have adverse impacts on state purchased health care programs serving low-income enrollees, including: (i) Diminished ability for the state to negotiate cost-effective contracts with managed health care systems; (ii) a potential for significant reduction in the willingness of providers to participate in managed health care system provider networks; (iii) a reduction in providers participating in the managed health care systems; and (iv) increased exposure for program enrollees to balance billing practices by nonparticipating providers. Ultimately, fewer eligible people will get the care they need as state purchased health care programs will operate with less efficiency and reduced access to cost-effective and quality health care coverage for program enrollees.

(2) It is the intent of the legislature to create a legislative solution that reduces the cost borne by the state to provide public health care coverage to low-income enrollees in managed health care systems, protects enrollees and state purchased health care programs from balance billing by nonparticipating providers, provides appropriate payment to health care providers for services provided to enrollees of state purchased health care programs, and limits the risk for managed health care systems that contract with the state programs." [2011 1st sp.s. c 9 s 1.]

**Intent—2011 c 205:** "The legislature intends to define eligibility for the basic health plan for periods subsequent to expiration of the 1115 medicaid demonstration project based upon recommendations from its joint select committee on health reform regarding whether the basic health plan should be offered as an enrollment option for persons who qualify for federal premium subsidies under the federal patient protection and affordable care act of 2010." [2011 c 205 s 2.]

**Effective date—2011 c 205:** "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 takes effect immediately [April 29, 2011]." [2011 c 205 s 3.]

**Subheadings not law—2007 c 259:** See note following RCW 7.70.060.

**Findings—2005 c 188:** "The legislature finds that the basic health plan is a valuable means of providing access to affordable health insurance coverage for low-income families and individuals in Washington state. The legislature further finds that persons studying in the United States as full-time students under temporary visas must show, as a condition of receiving their temporary visa, that they have sufficient funds available for self-support during their entire proposed course of study. For this reason, the legislature finds that

it is not appropriate to provide subsidized basic health plan coverage to this group of students." [2005 c 188 s 1.]

**Effective date—2004 c 192:** "This act takes effect January 1, 2005." [2004 c 192 s 6.]

**Effective date—Severability—2000 c 79:** See notes following RCW 48.04.010.

**Effective date—1995 c 266:** See note following RCW 70.47.060.

**Effective date—1995 c 2:** See note following RCW 43.72.090.

**Findings—Intent—1993 c 492:** See notes following RCW 43.20.050.

**Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492:** See RCW 43.72.910 through 43.72.915.

**RCW 70.47.030 Basic health plan trust account—Basic health plan subscription account.** (1) The basic health plan trust account is hereby established in the state treasury. Any nongeneral fund-state funds collected for this program shall be deposited in the basic health plan trust account and may be expended without further appropriation. 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.

During the 1995-97 fiscal biennium, the legislature may transfer funds from the basic health plan trust account to the state general fund.

(2) The basic health plan subscription account is created in the custody of the state treasurer. All receipts from amounts due from or on behalf of nonsubsidized enrollees and health coverage tax credit eligible enrollees shall be deposited into the account. Funds in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of nonsubsidized enrollees and health coverage tax credit eligible enrollees in the plan and payment of costs of administering the plan. The account is subject to allotment procedures under chapter 43.88 RCW, but no appropriation is required for expenditures.

(3) The *administrator shall take every precaution to see that none of the funds in the separate accounts created in this section or that any premiums paid either by subsidized or nonsubsidized enrollees are commingled in any way, except that the *administrator may combine funds designated for administration of the plan into a single administrative account. [2004 c 192 s 2; 1995 2nd sp.s. c 18 s 913; 1993 c 492 s 210; 1992 c 232 s 907. Prior: 1991 sp.s. c 13 s 68; 1991 sp.s. c 4 s 1; 1987 1st ex.s. c 5 s 5.]

***Reviser's note:** The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**Effective date—2004 c 192:** See note following RCW 70.47.020.

**Severability—Effective date—1995 2nd sp.s. c 18:** See notes following RCW 19.118.110.

**Findings—Intent—1993 c 492:** See notes following RCW 43.20.050.

**Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492:** See RCW 43.72.910 through 43.72.915.

**Severability—1992 c 232:** See note following RCW 43.33A.180.

**Effective dates—Severability—1991 sp.s. c 13:** See notes following RCW 18.08.240.

**Effective date—1991 sp.s. c 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." [1991 sp.s. c 4 s 4.]

**RCW 70.47.040 Basic health plan—Health care authority head to be administrator—Joint operations.** (1) The Washington basic health plan is created as a program within the Washington state health care authority. The administrative head and appointing authority of the plan shall be the *administrator of the Washington state health care authority. The *administrator shall appoint a medical director. The medical director and up to five other employees of the plan shall be exempt from the civil service law, chapter 41.06 RCW.

(2) The *administrator shall employ such other staff as are necessary to fulfill the responsibilities and duties of the *administrator, such staff to be subject to the civil service law, chapter 41.06 RCW. In addition, the *administrator may contract with third parties for services necessary to carry out its activities where this will promote economy, avoid duplication of effort, and make best use of available expertise. Any such contractor or consultant shall be prohibited from releasing, publishing, or otherwise using any information made available to it under its contractual responsibility without specific permission of the plan. The *administrator may call upon other agencies of the state to provide available information as necessary to assist the *administrator in meeting its responsibilities under this chapter, which information shall be supplied as promptly as circumstances permit.

(3) The *administrator may appoint such technical or advisory committees as he or she deems necessary.

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

(5) Whenever feasible, the *administrator shall reduce the administrative cost of operating the program by adopting joint policies or procedures applicable to both the basic health plan and employee health plans. [2010 1st sp.s. c 7 s 7; 1993 c 492 s 211; 1987 1st ex.s. c 5 s 6.]

***Reviser's note:** The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**Effective date—2010 1st sp.s. c 26; 2010 1st sp.s. c 7:** See note following RCW 43.03.027.

**Findings—Intent—1993 c 492:** See notes following RCW 43.20.050.

**Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492:** See RCW 43.72.910 through 43.72.915.

**RCW 70.47.050 Rules.** The *administrator may promulgate and adopt rules consistent with this chapter to carry out the purposes of this chapter. All rules shall be adopted in accordance with chapter 34.05 RCW. [1987 1st ex.s. c 5 s 7.]

***Reviser's note:** The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**RCW 70.47.060 Powers and duties of administrator—Schedule of services—Premiums, copayments, subsidies—Enrollment.** 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, prescription drugs and medications, and other services that may be necessary for basic health care. In addition, the *administrator may, to the extent that funds are available, offer as basic health plan services chemical dependency services, mental health services, and organ transplant services. All subsidized and nonsubsidized enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive covered basic health care services in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care and shall include all services necessary for prenatal, postnatal, and well-child care. However, with respect to coverage for subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the *administrator shall not contract for such services except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider. The schedule of services shall also include a separate schedule of basic health care services for children, eighteen years of age and younger, for those subsidized or nonsubsidized 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 48.47.030, and such other factors as the *administrator deems appropriate. The *administrator shall encourage enrollees who have been continually enrolled on basic health for a period of one year or more to complete a health risk assessment and participate in programs approved by the *administrator that may include wellness, smoking cessation, and chronic disease management programs. In approving

programs, the *administrator shall consider evidence that any such programs are proven to improve enrollee health status.

(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 subsidized enrollees under **RCW 70.47.020(9)(b). Premiums due for foster parents with gross family income up to two hundred percent of the federal poverty level shall be set at the minimum premium amount charged to enrollees with income below sixty-five percent of the federal poverty level. Premiums due for foster parents with gross family income between two hundred percent and three hundred percent of the federal poverty level shall not exceed one hundred dollars per month.

(c) 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.

(d) 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.

(e) 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.

(f) 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.

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

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

The notice shall include monthly sponsorship levels of fifteen dollars per month, thirty dollars per month, fifty dollars per month, and any other amounts deemed reasonable by the *administrator. The sponsorship levels shall be named "safety net contributor," "safety net hero," and "safety net champion" respectively. The donation amounts provided shall be tied to the level of coverage the employee will be purchasing for a working poor individual without access to health care coverage.

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

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

(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. To prevent the risk of overexpenditure, the *administrator may disenroll persons receiving subsidies from the program based on criteria adopted by the *administrator. The criteria may include: Length of continual enrollment on the program, income level, or eligibility for other coverage. The *administrator shall identify

enrollees who are eligible for other coverage, and, working with the department of social and health service as provided in RCW 70.47.010(5)(d), transition enrollees currently eligible for federally financed categorically needy or medically needy programs administered under chapter 74.09 RCW to that coverage. The *administrator shall develop criteria for persons disenrolled under this subsection to reapply for the 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 of services and availability of the plan to residents of the state, subject to the limitations contained in RCW 70.47.080 or any act appropriating funds for the plan.

(9) 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 for subsidized enrollees, nonsubsidized enrollees, or health coverage tax credit eligible enrollees. 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. Contracts with participating managed health care systems shall ensure that basic health plan enrollees who become eligible for medical assistance may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

(10) To receive periodic premiums from or on behalf of subsidized, nonsubsidized, and health coverage tax credit eligible 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.

(11) 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 as subsidized, nonsubsidized, or health coverage tax credit eligible enrollees, to give priority to members of the Washington national guard and reserves who served in Operation Enduring Freedom, Operation Iraqi Freedom, or Operation Noble Eagle, and their spouses and dependents, 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 on a reasonable schedule defined by the authority, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. The application is also considered an application for medical assistance under chapter 74.09 RCW and must include a social security number, if available, for each family member requesting coverage. Funds received by a family as part of participation in the adoption support program authorized under RCW 26.33.320 and 74.13A.005 through 74.13A.080 shall not be counted toward a family's current

gross family income for the purposes of this chapter. When an enrollee fails to report income or income changes accurately, the *administrator shall have the authority either to bill the enrollee for the amounts overpaid by the state or to impose civil penalties of up to two hundred percent of the amount of subsidy overpaid due to the enrollee incorrectly reporting income. The *administrator shall adopt rules to define the appropriate application of these sanctions and the processes to implement the sanctions provided in this subsection, within available resources. 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 reenroll in the plan.

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

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

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

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

(19) 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.

(20) To give priority in enrollment to persons who disenrolled from the program in order to enroll in medicaid, and subsequently became ineligible for medicaid coverage. [2011 c 284 s 2; 2009 c 568 s 3; 2007 c 259 s 36; 2006 c 343 s 9; 2004 c 192 s 3; 2001 c 196 s 13; 2000 c 79 s 34. Prior: 1998 c 314 s 17; 1998 c 148 s 1; prior: 1997 c 337 s 2; 1997 c 335 s 2; 1997 c 245 s 6; 1997 c 231 s 206; prior: 1995 c 266 s 1; 1995 c 2 s 4; 1994 c 309 s 5; 1993 c 492 s 212; 1992 c 232 s 908; prior: 1991 sp.s. c 4 s 2; 1991 c 3 s 339; 1987 1st ex.s. c 5 s 8.]

**Reviser's note:** *(1) The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**(2) RCW 70.47.020 was amended by 2011 1st sp.s. c 9 s 3, changing subsection (9)(b) to subsection (10)(b).

***(3) RCW 43.72.900 was repealed by 2009 c 479 s 29.

**Effective date—2009 c 568 s 3:** "Section 3 of 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 takes effect immediately [May 19, 2009]." [2009 c 568 s 8.]

**Subheadings not law—2007 c 259:** See note following RCW 7.70.060.

**Findings—2006 c 343:** See note following RCW 43.60A.160.

**Effective date—2004 c 192:** See note following RCW 70.47.020.

**Effective date—2001 c 196:** See note following RCW 48.20.025.

**Effective date—Severability—2000 c 79:** See notes following RCW 48.04.010.

**Effective date—1997 c 337 ss 1 and 2:** See note following RCW 70.47.015.

**Short title—Part headings and captions not law—Severability—Effective dates—1997 c 231:** See notes following RCW 48.43.005.

**Effective date—1995 c 266:** "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, 1995." [1995 c 266 s 5.]

**Effective date—1995 c 2:** See note following RCW 43.72.090.

**Contingency—1994 c 309 ss 5 and 6:** "If a court in a permanent injunction, permanent order, or final decision determines that the amendments made by sections 5 and 6, chapter 309, Laws of 1994, must be submitted to the people for their adoption and ratification, or rejection, as a result of section 13, chapter 2, Laws of 1994, the amendments made by sections 5 and 6, chapter 309, Laws of 1994, shall be null and void." [1994 c 309 s 7.]

**Findings—Intent—1993 c 492:** See notes following RCW 43.20.050.

**Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492:** See RCW 43.72.910 through 43.72.915.

**Severability—1992 c 232:** See note following RCW 43.33A.180.

**Effective date—1991 sp.s. c 4:** See note following RCW 70.47.030.

**RCW 70.47.0601 Income determination—Unemployment compensation.** The *administrator shall not count the twenty-five dollar increase paid as part of an individual's weekly benefit amount as provided in **RCW 50.20.1202 when determining an individual's gross family income, eligibility, and premium share. [2011 c 4 s 18.]

**Reviser's note:** *(1) The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**(2) RCW 50.20.1202 was repealed by 2021 c 2 s 27.

**Effective date—2011 c 4 ss 1-6 and 16-21:** See note following RCW 50.20.120.

**Conflict with federal requirements—2011 c 4:** See note following RCW 50.29.021.

**RCW 70.47.070 Benefits from other coverages not reduced.** The benefits available under the basic health plan shall be excess to the benefits payable under the terms of any insurance policy issued to or on the behalf of an enrollee that provides payments toward medical expenses without a determination of liability for the injury. Except where in conflict with federal or state law, the benefits of any other health plan or insurance which covers an enrollee shall be determined before the benefits of the basic health plan. The *administrator shall require that managed health care systems conduct and report on coordination of benefits activities as provided under this section. [2009 c 568 s 4; 1987 1st ex.s. c 5 s 9.]

***Reviser's note:** The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**RCW 70.47.080 Enrollment of applicants—Participation limitations.** On and after July 1, 1988, the *administrator shall accept for enrollment applicants eligible to receive covered basic health care services from the respective managed health care systems which are then participating in the plan.

Thereafter, total subsidized enrollment shall not result in expenditures that exceed the total amount that has been made available by the legislature in any act appropriating funds to the plan. To the extent that new funding is appropriated for expansion, the *administrator shall endeavor to secure participation contracts from managed health care systems in geographic areas of the state that are unserved by the plan at the time at which the new funding is appropriated. In the selection of any such areas 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.

The *administrator shall at all times closely monitor growth patterns of enrollment so as not to exceed that consistent with the orderly development of the plan as a whole, in any area of the state or in any participating managed health care system. The annual or biennial enrollment limitations derived from operation of the plan under this section do not apply to nonsubsidized enrollees as defined in **RCW 70.47.020(5). [1993 c 492 s 213; 1987 1st ex.s. c 5 s 10.]

**Reviser's note:** *(1) The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**(2) RCW 70.47.020 was amended by 2011 1st sp.s. c 9 s 3, changing subsection (5) to subsection (6).

**Findings—Intent—1993 c 492:** See notes following RCW 43.20.050.

**Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492:** See RCW 43.72.910 through 43.72.915.

**RCW 70.47.090 Removal of enrollees.** Any enrollee whose premium payments to the plan are delinquent or who moves his or her residence out of an area served by the plan may be dropped from enrollment status. An enrollee whose premium is the responsibility of the department of social and health services under RCW 70.47.110 may not be dropped solely because of nonpayment by the department. The *administrator shall provide delinquent enrollees with advance written notice of their removal from the plan and shall provide for a hearing under chapters 34.05 and 34.12 RCW for any enrollee who contests the decision to drop the enrollee from the plan. Upon removal of an enrollee from the plan, the *administrator shall promptly notify the managed health care system in which the enrollee has been enrolled, and shall not be responsible for payment for health care services provided to the enrollee (including, if applicable, members of the enrollee's family) after the date of notification. A managed health care system may contest the denial of payment for coverage of an enrollee through a hearing under chapters 34.05 and 34.12 RCW. [1987 1st ex.s. c 5 s 11.]

***Reviser's note:** The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**RCW 70.47.100 Participation by a managed health care system—Expiration of subsections.** (1) A managed health care system participating in the plan shall do so by contract with the director and shall provide, directly or by contract with other health care providers, covered basic health care services to each enrollee covered by its contract with the director as long as payments from the director on behalf of the enrollee are current. A participating managed health care system may offer, without additional cost, health care benefits or services not included in the schedule of covered services under the plan. A participating managed health care system shall not give preference in enrollment to enrollees who accept such additional health care benefits or services. Managed health care systems participating in the plan shall not discriminate against any potential or current enrollee based upon health status, sex, race, ethnicity, or religion. The director may receive and act upon complaints from enrollees regarding failure to provide covered services or efforts to obtain payment, other than authorized copayments, for covered services directly from enrollees, but nothing in this chapter empowers the director to impose any sanctions under Title 18 RCW or any other professional or facility licensing statute.

(2) A managed health care system shall pay a nonparticipating provider that provides a service covered under this chapter to the system's enrollee no more than the lowest amount paid for that service under the managed health care system's contracts with similar providers in the state.

(3) Pursuant to federal managed care access standards, 42 C.F.R. Sec. 438, managed health care systems must maintain a network of appropriate providers that is supported by written agreements sufficient to provide adequate access to all services covered under the contract with the authority, including hospital-based physician services. The authority will monitor and periodically report on the proportion of services provided by contracted providers and nonparticipating providers, by county, for each managed health care system to ensure that managed health care systems are meeting network adequacy requirements. No later than January 1st of each year, the authority will review and report its findings to the appropriate policy and fiscal committees of the legislature for the preceding state fiscal year.

(4) The plan shall allow, at least annually, an opportunity for enrollees to transfer their enrollments among participating managed health care systems serving their respective areas. The director shall establish a period of at least twenty days in a given year when this opportunity is afforded enrollees, and in those areas served by more than one participating managed health care system the director shall endeavor to establish a uniform period for such opportunity. The plan shall allow enrollees to transfer their enrollment to another participating managed health care system at any time upon a showing of good cause for the transfer.

(5) Prior to negotiating with any managed health care system, the director shall determine, on an actuarially sound basis, the reasonable cost of providing the schedule of basic health care services, expressed in terms of upper and lower limits, and

recognizing variations in the cost of providing the services through the various systems and in different areas of the state.

(6) In negotiating with managed health care systems for participation in the plan, the director shall adopt a uniform procedure that includes at least the following:

(a) The director shall issue a request for proposals, including standards regarding the quality of services to be provided; financial integrity of the responding systems; and responsiveness to the unmet health care needs of the local communities or populations that may be served;

(b) The director shall then review responsive proposals and may negotiate with respondents to the extent necessary to refine any proposals;

(c) The director may then select one or more systems to provide the covered services within a local area; and

(d) The director may adopt a policy that gives preference to respondents, such as nonprofit community health clinics, that have a history of providing quality health care services to low-income persons.

(7)(a) The director may contract with a managed health care system to provide covered basic health care services to subsidized enrollees, nonsubsidized enrollees, health coverage tax credit eligible enrollees, or any combination thereof. At a minimum, such contracts issued on or after January 1, 2012, must include:

(i) Provider reimbursement methods that incentivize chronic care management within health homes;

(ii) Provider reimbursement methods that reward health homes that, by using chronic care management, reduce emergency department and inpatient use; and

(iii) Promoting provider participation in the program of training and technical assistance regarding care of people with chronic conditions described in RCW 43.70.533, including allocation of funds to support provider participation in the training unless the managed care system is an integrated health delivery system that has programs in place for chronic care management.

(b) Health home services contracted for under this subsection may be prioritized to enrollees with complex, high cost, or multiple chronic conditions.

(c) For the purposes of this subsection, "chronic care management," "chronic condition," and "health home" have the same meaning as in RCW 74.09.010.

(d) Contracts that include the items in (a)(i) through (iii) of this subsection must not exceed the rates that would be paid in the absence of these provisions.

(8) The director may establish procedures and policies to further negotiate and contract with managed health care systems following completion of the request for proposal process in subsection (6) of this section, upon a determination by the director that it is necessary to provide access, as defined in the request for proposal documents, to covered basic health care services for enrollees.

(9) Subsections (2) and (3) of this section expire July 1, 2016. [2013 c 251 s 7. Prior: 2011 1st sp.s. c 9 s 4; 2011 c 316 s 5; 2009 c 568 s 5; 2004 c 192 s 4; 2000 c 79 s 35; 1987 1st ex.s. c 5 s 12.]

**Residual balance of funds—Effective date—2013 c 251:** See notes following RCW 41.06.280.

**Findings—Intent—2011 1st sp.s. c 9:** See note following RCW 70.47.020.

**Effective date—2004 c 192:** See note following RCW 70.47.020.

**Effective date—Severability—2000 c 79:** See notes following RCW 48.04.010.

**RCW 70.47.110 Enrollment of medical assistance recipients.** The health care authority may make payments to *managed health care systems, as defined in RCW 74.09.522 or in this chapter, on behalf of any person who is a recipient of medical care under chapter 74.09 RCW, up to the maximum rate allowable for federal matching purposes under Title XIX of the social security act. Any enrollee on whose behalf the health care authority makes such payments 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 director 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 director shall 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. [2014 c 198 s 1; 2011 1st sp.s. c 15 s 84; 1991 sp.s. c 4 s 3; 1987 1st ex.s. c 5 s 13.]

***Reviser's note:** RCW 74.09.522 was amended by 2023 c 51 s 43, removing the definition of "managed health care system" and changing "managed health care system" to "managed care organization."

**Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15:** See notes following RCW 74.09.010.

**Effective date—1991 sp.s. c 4:** See note following RCW 70.47.030.

**RCW 70.47.115 Enrollment of persons in timber impact areas.** (1) The *administrator, when specific funding is provided and where feasible, shall make the basic health plan available in timber impact areas. The *administrator shall prioritize making the plan available under this section to the timber impact areas meeting the following criteria, as determined by the employment security department: (a) A lumber and wood products employment location quotient at or above the state average; (b) a direct lumber and wood products job loss of one hundred positions or more; and (c) an annual unemployment rate twenty percent above the state average.

(2) Persons assisted under this section shall meet the requirements of enrollee as defined in **RCW 70.47.020(4).

(3) For purposes of this section, "timber impact area" means:

(a) A county having a population of less than five hundred thousand, or a city or town located within a county having a population of less than five hundred thousand, and meeting two of the following three criteria, as determined by the employment security department, for the most recent year such data is available: (i) A lumber and wood products employment location quotient at or above the state average; (ii) projected or actual direct lumber and wood products job losses of one hundred positions or more, except counties having a population greater than two hundred thousand but less than five hundred thousand must have direct lumber and wood products job losses of one thousand positions or more; or (iii) an annual unemployment rate twenty percent or more above the state average; or

(b) Additional communities as the economic recovery coordinating board, established in ***RCW 43.31.631, designates based on a finding by the board that each designated community is socially and economically integrated with areas that meet the definition of a timber impact area under (a) of this subsection. [1992 c 21 s 7; 1991 c 315 s 22.]

**Reviser's note:** *(1) The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**(2) RCW 70.47.020 was amended by 2004 c 192 s 1, changing subsection (4) to subsection (6), effective January 1, 2005. RCW 70.47.020 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsection (6) to subsection (9). RCW 70.47.020 was subsequently amended by 2011 1st sp.s. c 9 s 3, changing subsection (9) to subsection (10).

***(3) RCW 43.31.631 was repealed by 1995 c 226 s 33 and 1995 c 269 s 1902, effective July 1, 1995.

**Intent—1991 c 315:** See note following RCW 28B.50.030.

**Conflict with federal requirements—1991 c 315:** See RCW 50.70.901.

**RCW 70.47.120 Administrator—Contracts for services.** In addition to the powers and duties specified in RCW 70.47.040 and 70.47.060, the *administrator has the power to enter into contracts for the following functions and services:

(1) With public or private agencies, to assist the *administrator in her or his duties to design or revise the schedule of covered basic health care services, and/or to monitor or evaluate the performance of participating managed health care systems.

(2) With public or private agencies, to provide technical or professional assistance to health care providers, particularly public or private nonprofit organizations and providers serving rural areas, who show serious intent and apparent capability to participate in the plan as managed health care systems.

(3) With public or private agencies, including health care service contractors registered under RCW 48.44.015, and doing business in the state, for marketing and administrative services in connection with participation of managed health care systems, enrollment of enrollees, billing and collection services to the *administrator, and other administrative functions ordinarily performed by health care service contractors, other than insurance. Any activities of a health care service contractor pursuant to a contract with the *administrator

under this section shall be exempt from the provisions and requirements of Title 48 RCW except that persons appointed or authorized to solicit applications for enrollment in the basic health plan shall comply with chapter 48.17 RCW. [1997 c 337 s 7; 1987 1st ex.s. c 5 s 14.]

***Reviser's note:** The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**RCW 70.47.130 Exemption from insurance code.** (1) The activities and operations of the Washington basic health plan under this chapter, including those of managed health care systems to the extent of their participation in the plan, are exempt from the provisions and requirements of Title 48 RCW except:

(a) Benefits as provided in RCW 70.47.070;

(b) Managed health care systems are subject to the provisions of RCW 48.43.022, 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545, 48.43.550, 70.02.110, and 70.02.900;

(c) Persons appointed or authorized to solicit applications for enrollment in the basic health plan, including employees of the health care authority, must comply with chapter 48.17 RCW. For purposes of this subsection (1)(c), "solicit" does not include distributing information and applications for the basic health plan and responding to questions;

(d) Amounts paid to a managed health care system by the basic health plan for participating in the basic health plan and providing health care services for nonsubsidized enrollees in the basic health plan must comply with RCW 48.14.0201; and

(e) Administrative simplification requirements as provided in chapter 298, Laws of 2009.

(2) The purpose of the 1994 amendatory language to this section in chapter 309, Laws of 1994 is to clarify the intent of the legislature that premiums paid on behalf of nonsubsidized enrollees in the basic health plan are subject to the premium and prepayment tax. The legislature does not consider this clarifying language to either raise existing taxes nor to impose a tax that did not exist previously. [2016 c 139 s 5; 2009 c 298 s 4; 2004 c 115 s 2; 2000 c 5 s 21; 1997 c 337 s 8; 1994 c 309 s 6; 1987 1st ex.s. c 5 s 15.]

**Intent—Purpose—2000 c 5:** See RCW 48.43.500.

**Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5:** See notes following RCW 48.43.500.

**Contingency—1994 c 309 ss 5 and 6:** See note following RCW 70.47.060.

**RCW 70.47.140 Reservation of legislative power.** The legislature reserves the right to amend or repeal all or any part of this chapter at any time and there shall be no vested private right of any kind against such amendment or repeal. All the rights, privileges, or immunities conferred by this chapter or any acts done pursuant thereto shall exist subject to the power of the legislature to amend or repeal this chapter at any time. [1987 1st ex.s. c 5 s 2.]

**RCW 70.47.150 Confidentiality.** Notwithstanding the provisions of chapter 42.56 RCW, (1) records obtained, reviewed by, or on file with the plan containing information concerning medical treatment of individuals shall be exempt from public inspection and copying; and (2) actuarial formulas, statistics, and assumptions submitted in support of a rate filing by a managed health care system or submitted to the *administrator upon his or her request shall be exempt from public inspection and copying in order to preserve trade secrets or prevent unfair competition. [2005 c 274 s 336; 1990 c 54 s 1.]

***Reviser's note:** The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**RCW 70.47.160 Right of individuals to receive services—Right of providers, carriers, and facilities to refuse to participate in or pay for services for reason of conscience or religion—Requirements.** (1) The legislature recognizes that every individual possesses a fundamental right to exercise their religious beliefs and conscience. The legislature further recognizes that in developing public policy, conflicting religious and moral beliefs must be respected. Therefore, while recognizing the right of conscientious objection to participating in specific health services, the state shall also recognize the right of individuals enrolled with the basic health plan to receive the full range of services covered under the basic health plan.

(2)(a) No individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstances to participate in the provision of or payment for a specific service if they object to so doing for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objection.

(b) The provisions of this section are not intended to result in an enrollee being denied timely access to any service included in the basic health plan. Each health carrier shall:

(i) Provide written notice to enrollees, upon enrollment with the plan, listing services that the carrier refuses to cover for reason of conscience or religion;

(ii) Provide written information describing how an enrollee may directly access services in an expeditious manner; and

(iii) Ensure that enrollees refused services under this section have prompt access to the information developed pursuant to (b)(ii) of this subsection.

(c) The *administrator shall establish a mechanism or mechanisms to recognize the right to exercise conscience while ensuring enrollees timely access to services and to assure prompt payment to service providers.

(3)(a) No individual or organization with a religious or moral tenet opposed to a specific service may be required to purchase coverage for that service or services if they object to doing so for reason of conscience or religion.

(b) The provisions of this section shall not result in an enrollee being denied coverage of, and timely access to, any service or services excluded from their benefits package as a result of their employer's or another individual's exercise of the conscience clause in (a) of this subsection.

(c) The *administrator shall define the process through which health carriers may offer the basic health plan to individuals and organizations identified in (a) and (b) of this subsection in accordance with the provisions of subsection (2)(c) of this section.

(4) Nothing in this section requires the health care authority, health carriers, health care facilities, or health care providers to provide any basic health plan service without payment of appropriate premium share or enrollee cost sharing. [1995 c 266 s 3.]

***Reviser's note:** The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**Effective date—1995 c 266:** See note following RCW 70.47.060.

**RCW 70.47.170 Annual reporting requirement.** (1) Beginning in November 2012, the health care authority, in coordination with the department of social and health services, shall by November 15th of each year report to the legislature:

(a) The number of basic health plan enrollees who: (i) Upon enrollment or recertification had reported being employed, and beginning with the 2008 report, the month and year they reported being hired; or (ii) upon enrollment or recertification had reported being the dependent of someone who was employed, and beginning with the 2008 report, the month and year they reported the employed person was hired; and (iii) the total cost to the state for these enrollees. The information shall be reported by employer size for employers having more than fifty employees as enrollees or with dependents as enrollees. This information shall be provided for the preceding January and June of that year.

(b) The following aggregated information: (i) The number of employees who are enrollees or with dependents as enrollees by private and governmental employers; (ii) the number of employees who are enrollees or with dependents as enrollees by employer size for employers with fifty or fewer employees, fifty-one to one hundred employees, one hundred one to one thousand employees, one thousand one to five thousand employees and more than five thousand employees; and (iii) the number of employees who are enrollees or with dependents as enrollees by industry type.

(2) For each aggregated classification, the report will include the number of hours worked and total cost to the state for these enrollees. This information shall be for each quarter of the preceding year. [2009 c 568 s 7; 2006 c 264 s 1.]

**RCW 70.47.200 Mental health services—Definition—Coverage required, when.** (1) For the purposes of this section, "mental health services" means:

(a) For any schedule of benefits established or renewed by the Washington basic health plan before January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be determined by the director, by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and

services: (i) Substance related disorders; (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and (iv) court ordered treatment, unless the Washington basic health plan's or contracted managed health care system's medical director or designee determines the treatment to be medically necessary; and

(b) For any schedule of benefits established or renewed by the Washington basic health plan on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental health or substance use disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be determined by the director by rule, consistent with the purposes of chapter 6, Laws of 2005.

(2) Any schedule of benefits established or renewed by the Washington basic health plan shall provide coverage for:

(a) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the schedule of benefits. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the schedule of benefits imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the schedule of benefits imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and

(b) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered under the schedule of benefits.

(3) This section does not prohibit a requirement that mental health services be medically necessary, if a comparable requirement is applicable to medical and surgical services.

(4) Nothing in this section shall be construed to prevent the management of mental health services if a comparable requirement is applicable to medical and surgical services. [2020 c 228 s 7; 2005 c 6 s 6.]

**Findings—Intent—Severability—2005 c 6:** See notes following RCW 41.05.600.

**RCW 70.47.201 Mental health services—Rules.** The *administrator may adopt rules to implement RCW 70.47.200. [2005 c 6 s 11.]

***Reviser's note:** The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 s 83.

**Findings—Intent—Severability—2005 c 6:** See notes following RCW 41.05.600.

**RCW 70.47.210 Prostate cancer screening.** ***(Effective until June 30, 2027.)*** (1) Any schedule of benefits established or renewed by the Washington basic health plan after December 31, 2006, shall provide coverage for prostate cancer screening, provided that the screening is delivered upon the recommendation of the patient's physician, *advanced registered nurse practitioner, or physician assistant.

(2) This section shall not be construed to prevent the application of standard policy provisions applicable to other benefits, such as deductible or copayment provisions. This section does not limit the authority of the health care authority to negotiate rates and contract with specific providers for the delivery of prostate cancer screening services. [2006 c 367 s 7.]

***Reviser's note:** The term "advanced registered nurse practitioner" was changed to "advanced practice registered nurse" by 2024 c 239 s 1, effective June 30, 2027.

**RCW 70.47.210 Prostate cancer screening.** ***(Effective June 30, 2027.)*** (1) Any schedule of benefits established or renewed by the Washington basic health plan after December 31, 2006, shall provide coverage for prostate cancer screening, provided that the screening is delivered upon the recommendation of the patient's physician, advanced practice registered nurse, or physician assistant.

(2) This section shall not be construed to prevent the application of standard policy provisions applicable to other benefits, such as deductible or copayment provisions. This section does not limit the authority of the health care authority to negotiate rates and contract with specific providers for the delivery of prostate cancer screening services. [2025 c 58 s 5134; 2006 c 367 s 7.]

**Effective date—2025 c 58 ss 5058-5170:** See note following RCW 7.68.030.

**Explanatory note—2025 c 58:** See note following RCW 1.16.050.

**RCW 70.47.220 Increase in reimbursement rates not applicable.** The increases in inpatient and outpatient reimbursement rates included in chapter 74.60 RCW shall not be reflected in hospital payment rates for services provided to basic health enrollees under this chapter. [2010 1st sp.s. c 30 s 15.]

**RCW 70.47.240 Discontinuation of health coverage—Preexisting condition.** If a person was previously enrolled in a group health benefit plan, an individual health benefit plan, or a catastrophic health plan that is discontinued by the carrier by July 1, 2012, at any time during the sixty-three day period immediately preceding their application date for nonsubsidized coverage in the basic health plan as a nonsubsidized enrollee, the basic health plan must credit the applicant's period of prior coverage toward any preexisting condition

waiting period applicable under the basic health plan if the benefits under the previous plan provide equivalent or greater overall benefit coverage than that provided in the basic health plan for nonsubsidized enrollees. [2012 c 64 s 3.]

**Effective date—2012 c 64:** "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 takes effect immediately [March 23, 2012]." [2012 c 64 s 4.]

**RCW 70.47.250 Federal basic health option—Report to legislature—Certification—Director's findings—Program's guiding principles.** (1) On or before December 1, 2012, the director of the health care authority shall submit a report to the legislature on whether to proceed with implementation of a federal basic health option, under section 1331 of P.L. 111-148 of 2010, as amended. The report shall address whether:

(a) Sufficient funding is available to support the design and development work necessary for the program to provide health coverage to enrollees beginning January 1, 2014;

(b) Anticipated federal funding under section 1331 will be sufficient, absent any additional state funding, to cover the provision of essential health benefits and costs for administering the basic health plan. Enrollee premium levels will be below the levels that would apply to persons with income between one hundred thirty-four and two hundred percent of the federal poverty level through the exchange; and

(c) Health plan payment rates will be sufficient to ensure enrollee access to a robust provider network and health homes, as described under RCW 70.47.100.

(2) If the legislature determines to proceed with implementation of a federal basic health option, the director shall provide the necessary certifications to the secretary of the federal department of health and human services under section 1331 of P.L. 111-148 of 2010, as amended, to proceed with adoption of the federal basic health program option.

(3) Prior to making this finding, the director shall:

(a) Actively consult with the board of the Washington health benefit exchange, the office of the insurance commissioner, consumer advocates, provider organizations, carriers, and other interested organizations;

(b) Consider any available objective analysis specific to Washington state, by an independent nationally recognized consultant that has been actively engaged in analysis and economic modeling of the federal basic health program option for multiple states.

(4) The director shall report any findings and supporting analysis made under this section to the governor and relevant policy and fiscal committees of the legislature.

(5) To the extent funding is available specifically for this purpose in the operating budget, the health care authority shall assume the federal basic health plan option will be implemented in Washington state, and initiate the necessary design and development work. If the legislature determines under subsection (1) of this section not to proceed with implementation, the authority may cease activities related to basic health program implementation.

(6) If implemented, the federal basic health program must be guided by the following principles:

(a) Meeting the minimum state certification standards in section 1331 of the federal patient protection and affordable care act;

(b) To the extent allowed by the federal department of health and human services, twelve-month continuous eligibility for the basic health program, and corresponding twelve-month continuous enrollment in standard health plans by enrollees; or, in lieu of twelve-month continuous eligibility, financing mechanisms that enable enrollees to remain with a plan for the entire plan year;

(c) Achieving an appropriate balance between:

(i) Premiums and cost-sharing minimized to increase the affordability of insurance coverage;

(ii) Standard health plan contracting requirements that minimize plan and provider administrative costs, while incentivizing improvements in quality and enrollee health outcomes; and

(iii) Health plan payment rates and provider payment rates that are sufficient to ensure enrollee access to a robust provider network and health homes, as described under RCW 70.47.100; and

(d) Transparency in program administration, including active and ongoing consultation with basic health program enrollees and interested organizations, and ensuring adequate enrollee notice and appeal rights. [2012 c 87 s 15.]

**Spiritual care services—2012 c 87:** See RCW 43.71.901.

**RCW 70.47.900 Short title.** This chapter shall be known and may be cited as the health care access act of 1987. [1987 1st ex.s. c 5 s 1.]

**RCW 70.47.902 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.** For the purposes of this chapter, the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family shall be interpreted as applying equally to state registered domestic partnerships or individuals in state registered domestic partnerships as well as to marital relationships and married persons, and references to dissolution of marriage shall apply equally to state registered domestic partnerships that have been terminated, dissolved, or invalidated, to the extent that such interpretation does not conflict with federal law. Where necessary to implement chapter 521, Laws of 2009, gender-specific terms such as husband and wife used in any statute, rule, or other law shall be construed to be gender neutral, and applicable to individuals in state registered domestic partnerships. [2009 c 521 s 151.]

**Effective dates—2009 c 521 ss 5-8, 79, 87-103, 107, 151, 165, 166, 173-175, and 190-192:** See note following RCW 2.10.900.