

# HLTC Striking amendment for E2SHB 2319

Color: Gray

Offered by Senator Keiser

## **EFFECT of Amendment: (changes to house bill)**

- Inserts the definition of "self-sustaining" for the Exchange
- Removes changes to the Exchange board members
- Inserts additional reference to Exchange employees participating in the PERS and PEBB programs
- Modifies market rules:
  - Inserts the requirement that a carrier offering a small group health benefit plan must offer the identical plan inside and outside the market
  - Removes the trigger for the OIC to write rules on the bronze plan offerings inside and outside if there is adverse selection or inadequate choice, requiring the delay of one session before rules can go into effect
  - Allows the OIC, in consultation with the exchange and HCA, to adopt rules requiring a carrier to offer Bronze outside the Exchange if they offer Bronze inside the Exchange.
  - Requires the Exchange Board, in consultation with OIC, to complete a review of the market rules and recommend to the Legislature by December 1, 2016, whether to maintain or sunset the market rules.
  - The Exchange Board, in consultation with the OIC, may authorize the offering of a public option if the Board finds consumers do have an adequate choice of health plan options
- Qualified Health Plans:
  - the criteria for a plan to include tribal clinics as essential community providers is modified - if consistent with federal law integrated delivery system shall be exempt (vs may be) from the requirement to include ("all" is removed) essential community providers
  - the protection of privacy of patient's personal health information is removed from the list of rating factors the Board may include in the consumer rating guide
- Essential Health Benefits:
  - It is clarified that the selection of the benchmark plan for essential health benefits is for the individual and small group market
  - The benefits needed to supplement the benchmark plan must be to meet the "minimum" requirements of the ACA
  - When determining if a health plan is offering benefits substantially equal to the benchmark plan, the OIC "may" consider whether the plan has a benefit design that would create a risk of biased selection based on health status (*vs. must ensure the plan does not*)
- Basic Health Option:
  - Changes the date to 2013 (vs 2012) for the Governor to determine there is insufficient federal funding
  - Inserts reference to provider rates that exceed 2012 Medicaid payment rates (in addition to plan rates)
- Reinsurance and Risk Adjustment:
  - The OIC must include analysis of an invisible high risk pool option, in which the full premium and risk associated with certain high risk or high cost enrollees would be ceded to the transitional reinsurance program, to determine if the option would be allowed under the federal reinsurance regulations, whether the option would provide sufficiently comprehensive coverage, and how the option would be designed to ensure carriers ceding risk provide effective care management to high risk or high cost enrollees
  - The differential compensation for risk inside the Exchange and outside the Exchange is removed.

- Rules must identify the data needed to support operation of the reinsurance and risk adjustment programs and requirements related to the collection, validation, interpretation, and retention of the data.
- Removes reference for the rules to include requirements to encourage appropriate cost management measures by carriers such as care management or care coordination
- WSHIP:
  - The WSHIP analysis on the pool assessments shall also recommend whether the categories of members paying assessments should be adjusted to make the assessment fair and equitable among all payers.
  - The pool may contract with OIC to administer risk management functions; prior to entering into a contract, the pool may conduct pre-operational and planning activities
  - Reasonable costs for pre-operational and planning activities may be reimbursed from federal funds or from assessments collected to pay the administrative costs of the reinsurance program
  - If the pool contracts to administer and coordinate the reinsurance or risk adjustment program, the Board must submit recommendations to the Legislature for additional Board members
  - The section establishing the premium rating requirements for 2014 is removed.
- An emergency clause is added for the sections allowing Exchange employees to participate in the PERS and PEBB programs since they will be employed in March prior to the regular June 7 effective date.

**E2SHB 2319** - S COMM AMD

By Committee on Health & Long-Term Care

1 Strike everything after the enacting clause and insert the  
2 following:

3 "PART I  
4 DEFINITIONS

5 **Sec. 1.** RCW 48.43.005 and 2011 c 315 s 2 and 2011 c 314 s 3 are  
6 each reenacted and amended to read as follows:

7 Unless otherwise specifically provided, the definitions in this  
8 section apply throughout this chapter.

9 (1) "Adjusted community rate" means the rating method used to  
10 establish the premium for health plans adjusted to reflect actuarially  
11 demonstrated differences in utilization or cost attributable to  
12 geographic region, age, family size, and use of wellness activities.

13 (2) "Adverse benefit determination" means a denial, reduction, or  
14 termination of, or a failure to provide or make payment, in whole or in  
15 part, for a benefit, including a denial, reduction, termination, or  
16 failure to provide or make payment that is based on a determination of  
17 an enrollee's or applicant's eligibility to participate in a plan, and  
18 including, with respect to group health plans, a denial, reduction, or  
19 termination of, or a failure to provide or make payment, in whole or in  
20 part, for a benefit resulting from the application of any utilization  
21 review, as well as a failure to cover an item or service for which  
22 benefits are otherwise provided because it is determined to be  
23 experimental or investigational or not medically necessary or  
24 appropriate.

25 (3) "Applicant" means a person who applies for enrollment in an  
26 individual health plan as the subscriber or an enrollee, or the  
27 dependent or spouse of a subscriber or enrollee.

28 (4) "Basic health plan" means the plan described under chapter  
29 70.47 RCW, as revised from time to time.

1 (5) "Basic health plan model plan" means a health plan as required  
2 in RCW 70.47.060(2)(e).

3 (6) "Basic health plan services" means that schedule of covered  
4 health services, including the description of how those benefits are to  
5 be administered, that are required to be delivered to an enrollee under  
6 the basic health plan, as revised from time to time.

7 (7) "Board" means the governing board of the Washington health  
8 benefit exchange established in chapter 43.71 RCW.

9 (8)(a) For grandfathered health benefit plans issued before January  
10 1, 2014, and renewed thereafter, "catastrophic health plan" means:

11 ~~((a))~~ (i) In the case of a contract, agreement, or policy  
12 covering a single enrollee, a health benefit plan requiring a calendar  
13 year deductible of, at a minimum, one thousand seven hundred fifty  
14 dollars and an annual out-of-pocket expense required to be paid under  
15 the plan (other than for premiums) for covered benefits of at least  
16 three thousand five hundred dollars, both amounts to be adjusted  
17 annually by the insurance commissioner; and

18 ~~((b))~~ (ii) In the case of a contract, agreement, or policy  
19 covering more than one enrollee, a health benefit plan requiring a  
20 calendar year deductible of, at a minimum, three thousand five hundred  
21 dollars and an annual out-of-pocket expense required to be paid under  
22 the plan (other than for premiums) for covered benefits of at least six  
23 thousand dollars, both amounts to be adjusted annually by the insurance  
24 commissioner(~~or~~

25 ~~(c) Any health benefit plan that provides benefits for hospital~~  
26 ~~inpatient and outpatient services, professional and prescription drugs~~  
27 ~~provided in conjunction with such hospital inpatient and outpatient~~  
28 ~~services, and excludes or substantially limits outpatient physician~~  
29 ~~services and those services usually provided in an office setting)).~~

30 (b) In July 2008, and in each July thereafter, the insurance  
31 commissioner shall adjust the minimum deductible and out-of-pocket  
32 expense required for a plan to qualify as a catastrophic plan to  
33 reflect the percentage change in the consumer price index for medical  
34 care for a preceding twelve months, as determined by the United States  
35 department of labor. The adjusted amount shall apply on the following  
36 January 1st.

37 (c) For health benefit plans issued on or after January 1, 2014,  
38 "catastrophic health plan" means:

1        (i) A health benefit plan that meets the definition of catastrophic  
2 plan set forth in section 1302(e) of P.L. 111-148 of 2010, as amended;  
3 or

4        (ii) A health benefit plan offered outside the exchange marketplace  
5 that requires a calendar year deductible or out-of-pocket expenses  
6 under the plan, other than for premiums, for covered benefits, that  
7 meets or exceeds the commissioner's annual adjustment under (b) of this  
8 subsection.

9        ~~((+8+))~~ (9) "Certification" means a determination by a review  
10 organization that an admission, extension of stay, or other health care  
11 service or procedure has been reviewed and, based on the information  
12 provided, meets the clinical requirements for medical necessity,  
13 appropriateness, level of care, or effectiveness under the auspices of  
14 the applicable health benefit plan.

15        ~~((+9+))~~ (10) "Concurrent review" means utilization review conducted  
16 during a patient's hospital stay or course of treatment.

17        ~~((+10+))~~ (11) "Covered person" or "enrollee" means a person covered  
18 by a health plan including an enrollee, subscriber, policyholder,  
19 beneficiary of a group plan, or individual covered by any other health  
20 plan.

21        ~~((+11+))~~ (12) "Dependent" means, at a minimum, the enrollee's legal  
22 spouse and dependent children who qualify for coverage under the  
23 enrollee's health benefit plan.

24        ~~((+12+))~~ (13) "Emergency medical condition" means a medical  
25 condition manifesting itself by acute symptoms of sufficient severity,  
26 including severe pain, such that a prudent layperson, who possesses an  
27 average knowledge of health and medicine, could reasonably expect the  
28 absence of immediate medical attention to result in a condition (a)  
29 placing the health of the individual, or with respect to a pregnant  
30 woman, the health of the woman or her unborn child, in serious  
31 jeopardy, (b) serious impairment to bodily functions, or (c) serious  
32 dysfunction of any bodily organ or part.

33        ~~((+13+))~~ (14) "Emergency services" means a medical screening  
34 examination, as required under section 1867 of the social security act  
35 (42 U.S.C. 1395dd), that is within the capability of the emergency  
36 department of a hospital, including ancillary services routinely  
37 available to the emergency department to evaluate that emergency  
38 medical condition, and further medical examination and treatment, to

1 the extent they are within the capabilities of the staff and facilities  
2 available at the hospital, as are required under section 1867 of the  
3 social security act (42 U.S.C. 1395dd) to stabilize the patient.  
4 Stabilize, with respect to an emergency medical condition, has the  
5 meaning given in section 1867(e)(3) of the social security act (42  
6 U.S.C. 1395dd(e)(3)).

7 ~~((+14))~~ (15) "Employee" has the same meaning given to the term, as  
8 of January 1, 2008, under section 3(6) of the federal employee  
9 retirement income security act of 1974.

10 ~~((+15))~~ (16) "Enrollee point-of-service cost-sharing" means  
11 amounts paid to health carriers directly providing services, health  
12 care providers, or health care facilities by enrollees and may include  
13 copayments, coinsurance, or deductibles.

14 ~~((+16))~~ (17) "Exchange" means the Washington health benefit  
15 exchange established under chapter 43.71 RCW.

16 (18) "Final external review decision" means a determination by an  
17 independent review organization at the conclusion of an external  
18 review.

19 ~~((+17))~~ (19) "Final internal adverse benefit determination" means  
20 an adverse benefit determination that has been upheld by a health plan  
21 or carrier at the completion of the internal appeals process, or an  
22 adverse benefit determination with respect to which the internal  
23 appeals process has been exhausted under the exhaustion rules described  
24 in RCW 48.43.530 and 48.43.535.

25 ~~((+18))~~ (20) "Grandfathered health plan" means a group health plan  
26 or an individual health plan that under section 1251 of the patient  
27 protection and affordable care act, P.L. 111-148 (2010) and as amended  
28 by the health care and education reconciliation act, P.L. 111-152  
29 (2010) is not subject to subtitles A or C of the act as amended.

30 ~~((+19))~~ (21) "Grievance" means a written complaint submitted by or  
31 on behalf of a covered person regarding: (a) Denial of payment for  
32 medical services or nonprovision of medical services included in the  
33 covered person's health benefit plan, or (b) service delivery issues  
34 other than denial of payment for medical services or nonprovision of  
35 medical services, including dissatisfaction with medical care, waiting  
36 time for medical services, provider or staff attitude or demeanor, or  
37 dissatisfaction with service provided by the health carrier.

1        ~~((+20+))~~ (22) "Health care facility" or "facility" means hospices  
2 licensed under chapter 70.127 RCW, hospitals licensed under chapter  
3 70.41 RCW, rural health care facilities as defined in RCW 70.175.020,  
4 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes  
5 licensed under chapter 18.51 RCW, community mental health centers  
6 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment  
7 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,  
8 treatment, or surgical facilities licensed under chapter 70.41 RCW,  
9 drug and alcohol treatment facilities licensed under chapter 70.96A  
10 RCW, and home health agencies licensed under chapter 70.127 RCW, and  
11 includes such facilities if owned and operated by a political  
12 subdivision or instrumentality of the state and such other facilities  
13 as required by federal law and implementing regulations.

14        ~~((+21+))~~ (23) "Health care provider" or "provider" means:

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

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

20        ~~((+22+))~~ (24) "Health care service" means that service offered or  
21 provided by health care facilities and health care providers relating  
22 to the prevention, cure, or treatment of illness, injury, or disease.

23        ~~((+23+))~~ (25) "Health carrier" or "carrier" means a disability  
24 insurer regulated under chapter 48.20 or 48.21 RCW, a health care  
25 service contractor as defined in RCW 48.44.010, or a health maintenance  
26 organization as defined in RCW 48.46.020, and includes "issuers" as  
27 that term is used in the patient protection and affordable care act  
28 (P.L. 111-148).

29        ~~((+24+))~~ (26) "Health plan" or "health benefit plan" means any  
30 policy, contract, or agreement offered by a health carrier to provide,  
31 arrange, reimburse, or pay for health care services except the  
32 following:

33        (a) Long-term care insurance governed by chapter 48.84 or 48.83  
34 RCW;

35        (b) Medicare supplemental health insurance governed by chapter  
36 48.66 RCW;

37        (c) Coverage supplemental to the coverage provided under chapter  
38 55, Title 10, United States Code;

1 (d) Limited health care services offered by limited health care  
2 service contractors in accordance with RCW 48.44.035;

3 (e) Disability income;

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

7 (g) Workers' compensation coverage;

8 (h) Accident only coverage;

9 (i) Specified disease or illness-triggered fixed payment insurance,  
10 hospital confinement fixed payment insurance, or other fixed payment  
11 insurance offered as an independent, noncoordinated benefit;

12 (j) Employer-sponsored self-funded health plans;

13 (k) Dental only and vision only coverage; and

14 (l) Plans deemed by the insurance commissioner to have a short-term  
15 limited purpose or duration, or to be a student-only plan that is  
16 guaranteed renewable while the covered person is enrolled as a regular  
17 full-time undergraduate or graduate student at an accredited higher  
18 education institution, after a written request for such classification  
19 by the carrier and subsequent written approval by the insurance  
20 commissioner.

21 ~~((+25))~~ (27) "Material modification" means a change in the  
22 actuarial value of the health plan as modified of more than five  
23 percent but less than fifteen percent.

24 ~~((+26))~~ (28) "Open enrollment" means a period of time as defined  
25 in rule to be held at the same time each year, during which applicants  
26 may enroll in a carrier's individual health benefit plan without being  
27 subject to health screening or otherwise required to provide evidence  
28 of insurability as a condition for enrollment.

29 ~~((+27))~~ (29) "Preexisting condition" means any medical condition,  
30 illness, or injury that existed any time prior to the effective date of  
31 coverage.

32 ~~((+28))~~ (30) "Premium" means all sums charged, received, or  
33 deposited by a health carrier as consideration for a health plan or the  
34 continuance of a health plan. Any assessment or any "membership,"  
35 "policy," "contract," "service," or similar fee or charge made by a  
36 health carrier in consideration for a health plan is deemed part of the  
37 premium. "Premium" shall not include amounts paid as enrollee point-  
38 of-service cost-sharing.

1        ~~((+29+))~~ (31) "Review organization" means a disability insurer  
2 regulated under chapter 48.20 or 48.21 RCW, health care service  
3 contractor as defined in RCW 48.44.010, or health maintenance  
4 organization as defined in RCW 48.46.020, and entities affiliated with,  
5 under contract with, or acting on behalf of a health carrier to perform  
6 a utilization review.

7        ~~((+30+))~~ (32) "Small employer" or "small group" means any person,  
8 firm, corporation, partnership, association, political subdivision,  
9 sole proprietor, or self-employed individual that is actively engaged  
10 in business that employed an average of at least one but no more than  
11 fifty employees, during the previous calendar year and employed at  
12 least one employee on the first day of the plan year, is not formed  
13 primarily for purposes of buying health insurance, and in which a bona  
14 fide employer-employee relationship exists. In determining the number  
15 of employees, companies that are affiliated companies, or that are  
16 eligible to file a combined tax return for purposes of taxation by this  
17 state, shall be considered an employer. Subsequent to the issuance of  
18 a health plan to a small employer and for the purpose of determining  
19 eligibility, the size of a small employer shall be determined annually.  
20 Except as otherwise specifically provided, a small employer shall  
21 continue to be considered a small employer until the plan anniversary  
22 following the date the small employer no longer meets the requirements  
23 of this definition. A self-employed individual or sole proprietor who  
24 is covered as a group of one must also: (a) Have been employed by the  
25 same small employer or small group for at least twelve months prior to  
26 application for small group coverage, and (b) verify that he or she  
27 derived at least seventy-five percent of his or her income from a trade  
28 or business through which the individual or sole proprietor has  
29 attempted to earn taxable income and for which he or she has filed the  
30 appropriate internal revenue service form 1040, schedule C or F, for  
31 the previous taxable year, except a self-employed individual or sole  
32 proprietor in an agricultural trade or business, must have derived at  
33 least fifty-one percent of his or her income from the trade or business  
34 through which the individual or sole proprietor has attempted to earn  
35 taxable income and for which he or she has filed the appropriate  
36 internal revenue service form 1040, for the previous taxable year.

37        ~~((+31+))~~ (33) "Special enrollment" means a defined period of time  
38 of not less than thirty-one days, triggered by a specific qualifying

1 event experienced by the applicant, during which applicants may enroll  
2 in the carrier's individual health benefit plan without being subject  
3 to health screening or otherwise required to provide evidence of  
4 insurability as a condition for enrollment.

5 ~~((+32+))~~ (34) "Standard health questionnaire" means the standard  
6 health questionnaire designated under chapter 48.41 RCW.

7 ~~((+33+))~~ (35) "Utilization review" means the prospective,  
8 concurrent, or retrospective assessment of the necessity and  
9 appropriateness of the allocation of health care resources and services  
10 of a provider or facility, given or proposed to be given to an enrollee  
11 or group of enrollees.

12 ~~((+34+))~~ (36) "Wellness activity" means an explicit program of an  
13 activity consistent with department of health guidelines, such as,  
14 smoking cessation, injury and accident prevention, reduction of alcohol  
15 misuse, appropriate weight reduction, exercise, automobile and  
16 motorcycle safety, blood cholesterol reduction, and nutrition education  
17 for the purpose of improving enrollee health status and reducing health  
18 service costs.

19 **PART II**

20 **THE WASHINGTON HEALTH BENEFIT EXCHANGE**

21 **Sec. 2.** RCW 43.71.010 and 2011 c 317 s 2 are each amended to read  
22 as follows:

23 The definitions in this section apply throughout this chapter  
24 unless the context clearly requires otherwise. Terms and phrases used  
25 in this chapter that are not defined in this section must be defined as  
26 consistent with implementation of a state health benefit exchange  
27 pursuant to the affordable care act.

28 (1) "Affordable care act" means the federal patient protection and  
29 affordable care act, P.L. 111-148, as amended by the federal health  
30 care and education reconciliation act of 2010, P.L. 111-152, or federal  
31 regulations or guidance issued under the affordable care act.

32 (2) "Authority" means the Washington state health care authority,  
33 established under chapter 41.05 RCW.

34 (3) "Board" means the governing board established in RCW 43.71.020.

35 (4) "Commissioner" means the insurance commissioner, established in  
36 Title 48 RCW.

1 (5) "Exchange" means the Washington health benefit exchange  
2 established in RCW 43.71.020.

3 (6) "Self-sustaining" means capable of operating without direct  
4 state tax subsidy. Self-sustaining sources include, but are not  
5 limited to, federal grants, federal premium tax subsidies and credits,  
6 charges to participating insurance carriers, and premiums paid by  
7 participating enrollees.

8 **Sec. 3.** RCW 43.71.020 and 2011 c 317 s 3 are each amended to read  
9 as follows:

10 (1) The Washington health benefit exchange is established and  
11 constitutes a self-sustaining public-private partnership separate and  
12 distinct from the state, exercising functions delineated in chapter  
13 317, Laws of 2011. The exchange shall be known as the evergreen health  
14 marketplace. By January 1, 2014, the exchange shall operate consistent  
15 with the affordable care act subject to statutory authorization. The  
16 exchange shall have a governing board consisting of persons with  
17 expertise in the Washington health care system and private and public  
18 health care coverage. The initial membership of the board shall be  
19 appointed as follows:

20 (a) By October 1, 2011, each of the two largest caucuses in both  
21 the house of representatives and the senate shall submit to the  
22 governor a list of five nominees who are not legislators or employees  
23 of the state or its political subdivisions, with no caucus submitting  
24 the same nominee.

25 (i) The nominations from the largest caucus in the house of  
26 representatives must include at least one employee benefit specialist;

27 (ii) The nominations from the second largest caucus in the house of  
28 representatives must include at least one health economist or actuary;

29 (iii) The nominations from the largest caucus in the senate must  
30 include at least one representative of health consumer advocates;

31 (iv) The nominations from the second largest caucus in the senate  
32 must include at least one representative of small business;

33 (v) The remaining nominees must have demonstrated and acknowledged  
34 expertise in at least one of the following areas: Individual health  
35 care coverage, small employer health care coverage, health benefits  
36 plan administration, health care finance and economics, actuarial

1 science, or administering a public or private health care delivery  
2 system.

3 (b) By December 15, 2011, the governor shall appoint two members  
4 from each list submitted by the caucuses under (a) of this subsection.  
5 The appointments made under this subsection (1)(b) must include at  
6 least one employee benefits specialist, one health economist or  
7 actuary, one representative of small business, and one representative  
8 of health consumer advocates. The remaining four members must have a  
9 demonstrated and acknowledged expertise in at least one of the  
10 following areas: Individual health care coverage, small employer  
11 health care coverage, health benefits plan administration, health care  
12 finance and economics, actuarial science, or administering a public or  
13 private health care delivery system.

14 (c) By December 15, 2011, the governor shall appoint a ninth member  
15 to serve as chair. The chair may not be an employee of the state or  
16 its political subdivisions. The chair shall serve as a nonvoting  
17 member except in the case of a tie.

18 (d) The following members shall serve as nonvoting, ex officio  
19 members of the board:

20 (i) The insurance commissioner or his or her designee; and

21 (ii) The administrator of the health care authority, or his or her  
22 designee.

23 (2) Initial members of the board shall serve staggered terms not to  
24 exceed four years. Members appointed thereafter shall serve two-year  
25 terms.

26 (3) A member of the board whose term has expired or who otherwise  
27 leaves the board shall be replaced by gubernatorial appointment. When  
28 the person leaving was nominated by one of the caucuses of the house of  
29 representatives or the senate, his or her replacement shall be  
30 appointed from a list of five nominees submitted by that caucus within  
31 thirty days after the person leaves. If the member to be replaced is  
32 the chair, the governor shall appoint a new chair within thirty days  
33 after the vacancy occurs. A person appointed to replace a member who  
34 leaves the board prior to the expiration of his or her term shall serve  
35 only the duration of the unexpired term. Members of the board may be  
36 reappointed to multiple terms.

37 (4) No board member may be appointed if his or her participation in  
38 the decisions of the board could benefit his or her own financial

1 interests or the financial interests of an entity he or she represents.  
2 A board member who develops such a conflict of interest shall resign or  
3 be removed from the board.

4 (5) Members of the board must be reimbursed for their travel  
5 expenses while on official business in accordance with RCW 43.03.050  
6 and 43.03.060. The board shall prescribe rules for the conduct of its  
7 business. Meetings of the board are at the call of the chair.

8 (6) The exchange and the board are subject only to the provisions  
9 of chapter 42.30 RCW, the open public meetings act, and chapter 42.56  
10 RCW, the public records act, and not to any other law or regulation  
11 generally applicable to state agencies. Consistent with the open  
12 public meetings act, the board may hold executive sessions to consider  
13 proprietary or confidential nonpublished information.

14 (7)(a) The board shall establish an advisory committee to allow for  
15 the views of the health care industry and other stakeholders to be  
16 heard in the operation of the health benefit exchange.

17 (b) The board may establish technical advisory committees or seek  
18 the advice of technical experts when necessary to execute the powers  
19 and duties included in chapter 317, Laws of 2011.

20 (8) Members of the board are not civilly or criminally liable and  
21 may not have any penalty or cause of action of any nature arise against  
22 them for any action taken or not taken, including any discretionary  
23 decision or failure to make a discretionary decision, when the action  
24 or inaction is done in good faith and in the performance of the powers  
25 and duties under chapter 317, Laws of 2011. Nothing in this section  
26 prohibits legal actions against the board to enforce the board's  
27 statutory or contractual duties or obligations.

28 (9) In recognition of the government-to-government relationship  
29 between the state of Washington and the federally recognized tribes in  
30 the state of Washington, the board shall consult with the American  
31 Indian health commission.

32 **Sec. 4.** RCW 43.71.030 and 2011 c 317 s 4 are each amended to read  
33 as follows:

34 (1) The exchange may, consistent with the purposes of this chapter:  
35 (a) Sue and be sued in its own name; (b) make and execute agreements,  
36 contracts, and other instruments, with any public or private person or  
37 entity; (c) employ, contract with, or engage personnel; (d) pay

1 administrative costs; ~~((and))~~ (e) accept grants, donations, loans of  
2 funds, and contributions in money, services, materials or otherwise,  
3 from the United States or any of its agencies, from the state of  
4 Washington and its agencies or from any other source, and use or expend  
5 those moneys, services, materials, or other contributions; (f)  
6 aggregate or delegate the aggregation of funds that comprise the  
7 premium for a health plan; and (g) complete other duties necessary to  
8 begin open enrollment in qualified health plans through the exchange  
9 beginning October 1, 2013.

10 (2) ~~((The powers and duties of the exchange and the board are~~  
11 ~~limited to those necessary to apply for and administer grants,~~  
12 ~~establish information technology infrastructure, and undertake~~  
13 ~~additional administrative functions necessary to begin operation of the~~  
14 ~~exchange by January 1, 2014. Any actions relating to substantive~~  
15 ~~issues included in RCW 43.71.040 must be consistent with statutory~~  
16 ~~direction on those issues.))~~ The exchange may charge and equitably  
17 apportion among participating carriers the administrative costs and  
18 expenses incurred consistent with the provisions of this chapter, and  
19 must develop the methodology to ensure the exchange is self-sustaining.

20 (3) The board shall establish policies that permit city and county  
21 governments, Indian tribes, tribal organizations, urban Indian  
22 organizations, private foundations, and other entities to pay premiums  
23 on behalf of qualified individuals.

24 (4) The employees of the exchange may participate in the public  
25 employees' retirement system under chapter 41.40 RCW and the public  
26 employees' benefits board under chapter 41.05 RCW.

27 (5) The exchange shall report its activities and status to the  
28 governor and the legislature as requested, and no less often than  
29 annually.

30 **Sec. 5.** RCW 43.71.060 and 2011 c 317 s 7 are each amended to read  
31 as follows:

32 (1) The health benefit exchange account is created in the custody  
33 of the state treasurer. All receipts from federal grants received  
34 under the affordable care act shall be deposited into the account.  
35 Expenditures from the account may be used only for purposes consistent  
36 with the grants. Until March 15, 2012, only the administrator of the  
37 health care authority, or his or her designee, may authorize

1 expenditures from the account. (~~Beginning March 15, 2012, only the~~  
2 ~~board of the Washington health benefit exchange may authorize~~  
3 ~~expenditures from the account.~~) The account is subject to allotment  
4 procedures under chapter 43.88 RCW, but an appropriation is not  
5 required for expenditures.

6 (2) This section expires January 1, 2014.

7 **PART III**  
8 **MARKET RULES**

9 NEW SECTION. **Sec. 6.** A new section is added to chapter 48.43 RCW  
10 to read as follows:

11 (1) For plan or policy years beginning January 1, 2014, a carrier  
12 must offer individual or small group health benefit plans outside the  
13 exchange that meet the definition of silver and gold level plans in  
14 section 1302 of P.L. 111-148 of 2010, as amended, if the carrier offers  
15 an individual or small group plan outside the exchange that meets the  
16 bronze level definition in section 1302 of P.L. 111-148 of 2010, as  
17 amended.

18 (2) A carrier offering a small group health benefit plan must offer  
19 the identical plan inside and outside the exchange.

20 (3) A health benefit plan meeting the definition of a catastrophic  
21 plan in RCW 48.43.005(8)(c)(i) may only be sold through the exchange.

22 (4) The commissioner, in consultation with the exchange and the  
23 health care authority, may adopt rules requiring a carrier to offer a  
24 plan that meets the definition of a bronze level plan outside the  
25 exchange if they offer a bronze level plan inside the exchange.

26 (5) By December 1, 2016, the exchange board, in consultation with  
27 the commissioner, must complete a review of the impact of subsections  
28 (1) through (4) of this section on the health and viability of the  
29 markets inside and outside the exchange and submit the recommendations  
30 to the legislature on the need to maintain or sunset the market rules.

31 (6) The commissioner shall evaluate plans offered at each actuarial  
32 value defined in section 1302 of P.L. 111-148 of 2010, as amended, and  
33 determine whether variation in prescription drug benefits, including  
34 cost-sharing, both inside and outside the exchange in both the  
35 individual and small group markets results in adverse selection. If

1 so, the commissioner may adopt rules to assure substantial equivalence  
2 of prescription drug cost-sharing.

3 (7) If the exchange board finds the consumers in the exchange do  
4 not have an adequate choice of health plan options among the actuarial  
5 value tiers specified in section 1302 of P.L. 111-148 of 2010, as  
6 amended, in the exchange, the exchange board in consultation with the  
7 commissioner, may authorize the offering of a public plan and pursue  
8 the opportunity for a waiver under section 1332 of P.L. 111-148 of  
9 2010, as amended.

10 NEW SECTION. **Sec. 7.** A new section is added to chapter 48.43 RCW  
11 to read as follows:

12 All health plans, other than catastrophic health plans, offered  
13 outside of the exchange must conform with the actuarial value tiers  
14 specified in section 1302 of P.L. 111-148 of 2010, as amended, as  
15 bronze, silver, gold, or platinum.

16 **PART IV**  
17 **QUALIFIED HEALTH PLANS**

18 NEW SECTION. **Sec. 8.** A new section is added to chapter 43.71 RCW  
19 to read as follows:

20 (1) The board shall certify a plan as a qualified health plan to be  
21 offered through the exchange if the plan:

22 (a) Is determined by the insurance commissioner to meet the  
23 requirements of Title 48 RCW and rules adopted by the commissioner  
24 pursuant to chapter 34.05 RCW;

25 (b) Is determined by the board to meet the requirements of the  
26 affordable care act for certification as a qualified health plan; and

27 (c) Is determined by the board to include tribal clinics and urban  
28 Indian clinics as essential community providers in the plan's provider  
29 network consistent with federal law. If consistent with federal law,  
30 integrated delivery systems shall be exempt from the requirement to  
31 include essential community providers in the provider network.

32 (2) Consistent with section 1311 of P.L. 111-148 of 2010, as  
33 amended, the board shall allow stand-alone dental plans to offer  
34 coverage in the exchange beginning January 1, 2014. Dental benefits

1 offered in the exchange must be offered and priced separately to assure  
2 transparency for consumers.

3 (3) Upon request by the board, a state agency shall provide  
4 information to the board for its use in determining if the requirements  
5 under subsection (1)(b) or (c) of this section have been met. Unless  
6 the agency and the board agree to a later date, the agency shall  
7 provide the information within sixty days of the request. The exchange  
8 shall reimburse the agency for the cost of compiling and providing the  
9 requested information within one hundred eighty days of its receipt.

10 (4) A decision by the board denying a request to certify or  
11 recertify a plan as a qualified health plan may be appealed according  
12 to procedures adopted by the board.

13 NEW SECTION. **Sec. 9.** A new section is added to chapter 43.71 RCW  
14 to read as follows:

15 The board shall establish a rating system for qualified health  
16 plans to assist consumers in evaluating plan choices in the exchange.  
17 Rating factors established by the board must include, but are not  
18 limited to:

19 (1) Affordability with respect to premiums, deductibles, and point-  
20 of-service cost-sharing;

21 (2) Enrollee satisfaction;

22 (3) Provider reimbursement methods that incentivize health homes or  
23 chronic care management or care coordination for enrollees with  
24 complex, high-cost, or multiple chronic conditions;

25 (4) Promotion of appropriate primary care and preventive services  
26 utilization;

27 (5) High standards for provider network adequacy, including  
28 consumer choice of providers and service locations and robust provider  
29 participation intended to improve access to underserved populations  
30 through participation of essential community providers, family planning  
31 providers and pediatric providers;

32 (6) High standards for covered services, including languages spoken  
33 or transportation assistance; and

34 (7) Coverage of benefits for spiritual care services that are  
35 deductible under section 213(d) of the internal revenue code.



1 **ESSENTIAL HEALTH BENEFITS**

2 NEW SECTION. **Sec. 13.** A new section is added to chapter 48.43 RCW  
3 to read as follows:

4 (1) Consistent with federal law, the commissioner, in consultation  
5 with the board and the health care authority, shall, by rule, select  
6 the largest small group plan in the state by enrollment shall be the  
7 benchmark plan for the individual and small group market for purposes  
8 of establishing the essential health benefits in Washington state under  
9 P.L. 111-148 of 2010, as amended.

10 (2) If the essential health benefits benchmark plan for the  
11 individual and small group market does not include all of the ten  
12 benefit categories specified by section 1302 of P.L. 111-148, as  
13 amended, the commissioner, in consultation with the board and the  
14 health care authority, shall, by rule, supplement the benchmark plan  
15 benefits as needed to meet the minimum requirements of section 1302.

16 (3) A health plan required to offer the essential health benefits,  
17 other than a health plan offered through the federal basic health  
18 program or medicaid, under P.L. 111-148 of 2010, as amended, may not be  
19 offered in the state unless the commissioner finds that it is  
20 substantially equal to the benchmark plan. When making this  
21 determination, the commissioner must ensure that the plan:

22 (a) Covers the ten essential health benefits categories specified  
23 in section 1302 of P.L. 111-148 of 2010, as amended; and

24 (b) May consider whether the health plan has a benefit design that  
25 would create a risk of biased selection based on health status and  
26 whether the health plan contains meaningful scope and level of benefits  
27 in each of the ten essential health benefits categories specified by  
28 section 1302 of P.L. 111-148 of 2010, as amended.

29 (4) Beginning December 15, 2012, and every year thereafter, the  
30 commissioner shall submit to the legislature a list of state-mandated  
31 health benefits, the enforcement of which will result in federally  
32 imposed costs to the state related to the plans sold through the  
33 exchange because the benefits are not included in the essential health  
34 benefits designated under federal law. The list must include the  
35 anticipated costs to the state of each state-mandated health benefit on  
36 the list. The commissioner may enforce a mandate on the list for the  
37 entire market only if funds are appropriated in an omnibus

1 appropriations act specifically to pay for the identified costs.  
2 During any period of time such funds are not appropriated, the mandate  
3 must be suspended for the entire market and may not be enforced by the  
4 commissioner.

5 NEW SECTION. **Sec. 14.** Nothing in this act prohibits the offering  
6 of benefits for spiritual care services deductible under section 213(d)  
7 of the internal revenue code in health plans inside and outside of the  
8 exchange.

9 **PART VI**

10 **THE BASIC HEALTH OPTION**

11 NEW SECTION. **Sec. 15.** A new section is added to chapter 70.47 RCW  
12 to read as follows:

13 (1) The director of the health care authority shall provide the  
14 necessary certifications to the secretary of the federal department of  
15 health and human services under section 1331 of P.L. 111-148 of 2010,  
16 as amended, for the purposes of Washington state's adoption of the  
17 federal basic health program option, unless, by September 1, 2013, the  
18 governor finds that:

19 (a) Anticipated federal funding under section 1331 will be  
20 insufficient, absent any additional funding from the state, to provide  
21 at least the essential health benefits to eligible individuals under  
22 section 1331 during the period of calendar years 2014 through 2019:

23 (i) At enrollee premium levels below the levels that would be  
24 applicable to persons with income between one hundred thirty-four and  
25 two hundred percent of the federal poverty level through the Washington  
26 health benefits exchange;

27 (ii) Using health plan payment rates that exceed 2012 medicaid  
28 payment rates for the same services and are sufficient to ensure access  
29 to care for enrollees and incentivize an adequate provider network, in  
30 conjunction with innovative payment methodologies and standard health  
31 plan performance measures that will create incentives for the use of  
32 effective cost containment and health care quality strategies; and

33 (iii) Assuming reasonable basic health program administrative costs  
34 and the potential impact of federal basic health plan program funding  
35 reconciliation under section 1331(d) of the affordable care act; and

1 (b) Sufficient funds are not available to support the design and  
2 development work necessary for the program to begin providing health  
3 coverage to enrollees beginning January 1, 2014.

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

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

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

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

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

18 (a) Meeting the minimum state certification standards in section  
19 1331 of the federal patient protection and affordable care act;

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

26 (c) Achieving an appropriate balance between:

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

29 (ii) Standard health plan contracting requirements that minimize  
30 plan and provider administrative costs, while holding standard health  
31 plans accountable for performance and enrollee health outcomes, and  
32 ensuring adequate enrollee notice and appeal rights; and

33 (iii) Health plan payment rates and provider payment rates that  
34 exceed the 2012 medicaid payment rates for the same services and are  
35 sufficient to ensure access to care for enrollees and incentivize an  
36 adequate provider network, in conjunction with innovative payment  
37 methodologies and standard health plan performance measures that will

1 create incentives for the use of effective cost containment and health  
2 care quality; and

3 (d) Transparency in program administration, including active and  
4 ongoing consultation with basic health program enrollees and interested  
5 organizations.

6 **PART VII**

7 **RISK ADJUSTMENT AND REINSURANCE**

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

10 (1)(a) The commissioner, in consultation with the board, shall  
11 adopt rules establishing the reinsurance and risk adjustment programs  
12 required by P.L. 111-148 of 2010, as amended.

13 (b) The commissioner must include in deliberations related to  
14 reinsurance rule making an analysis of an invisible high risk pool  
15 option, in which the full premium and risk associated with certain  
16 high-risk or high-cost enrollees would be ceded to the transitional  
17 reinsurance program. The analysis must include a determination as to  
18 whether that option would be allowed under the federal reinsurance  
19 program regulations, whether the option would provide sufficiently  
20 comprehensive coverage for current nonmedicare high risk pool  
21 enrollees, and how an invisible high risk pool option could be designed  
22 to ensure that carriers ceding risk provide effective care management  
23 to high-risk or high-cost enrollees.

24 (2) Consistent with federal law, the rules for the reinsurance  
25 program must, at a minimum, establish:

26 (a) A mechanism to collect reinsurance contribution funds;

27 (b) A reinsurance payment formula; and

28 (c) A mechanism to disburse reinsurance payments.

29 (3)(a) The commissioner may adjust the rules adopted under this  
30 section as needed to preserve a healthy market both inside and outside  
31 of the exchange.

32 (b) The rules adopted under this section shall also identify the  
33 data that health carriers, third-party administrators, and other  
34 entities must provide to support operation of the reinsurance and risk  
35 adjustment programs established under this section, and requirements

1 related to the collection, validation, interpretation, and retention of  
2 the data.

3 (4) The commissioner shall contract with one or more nonprofit  
4 entities to administer the risk adjustment and reinsurance programs.

5 **PART VIII**

6 **THE WASHINGTON STATE HEALTH INSURANCE POOL**

7 NEW SECTION. **Sec. 17.** A new section is added to chapter 48.41 RCW  
8 to read as follows:

9 (1) The board shall evaluate the populations that may need ongoing  
10 access to the pool coverage with specific attention to those persons  
11 who may be excluded from coverage in 2014, such as persons with end-  
12 stage renal disease or HIV/AIDS, or persons not eligible for coverage  
13 in the exchange.

14 (2) The board shall evaluate the eligibility requirements for the  
15 purchase of health care coverage through the pool and submit  
16 recommendations regarding any modifications to pool eligibility  
17 requirements that might allow new enrollees on or after January 1,  
18 2014. The recommendations must address any needed modifications to the  
19 standard health questionnaire or other eligibility screening tool that  
20 could be used in a manner consistent with federal law to determine  
21 eligibility for enrollment in the pool.

22 (3) The board shall complete an analysis of the pool assessments in  
23 relation to the assessments for the reinsurance program and recommend  
24 changes for the assessment or any credits that may be considered for  
25 the reinsurance program. The analysis shall also recommend whether the  
26 categories of members paying assessments should be adjusted to make the  
27 assessment fair and equitable among all payers.

28 (4) The board shall report its recommendations to the governor and  
29 the legislature by December 1, 2012.

30 NEW SECTION. **Sec. 18.** A new section is added to chapter 48.41 RCW  
31 to read as follows:

32 (1) The pool is authorized to contract with the commissioner to  
33 administer risk management functions, consistent with section 17 of  
34 this act, and consistent with P.L. 111-148 of 2010, as amended. Prior  
35 to entering into a contract, the pool may conduct preoperational and

1 planning activities related to these programs, including defining and  
2 implementing an appropriate legal structure or structures to administer  
3 and coordinate the reinsurance or risk adjustment programs.

4 (2) The reasonable costs incurred by the pool for preoperational  
5 and planning activities related to the reinsurance program may be  
6 reimbursed from federal funds or from the additional contributions  
7 collected to pay the administrative costs of the reinsurance program.

8 (3) If the pool contracts to administer and coordinate the  
9 reinsurance or risk adjustment program, the board must submit  
10 recommendations to the legislature with suggestions for additional  
11 consumer representatives or other representative members to the board.

12 (4) The pool shall report on these activities to the appropriate  
13 committees of the senate and house of representatives by December 15,  
14 2012, and December 15, 2013.

15 **PART IX**  
16 **EXCHANGE EMPLOYEES**

17 NEW SECTION. **Sec. 19.** A new section is added to chapter 41.04 RCW  
18 to read as follows:

19 Except for chapters 41.05 and 41.40 RCW, this title does not apply  
20 to any position in or employee of the Washington health benefit  
21 exchange established in chapter 43.71 RCW.

22 NEW SECTION. **Sec. 20.** A new section is added to chapter 43.01 RCW  
23 to read as follows:

24 This chapter does not apply to any position in or employee of the  
25 Washington health benefit exchange established in chapter 43.71 RCW.

26 NEW SECTION. **Sec. 21.** A new section is added to chapter 43.03 RCW  
27 to read as follows:

28 This chapter does not apply to any position in or employee of the  
29 Washington health benefit exchange established in chapter 43.71 RCW.

30 **Sec. 22.** RCW 41.05.011 and 2011 1st sp.s. c 15 s 54 are each  
31 reenacted and amended to read as follows:

32 The definitions in this section apply throughout this chapter  
33 unless the context clearly requires otherwise.

- 1 (1) "Authority" means the Washington state health care authority.
- 2 (2) "Board" means the public employees' benefits board established  
3 under RCW 41.05.055.
- 4 (3) "Dependent care assistance program" means a benefit plan  
5 whereby state and public employees may pay for certain employment  
6 related dependent care with pretax dollars as provided in the salary  
7 reduction plan under this chapter pursuant to 26 U.S.C. Sec. 129 or  
8 other sections of the internal revenue code.
- 9 (4) "Director" means the director of the authority.
- 10 (5) "Emergency service personnel killed in the line of duty" means  
11 law enforcement officers and firefighters as defined in RCW 41.26.030,  
12 members of the Washington state patrol retirement fund as defined in  
13 RCW 43.43.120, and reserve officers and firefighters as defined in RCW  
14 41.24.010 who die as a result of injuries sustained in the course of  
15 employment as determined consistent with Title 51 RCW by the department  
16 of labor and industries.
- 17 (6) "Employee" includes all employees of the state, whether or not  
18 covered by civil service; elected and appointed officials of the  
19 executive branch of government, including full-time members of boards,  
20 commissions, or committees; justices of the supreme court and judges of  
21 the court of appeals and the superior courts; and members of the state  
22 legislature. Pursuant to contractual agreement with the authority,  
23 "employee" may also include: (a) Employees of a county, municipality,  
24 or other political subdivision of the state and members of the  
25 legislative authority of any county, city, or town who are elected to  
26 office after February 20, 1970, if the legislative authority of the  
27 county, municipality, or other political subdivision of the state seeks  
28 and receives the approval of the authority to provide any of its  
29 insurance programs by contract with the authority, as provided in RCW  
30 41.04.205 and 41.05.021(1)(g); (b) employees of employee organizations  
31 representing state civil service employees, at the option of each such  
32 employee organization, and, effective October 1, 1995, employees of  
33 employee organizations currently pooled with employees of school  
34 districts for the purpose of purchasing insurance benefits, at the  
35 option of each such employee organization; (c) employees of a school  
36 district if the authority agrees to provide any of the school  
37 districts' insurance programs by contract with the authority as  
38 provided in RCW 28A.400.350; (~~and~~) (d) employees of a tribal

1 government, if the governing body of the tribal government seeks and  
2 receives the approval of the authority to provide any of its insurance  
3 programs by contract with the authority, as provided in RCW  
4 41.05.021(1) (f) and (g); and (e) employees of the Washington health  
5 benefit exchange if the governing board of the exchange established in  
6 RCW 43.71.020 seeks and receives approval of the authority to provide  
7 any of its insurance programs by contract with the authority, as  
8 provided in RCW 41.05.021(1) (g) and (n). "Employee" does not include:  
9 Adult family homeowners; unpaid volunteers; patients of state  
10 hospitals; inmates; employees of the Washington state convention and  
11 trade center as provided in RCW 41.05.110; students of institutions of  
12 higher education as determined by their institution; and any others not  
13 expressly defined as employees under this chapter or by the authority  
14 under this chapter.

15 (7) "Employer" means the state of Washington.

16 (8) "Employing agency" means a division, department, or separate  
17 agency of state government, including an institution of higher  
18 education; a county, municipality, school district, educational service  
19 district, or other political subdivision; and a tribal government  
20 covered by this chapter.

21 (9) "Faculty" means an academic employee of an institution of  
22 higher education whose workload is not defined by work hours but whose  
23 appointment, workload, and duties directly serve the institution's  
24 academic mission, as determined under the authority of its enabling  
25 statutes, its governing body, and any applicable collective bargaining  
26 agreement.

27 (10) "Flexible benefit plan" means a benefit plan that allows  
28 employees to choose the level of health care coverage provided and the  
29 amount of employee contributions from among a range of choices offered  
30 by the authority.

31 (11) "Insuring entity" means an insurer as defined in chapter 48.01  
32 RCW, a health care service contractor as defined in chapter 48.44 RCW,  
33 or a health maintenance organization as defined in chapter 48.46 RCW.

34 (12) "Medical flexible spending arrangement" means a benefit plan  
35 whereby state and public employees may reduce their salary before taxes  
36 to pay for medical expenses not reimbursed by insurance as provided in  
37 the salary reduction plan under this chapter pursuant to 26 U.S.C. Sec.  
38 125 or other sections of the internal revenue code.

1 (13) "Participant" means an individual who fulfills the eligibility  
2 and enrollment requirements under the salary reduction plan.

3 (14) "Plan year" means the time period established by the  
4 authority.

5 (15) "Premium payment plan" means a benefit plan whereby state and  
6 public employees may pay their share of group health plan premiums with  
7 pretax dollars as provided in the salary reduction plan under this  
8 chapter pursuant to 26 U.S.C. Sec. 125 or other sections of the  
9 internal revenue code.

10 (16) "Retired or disabled school employee" means:

11 (a) Persons who separated from employment with a school district or  
12 educational service district and are receiving a retirement allowance  
13 under chapter 41.32 or 41.40 RCW as of September 30, 1993;

14 (b) Persons who separate from employment with a school district or  
15 educational service district on or after October 1, 1993, and  
16 immediately upon separation receive a retirement allowance under  
17 chapter 41.32, 41.35, or 41.40 RCW;

18 (c) Persons who separate from employment with a school district or  
19 educational service district due to a total and permanent disability,  
20 and are eligible to receive a deferred retirement allowance under  
21 chapter 41.32, 41.35, or 41.40 RCW.

22 (17) "Salary" means a state employee's monthly salary or wages.

23 (18) "Salary reduction plan" means a benefit plan whereby state and  
24 public employees may agree to a reduction of salary on a pretax basis  
25 to participate in the dependent care assistance program, medical  
26 flexible spending arrangement, or premium payment plan offered pursuant  
27 to 26 U.S.C. Sec. 125 or other sections of the internal revenue code.

28 (19) "Seasonal employee" means an employee hired to work during a  
29 recurring, annual season with a duration of three months or more, and  
30 anticipated to return each season to perform similar work.

31 (20) "Separated employees" means persons who separate from  
32 employment with an employer as defined in:

33 (a) RCW 41.32.010(17) on or after July 1, 1996; or

34 (b) RCW 41.35.010 on or after September 1, 2000; or

35 (c) RCW 41.40.010 on or after March 1, 2002;

36 and who are at least age fifty-five and have at least ten years of  
37 service under the teachers' retirement system plan 3 as defined in RCW

1 41.32.010(33), the Washington school employees' retirement system plan  
2 3 as defined in RCW 41.35.010, or the public employees' retirement  
3 system plan 3 as defined in RCW 41.40.010.

4 (21) "State purchased health care" or "health care" means medical  
5 and health care, pharmaceuticals, and medical equipment purchased with  
6 state and federal funds by the department of social and health  
7 services, the department of health, the basic health plan, the state  
8 health care authority, the department of labor and industries, the  
9 department of corrections, the department of veterans affairs, and  
10 local school districts.

11 (22) "Tribal government" means an Indian tribal government as  
12 defined in section 3(32) of the employee retirement income security act  
13 of 1974, as amended, or an agency or instrumentality of the tribal  
14 government, that has government offices principally located in this  
15 state.

16 **Sec. 23.** RCW 41.05.021 and 2011 1st sp.s. c 15 s 56 are each  
17 amended to read as follows:

18 (1) The Washington state health care authority is created within  
19 the executive branch. The authority shall have a director appointed by  
20 the governor, with the consent of the senate. The director shall serve  
21 at the pleasure of the governor. The director may employ a deputy  
22 director, and such assistant directors and special assistants as may be  
23 needed to administer the authority, who shall be exempt from chapter  
24 41.06 RCW, and any additional staff members as are necessary to  
25 administer this chapter. The director may delegate any power or duty  
26 vested in him or her by law, including authority to make final  
27 decisions and enter final orders in hearings conducted under chapter  
28 34.05 RCW. The primary duties of the authority shall be to:  
29 Administer state employees' insurance benefits and retired or disabled  
30 school employees' insurance benefits; administer the basic health plan  
31 pursuant to chapter 70.47 RCW; administer the children's health program  
32 pursuant to chapter 74.09 RCW; study state-purchased health care  
33 programs in order to maximize cost containment in these programs while  
34 ensuring access to quality health care; implement state initiatives,  
35 joint purchasing strategies, and techniques for efficient  
36 administration that have potential application to all state-purchased

1 health services; and administer grants that further the mission and  
2 goals of the authority. The authority's duties include, but are not  
3 limited to, the following:

4 (a) To administer health care benefit programs for employees and  
5 retired or disabled school employees as specifically authorized in RCW  
6 41.05.065 and in accordance with the methods described in RCW  
7 41.05.075, 41.05.140, and other provisions of this chapter;

8 (b) To analyze state-purchased health care programs and to explore  
9 options for cost containment and delivery alternatives for those  
10 programs that are consistent with the purposes of those programs,  
11 including, but not limited to:

12 (i) Creation of economic incentives for the persons for whom the  
13 state purchases health care to appropriately utilize and purchase  
14 health care services, including the development of flexible benefit  
15 plans to offset increases in individual financial responsibility;

16 (ii) Utilization of provider arrangements that encourage cost  
17 containment, including but not limited to prepaid delivery systems,  
18 utilization review, and prospective payment methods, and that ensure  
19 access to quality care, including assuring reasonable access to local  
20 providers, especially for employees residing in rural areas;

21 (iii) Coordination of state agency efforts to purchase drugs  
22 effectively as provided in RCW 70.14.050;

23 (iv) Development of recommendations and methods for purchasing  
24 medical equipment and supporting services on a volume discount basis;

25 (v) Development of data systems to obtain utilization data from  
26 state-purchased health care programs in order to identify cost centers,  
27 utilization patterns, provider and hospital practice patterns, and  
28 procedure costs, utilizing the information obtained pursuant to RCW  
29 41.05.031; and

30 (vi) In collaboration with other state agencies that administer  
31 state purchased health care programs, private health care purchasers,  
32 health care facilities, providers, and carriers:

33 (A) Use evidence-based medicine principles to develop common  
34 performance measures and implement financial incentives in contracts  
35 with insuring entities, health care facilities, and providers that:

36 (I) Reward improvements in health outcomes for individuals with  
37 chronic diseases, increased utilization of appropriate preventive  
38 health services, and reductions in medical errors; and

1 (II) Increase, through appropriate incentives to insuring entities,  
2 health care facilities, and providers, the adoption and use of  
3 information technology that contributes to improved health outcomes,  
4 better coordination of care, and decreased medical errors;

5 (B) Through state health purchasing, reimbursement, or pilot  
6 strategies, promote and increase the adoption of health information  
7 technology systems, including electronic medical records, by hospitals  
8 as defined in RCW 70.41.020(4), integrated delivery systems, and  
9 providers that:

10 (I) Facilitate diagnosis or treatment;

11 (II) Reduce unnecessary duplication of medical tests;

12 (III) Promote efficient electronic physician order entry;

13 (IV) Increase access to health information for consumers and their  
14 providers; and

15 (V) Improve health outcomes;

16 (C) Coordinate a strategy for the adoption of health information  
17 technology systems using the final health information technology report  
18 and recommendations developed under chapter 261, Laws of 2005;

19 (c) To analyze areas of public and private health care interaction;

20 (d) To provide information and technical and administrative  
21 assistance to the board;

22 (e) To review and approve or deny applications from counties,  
23 municipalities, and other political subdivisions of the state to  
24 provide state-sponsored insurance or self-insurance programs to their  
25 employees in accordance with the provisions of RCW 41.04.205 and (g) of  
26 this subsection, setting the premium contribution for approved groups  
27 as outlined in RCW 41.05.050;

28 (f) To review and approve or deny the application when the  
29 governing body of a tribal government applies to transfer their  
30 employees to an insurance or self-insurance program administered under  
31 this chapter. In the event of an employee transfer pursuant to this  
32 subsection (1)(f), members of the governing body are eligible to be  
33 included in such a transfer if the members are authorized by the tribal  
34 government to participate in the insurance program being transferred  
35 from and subject to payment by the members of all costs of insurance  
36 for the members. The authority shall: (i) Establish the conditions  
37 for participation; (ii) have the sole right to reject the application;  
38 and (iii) set the premium contribution for approved groups as outlined

1 in RCW 41.05.050. Approval of the application by the authority  
2 transfers the employees and dependents involved to the insurance,  
3 self-insurance, or health care program approved by the authority;

4 (g) To ensure the continued status of the employee insurance or  
5 self-insurance programs administered under this chapter as a  
6 governmental plan under section 3(32) of the employee retirement income  
7 security act of 1974, as amended, the authority shall limit the  
8 participation of employees of a county, municipal, school district,  
9 educational service district, or other political subdivision, the  
10 Washington health benefit exchange, or a tribal government, including  
11 providing for the participation of those employees whose services are  
12 substantially all in the performance of essential governmental  
13 functions, but not in the performance of commercial activities;

14 (h) To establish billing procedures and collect funds from school  
15 districts in a way that minimizes the administrative burden on  
16 districts;

17 (i) To publish and distribute to nonparticipating school districts  
18 and educational service districts by October 1st of each year a  
19 description of health care benefit plans available through the  
20 authority and the estimated cost if school districts and educational  
21 service district employees were enrolled;

22 (j) To apply for, receive, and accept grants, gifts, and other  
23 payments, including property and service, from any governmental or  
24 other public or private entity or person, and make arrangements as to  
25 the use of these receipts to implement initiatives and strategies  
26 developed under this section;

27 (k) To issue, distribute, and administer grants that further the  
28 mission and goals of the authority;

29 (l) To adopt rules consistent with this chapter as described in RCW  
30 41.05.160 including, but not limited to:

31 (i) Setting forth the criteria established by the board under RCW  
32 41.05.065 for determining whether an employee is eligible for benefits;

33 (ii) Establishing an appeal process in accordance with chapter  
34 34.05 RCW by which an employee may appeal an eligibility determination;

35 (iii) Establishing a process to assure that the eligibility  
36 determinations of an employing agency comply with the criteria under  
37 this chapter, including the imposition of penalties as may be  
38 authorized by the board;

1 (m)(i) To administer the medical services programs established  
2 under chapter 74.09 RCW as the designated single state agency for  
3 purposes of Title XIX of the federal social security act;

4 (ii) To administer the state children's health insurance program  
5 under chapter 74.09 RCW for purposes of Title XXI of the federal social  
6 security act;

7 (iii) To enter into agreements with the department of social and  
8 health services for administration of medical care services programs  
9 under Titles XIX and XXI of the social security act. The agreements  
10 shall establish the division of responsibilities between the authority  
11 and the department with respect to mental health, chemical dependency,  
12 and long-term care services, including services for persons with  
13 developmental disabilities. The agreements shall be revised as  
14 necessary, to comply with the final implementation plan adopted under  
15 section 116, chapter 15, Laws of 2011 1st sp. sess.;

16 (iv) To adopt rules to carry out the purposes of chapter 74.09 RCW;

17 (v) To appoint such advisory committees or councils as may be  
18 required by any federal statute or regulation as a condition to the  
19 receipt of federal funds by the authority. The director may appoint  
20 statewide committees or councils in the following subject areas: (A)  
21 Health facilities; (B) children and youth services; (C) blind services;  
22 (D) medical and health care; (E) drug abuse and alcoholism; (F)  
23 rehabilitative services; and (G) such other subject matters as are or  
24 come within the authority's responsibilities. The statewide councils  
25 shall have representation from both major political parties and shall  
26 have substantial consumer representation. Such committees or councils  
27 shall be constituted as required by federal law or as the director in  
28 his or her discretion may determine. The members of the committees or  
29 councils shall hold office for three years except in the case of a  
30 vacancy, in which event appointment shall be only for the remainder of  
31 the unexpired term for which the vacancy occurs. No member shall serve  
32 more than two consecutive terms. Members of such state advisory  
33 committees or councils may be paid their travel expenses in accordance  
34 with RCW 43.03.050 and 43.03.060 as now existing or hereafter amended;

35 (n) To review and approve or deny the application from the  
36 governing board of the Washington health benefit exchange to provide  
37 state-sponsored insurance or self-insurance programs to employees of  
38 the exchange. The authority shall (i) establish the conditions for

1 participation; (ii) have the sole right to reject an application; and  
2 (iii) set the premium contribution for approved groups as outlined in  
3 RCW 41.05.050.

4 (2) On and after January 1, 1996, the public employees' benefits  
5 board may implement strategies to promote managed competition among  
6 employee health benefit plans. Strategies may include but are not  
7 limited to:

8 (a) Standardizing the benefit package;

9 (b) Soliciting competitive bids for the benefit package;

10 (c) Limiting the state's contribution to a percent of the lowest  
11 priced qualified plan within a geographical area;

12 (d) Monitoring the impact of the approach under this subsection  
13 with regards to: Efficiencies in health service delivery, cost shifts  
14 to subscribers, access to and choice of managed care plans statewide,  
15 and quality of health services. The health care authority shall also  
16 advise on the value of administering a benchmark employer-managed plan  
17 to promote competition among managed care plans.

18 **PART X**

19 **MISCELLANEOUS**

20 NEW SECTION. **Sec. 24.** The health care authority shall pursue an  
21 application for the state to participate in the individual market  
22 wellness program demonstration as described in section 2705 of P.L.  
23 111-148 of 2010, as amended. The health care authority shall pursue  
24 activities that will prepare the state to apply for the demonstration  
25 project once announced by the United States department of health and  
26 human services.

27 NEW SECTION. **Sec. 25.** If any provision of this act or its  
28 application to any person or circumstance is held invalid, the  
29 remainder of the act or the application of the provision to other  
30 persons or circumstances is not affected.

31 NEW SECTION. **Sec. 26.** Sections 4 and 19 through 23 of this act  
32 are necessary for the immediate preservation of the public peace,  
33 health, or safety, or support of the state government and its existing  
34 public institutions, and take effect immediately."

**E2SHB 2319** - S COMM AMD

By Committee on Health & Long-Term Care

1        On page 1, line 2 of the title, after "act;" strike the remainder  
2 of the title and insert "amending RCW 43.71.010, 43.71.020, 43.71.030,  
3 43.71.060, 48.42.010, 48.42.020, and 41.05.021; reenacting and amending  
4 RCW 48.43.005 and 41.05.011; adding new sections to chapter 48.43 RCW;  
5 adding new sections to chapter 43.71 RCW; adding a new section to  
6 chapter 70.47 RCW; adding new sections to chapter 48.41 RCW; adding a  
7 new section to chapter 41.04 RCW; adding a new section to chapter 43.01  
8 RCW; adding a new section to chapter 43.03 RCW; creating new sections;  
9 providing an expiration date; and declaring an emergency."

--- END ---