

CERTIFICATION OF ENROLLMENT
ENGROSSED SECOND SUBSTITUTE HOUSE BILL 2319

62nd Legislature
2012 Regular Session

Passed by the House March 3, 2012
Yeas 55 Nays 41

Speaker of the House of Representatives

Passed by the Senate March 1, 2012
Yeas 27 Nays 22

President of the Senate

Approved

Governor of the State of Washington

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE HOUSE BILL 2319** as passed by the House of Representatives and the Senate on the dates hereon set forth.

Chief Clerk

FILED

**Secretary of State
State of Washington**

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

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

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

20 (4) "Basic health plan" means the plan described under chapter
21 70.47 RCW, as revised from time to time.

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

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

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

30 (8)(a) For grandfathered health benefit plans issued before January
31 1, 2014, and renewed thereafter, "catastrophic health plan" means:

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

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

8 ~~(c) Any health benefit plan that provides benefits for hospital
9 inpatient and outpatient services, professional and prescription drugs
10 provided in conjunction with such hospital inpatient and outpatient
11 services, and excludes or substantially limits outpatient physician
12 services and those services usually provided in an office setting)).~~

13 (b) In July 2008, and in each July thereafter, the insurance
14 commissioner shall adjust the minimum deductible and out-of-pocket
15 expense required for a plan to qualify as a catastrophic plan to
16 reflect the percentage change in the consumer price index for medical
17 care for a preceding twelve months, as determined by the United States
18 department of labor. For a plan year beginning in 2014, the out-of-
19 pocket limits must be adjusted as specified in section 1302(c)(1) of
20 P.L. 111-148 of 2010, as amended. The adjusted amount shall apply on
21 the following January 1st.

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

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

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

32 ~~((8))~~ (9) "Certification" means a determination by a review
33 organization that an admission, extension of stay, or other health care
34 service or procedure has been reviewed and, based on the information
35 provided, meets the clinical requirements for medical necessity,
36 appropriateness, level of care, or effectiveness under the auspices of
37 the applicable health benefit plan.

1 ~~((9))~~ (10) "Concurrent review" means utilization review conducted
2 during a patient's hospital stay or course of treatment.

3 ~~((10))~~ (11) "Covered person" or "enrollee" means a person covered
4 by a health plan including an enrollee, subscriber, policyholder,
5 beneficiary of a group plan, or individual covered by any other health
6 plan.

7 ~~((11))~~ (12) "Dependent" means, at a minimum, the enrollee's legal
8 spouse and dependent children who qualify for coverage under the
9 enrollee's health benefit plan.

10 ~~((12))~~ (13) "Emergency medical condition" means a medical
11 condition manifesting itself by acute symptoms of sufficient severity,
12 including severe pain, such that a prudent layperson, who possesses an
13 average knowledge of health and medicine, could reasonably expect the
14 absence of immediate medical attention to result in a condition (a)
15 placing the health of the individual, or with respect to a pregnant
16 woman, the health of the woman or her unborn child, in serious
17 jeopardy, (b) serious impairment to bodily functions, or (c) serious
18 dysfunction of any bodily organ or part.

19 ~~((13))~~ (14) "Emergency services" means a medical screening
20 examination, as required under section 1867 of the social security act
21 (42 U.S.C. 1395dd), that is within the capability of the emergency
22 department of a hospital, including ancillary services routinely
23 available to the emergency department to evaluate that emergency
24 medical condition, and further medical examination and treatment, to
25 the extent they are within the capabilities of the staff and facilities
26 available at the hospital, as are required under section 1867 of the
27 social security act (42 U.S.C. 1395dd) to stabilize the patient.
28 Stabilize, with respect to an emergency medical condition, has the
29 meaning given in section 1867(e)(3) of the social security act (42
30 U.S.C. 1395dd(e)(3)).

31 ~~((14))~~ (15) "Employee" has the same meaning given to the term, as
32 of January 1, 2008, under section 3(6) of the federal employee
33 retirement income security act of 1974.

34 ~~((15))~~ (16) "Enrollee point-of-service cost-sharing" means
35 amounts paid to health carriers directly providing services, health
36 care providers, or health care facilities by enrollees and may include
37 copayments, coinsurance, or deductibles.

1 ~~((16))~~ (17) "Exchange" means the Washington health benefit
2 exchange established under chapter 43.71 RCW.

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

6 ~~((17))~~ (19) "Final internal adverse benefit determination" means
7 an adverse benefit determination that has been upheld by a health plan
8 or carrier at the completion of the internal appeals process, or an
9 adverse benefit determination with respect to which the internal
10 appeals process has been exhausted under the exhaustion rules described
11 in RCW 48.43.530 and 48.43.535.

12 ~~((18))~~ (20) "Grandfathered health plan" means a group health plan
13 or an individual health plan that under section 1251 of the patient
14 protection and affordable care act, P.L. 111-148 (2010) and as amended
15 by the health care and education reconciliation act, P.L. 111-152
16 (2010) is not subject to subtitles A or C of the act as amended.

17 ~~((19))~~ (21) "Grievance" means a written complaint submitted by or
18 on behalf of a covered person regarding: (a) Denial of payment for
19 medical services or nonprovision of medical services included in the
20 covered person's health benefit plan, or (b) service delivery issues
21 other than denial of payment for medical services or nonprovision of
22 medical services, including dissatisfaction with medical care, waiting
23 time for medical services, provider or staff attitude or demeanor, or
24 dissatisfaction with service provided by the health carrier.

25 ~~((20))~~ (22) "Health care facility" or "facility" means hospices
26 licensed under chapter 70.127 RCW, hospitals licensed under chapter
27 70.41 RCW, rural health care facilities as defined in RCW 70.175.020,
28 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes
29 licensed under chapter 18.51 RCW, community mental health centers
30 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment
31 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,
32 treatment, or surgical facilities licensed under chapter 70.41 RCW,
33 drug and alcohol treatment facilities licensed under chapter 70.96A
34 RCW, and home health agencies licensed under chapter 70.127 RCW, and
35 includes such facilities if owned and operated by a political
36 subdivision or instrumentality of the state and such other facilities
37 as required by federal law and implementing regulations.

38 ~~((21))~~ (23) "Health care provider" or "provider" means:

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

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

6 ~~((+22+))~~ (24) "Health care service" means that service offered or
7 provided by health care facilities and health care providers relating
8 to the prevention, cure, or treatment of illness, injury, or disease.

9 ~~((+23+))~~ (25) "Health carrier" or "carrier" means a disability
10 insurer regulated under chapter 48.20 or 48.21 RCW, a health care
11 service contractor as defined in RCW 48.44.010, or a health maintenance
12 organization as defined in RCW 48.46.020, and includes "issuers" as
13 that term is used in the patient protection and affordable care act
14 (P.L. 111-148).

15 ~~((+24+))~~ (26) "Health plan" or "health benefit plan" means any
16 policy, contract, or agreement offered by a health carrier to provide,
17 arrange, reimburse, or pay for health care services except the
18 following:

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

21 (b) Medicare supplemental health insurance governed by chapter
22 48.66 RCW;

23 (c) Coverage supplemental to the coverage provided under chapter
24 55, Title 10, United States Code;

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

27 (e) Disability income;

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

31 (g) Workers' compensation coverage;

32 (h) Accident only coverage;

33 (i) Specified disease or illness-triggered fixed payment insurance,
34 hospital confinement fixed payment insurance, or other fixed payment
35 insurance offered as an independent, noncoordinated benefit;

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

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

1 (1) Plans deemed by the insurance commissioner to have a short-term
2 limited purpose or duration, or to be a student-only plan that is
3 guaranteed renewable while the covered person is enrolled as a regular
4 full-time undergraduate or graduate student at an accredited higher
5 education institution, after a written request for such classification
6 by the carrier and subsequent written approval by the insurance
7 commissioner.

8 ~~((+25+))~~ (27) "Material modification" means a change in the
9 actuarial value of the health plan as modified of more than five
10 percent but less than fifteen percent.

11 ~~((+26+))~~ (28) "Open enrollment" means a period of time as defined
12 in rule to be held at the same time each year, during which applicants
13 may enroll in a carrier's individual health benefit plan without being
14 subject to health screening or otherwise required to provide evidence
15 of insurability as a condition for enrollment.

16 ~~((+27+))~~ (29) "Preexisting condition" means any medical condition,
17 illness, or injury that existed any time prior to the effective date of
18 coverage.

19 ~~((+28+))~~ (30) "Premium" means all sums charged, received, or
20 deposited by a health carrier as consideration for a health plan or the
21 continuance of a health plan. Any assessment or any "membership,"
22 "policy," "contract," "service," or similar fee or charge made by a
23 health carrier in consideration for a health plan is deemed part of the
24 premium. "Premium" shall not include amounts paid as enrollee point-
25 of-service cost-sharing.

26 ~~((+29+))~~ (31) "Review organization" means a disability insurer
27 regulated under chapter 48.20 or 48.21 RCW, health care service
28 contractor as defined in RCW 48.44.010, or health maintenance
29 organization as defined in RCW 48.46.020, and entities affiliated with,
30 under contract with, or acting on behalf of a health carrier to perform
31 a utilization review.

32 ~~((+30+))~~ (32) "Small employer" or "small group" means any person,
33 firm, corporation, partnership, association, political subdivision,
34 sole proprietor, or self-employed individual that is actively engaged
35 in business that employed an average of at least one but no more than
36 fifty employees, during the previous calendar year and employed at
37 least one employee on the first day of the plan year, is not formed
38 primarily for purposes of buying health insurance, and in which a bona

1 fide employer-employee relationship exists. In determining the number
2 of employees, companies that are affiliated companies, or that are
3 eligible to file a combined tax return for purposes of taxation by this
4 state, shall be considered an employer. Subsequent to the issuance of
5 a health plan to a small employer and for the purpose of determining
6 eligibility, the size of a small employer shall be determined annually.
7 Except as otherwise specifically provided, a small employer shall
8 continue to be considered a small employer until the plan anniversary
9 following the date the small employer no longer meets the requirements
10 of this definition. A self-employed individual or sole proprietor who
11 is covered as a group of one must also: (a) Have been employed by the
12 same small employer or small group for at least twelve months prior to
13 application for small group coverage, and (b) verify that he or she
14 derived at least seventy-five percent of his or her income from a trade
15 or business through which the individual or sole proprietor has
16 attempted to earn taxable income and for which he or she has filed the
17 appropriate internal revenue service form 1040, schedule C or F, for
18 the previous taxable year, except a self-employed individual or sole
19 proprietor in an agricultural trade or business, must have derived at
20 least fifty-one percent of his or her income from the trade or business
21 through which the individual or sole proprietor has attempted to earn
22 taxable income and for which he or she has filed the appropriate
23 internal revenue service form 1040, for the previous taxable year.

24 ~~((+31+))~~ (33) "Special enrollment" means a defined period of time
25 of not less than thirty-one days, triggered by a specific qualifying
26 event experienced by the applicant, during which applicants may enroll
27 in the carrier's individual health benefit plan without being subject
28 to health screening or otherwise required to provide evidence of
29 insurability as a condition for enrollment.

30 ~~((+32+))~~ (34) "Standard health questionnaire" means the standard
31 health questionnaire designated under chapter 48.41 RCW.

32 ~~((+33+))~~ (35) "Utilization review" means the prospective,
33 concurrent, or retrospective assessment of the necessity and
34 appropriateness of the allocation of health care resources and services
35 of a provider or facility, given or proposed to be given to an enrollee
36 or group of enrollees.

37 ~~((+34+))~~ (36) "Wellness activity" means an explicit program of an
38 activity consistent with department of health guidelines, such as,

1 smoking cessation, injury and accident prevention, reduction of alcohol
2 misuse, appropriate weight reduction, exercise, automobile and
3 motorcycle safety, blood cholesterol reduction, and nutrition education
4 for the purpose of improving enrollee health status and reducing health
5 service costs.

6 **PART II**

7 **THE WASHINGTON HEALTH BENEFIT EXCHANGE**

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

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

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

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

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

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

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

26 (6) "Self-sustaining" means capable of operating without direct
27 state tax subsidy. Self-sustaining sources include, but are not
28 limited to, federal grants, federal premium tax subsidies and credits,
29 charges to health carriers, and premiums paid by enrollees.

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

32 (1) The Washington health benefit exchange is established and
33 constitutes a self-sustaining public-private partnership separate and
34 distinct from the state, exercising functions delineated in chapter
35 317, Laws of 2011. By January 1, 2014, the exchange shall operate

1 consistent with the affordable care act subject to statutory
2 authorization. The exchange shall have a governing board consisting of
3 persons with expertise in the Washington health care system and private
4 and public health care coverage. The initial membership of the board
5 shall be appointed as follows:

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

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

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

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

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

19 (v) The remaining nominees must have demonstrated and acknowledged
20 expertise in at least one of the following areas: Individual health
21 care coverage, small employer health care coverage, health benefits
22 plan administration, health care finance and economics, actuarial
23 science, or administering a public or private health care delivery
24 system.

25 (b) By December 15, 2011, the governor shall appoint two members
26 from each list submitted by the caucuses under (a) of this subsection.
27 The appointments made under this subsection (1)(b) must include at
28 least one employee benefits specialist, one health economist or
29 actuary, one representative of small business, and one representative
30 of health consumer advocates. The remaining four members must have a
31 demonstrated and acknowledged expertise in at least one of the
32 following areas: Individual health care coverage, small employer
33 health care coverage, health benefits plan administration, health care
34 finance and economics, actuarial science, or administering a public or
35 private health care delivery system.

36 (c) By December 15, 2011, the governor shall appoint a ninth member
37 to serve as chair. The chair may not be an employee of the state or

1 its political subdivisions. The chair shall serve as a nonvoting
2 member except in the case of a tie.

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

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

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

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

11 (3) A member of the board whose term has expired or who otherwise
12 leaves the board shall be replaced by gubernatorial appointment. When
13 the person leaving was nominated by one of the caucuses of the house of
14 representatives or the senate, his or her replacement shall be
15 appointed from a list of five nominees submitted by that caucus within
16 thirty days after the person leaves. If the member to be replaced is
17 the chair, the governor shall appoint a new chair within thirty days
18 after the vacancy occurs. A person appointed to replace a member who
19 leaves the board prior to the expiration of his or her term shall serve
20 only the duration of the unexpired term. Members of the board may be
21 reappointed to multiple terms.

22 (4) No board member may be appointed if his or her participation in
23 the decisions of the board could benefit his or her own financial
24 interests or the financial interests of an entity he or she represents.
25 A board member who develops such a conflict of interest shall resign or
26 be removed from the board.

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

31 (6) The exchange and the board are subject only to the provisions
32 of chapter 42.30 RCW, the open public meetings act, and chapter 42.56
33 RCW, the public records act, and not to any other law or regulation
34 generally applicable to state agencies. Consistent with the open
35 public meetings act, the board may hold executive sessions to consider
36 proprietary or confidential nonpublished information.

37 (7)(a) The board shall establish an advisory committee to allow for

1 the views of the health care industry and other stakeholders to be
2 heard in the operation of the health benefit exchange.

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

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

14 (9) In recognition of the government-to-government relationship
15 between the state of Washington and the federally recognized tribes in
16 the state of Washington, the board shall consult with the American
17 Indian health commission.

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

20 (1) The exchange may, consistent with the purposes of this chapter:
21 (a) Sue and be sued in its own name; (b) make and execute agreements,
22 contracts, and other instruments, with any public or private person or
23 entity; (c) employ, contract with, or engage personnel; (d) pay
24 administrative costs; ~~((and))~~ (e) accept grants, donations, loans of
25 funds, and contributions in money, services, materials or otherwise,
26 from the United States or any of its agencies, from the state of
27 Washington and its agencies or from any other source, and use or expend
28 those moneys, services, materials, or other contributions; (f)
29 aggregate or delegate the aggregation of funds that comprise the
30 premium for a health plan; and (g) complete other duties necessary to
31 begin open enrollment in qualified health plans through the exchange
32 beginning October 1, 2013.

33 ~~(2) ((The powers and duties of the exchange and the board are~~
34 ~~limited to those necessary to apply for and administer grants,~~
35 ~~establish information technology infrastructure, and undertake~~
36 ~~additional administrative functions necessary to begin operation of the~~
37 ~~exchange by January 1, 2014. Any actions relating to substantive~~

1 ~~issues included in RCW 43.71.040 must be consistent with statutory~~
2 ~~direction on those issues.))~~ The board shall develop a methodology to
3 ensure the exchange is self-sustaining after December 31, 2014. The
4 board shall seek input from health carriers to develop funding
5 mechanisms that fairly and equitably apportion among carriers the
6 reasonable administrative costs and expenses incurred to implement the
7 provisions of this chapter. The board shall submit its recommendations
8 to the legislature by December 1, 2012. If the legislature does not
9 enact legislation during the 2013 regular session to modify or reject
10 the board's recommendations, the board may proceed with implementation
11 of the recommendations.

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

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

19 (5) Qualified employers may access coverage for their employees
20 through the exchange for small groups under section 1311 of P.L. 111-
21 148 of 2010, as amended. The exchange shall enable any qualified
22 employer to specify a level of coverage so that any of its employees
23 may enroll in any qualified health plan offered through the small group
24 exchange at the specified level of coverage.

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

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

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

1 may authorize expenditures from the account. The account is subject to
2 allotment procedures under chapter 43.88 RCW, but an appropriation is
3 not required for expenditures.

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

5 **PART III**
6 **MARKET RULES**

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

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

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

17 (3) By December 1, 2016, the exchange board, in consultation with
18 the commissioner, must complete a review of the impact of this section
19 on the health and viability of the markets inside and outside the
20 exchange and submit the recommendations to the legislature on whether
21 to maintain the market rules or let them expire.

22 (4) The commissioner shall evaluate plans offered at each actuarial
23 value defined in section 1302 of P.L. 111-148 of 2010, as amended, and
24 determine whether variation in prescription drug benefit cost-sharing,
25 both inside and outside the exchange in both the individual and small
26 group markets results in adverse selection. If so, the commissioner
27 may adopt rules to assure substantial equivalence of prescription drug
28 cost-sharing.

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

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

PART IV
QUALIFIED HEALTH PLANS

1
2
3 NEW SECTION. **Sec. 8.** A new section is added to chapter 43.71 RCW
4 to read as follows:

5 (1) The board shall certify a plan as a qualified health plan to be
6 offered through the exchange if the plan is determined by the:

7 (a) Insurance commissioner to meet the requirements of Title 48 RCW
8 and rules adopted by the commissioner pursuant to chapter 34.05 RCW to
9 implement the requirements of Title 48 RCW;

10 (b) Board to meet the requirements of the affordable care act for
11 certification as a qualified health plan; and

12 (c) Board to include tribal clinics and urban Indian clinics as
13 essential community providers in the plan's provider network consistent
14 with federal law. If consistent with federal law, integrated delivery
15 systems shall be exempt from the requirement to include essential
16 community providers in the provider network.

17 (2) Consistent with section 1311 of P.L. 111-148 of 2010, as
18 amended, the board shall allow stand-alone dental plans to offer
19 coverage in the exchange beginning January 1, 2014. Dental benefits
20 offered in the exchange must be offered and priced separately to assure
21 transparency for consumers.

22 (3) The board may permit direct primary care medical home plans,
23 consistent with section 1301 of P.L. 111-148 of 2010, as amended, to be
24 offered in the exchange beginning January 1, 2014.

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

32 (5) A decision by the board denying a request to certify or
33 recertify a plan as a qualified health plan may be appealed according
34 to procedures adopted by the board.

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

37 The board shall establish a rating system consistent with section

1 1311 of P.L. 111-148 of 2010, as amended, for qualified health plans to
2 assist consumers in evaluating plan choices in the exchange. Rating
3 factors established by the board may include, but are not limited to:

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

6 (2) Enrollee satisfaction;

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

10 (4) Promotion of appropriate primary care and preventive services
11 utilization;

12 (5) High standards for provider network adequacy, including
13 consumer choice of providers and service locations and robust provider
14 participation intended to improve access to underserved populations
15 through participation of essential community providers, family planning
16 providers and pediatric providers;

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

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

21 **Sec. 10.** RCW 48.42.010 and 1985 c 264 s 15 are each amended to
22 read as follows:

23 (1) Notwithstanding any other provision of law, and except as
24 provided in this chapter, any person or other entity which provides
25 coverage in this state for life insurance, annuities, loss of time,
26 medical, surgical, chiropractic, physical therapy, speech pathology,
27 audiology, professional mental health, dental, hospital, or optometric
28 expenses, whether the coverage is by direct payment, reimbursement, the
29 providing of services, or otherwise, shall be subject to the authority
30 of the state insurance commissioner, unless the person or other entity
31 shows that while providing the services it is subject to the
32 jurisdiction and regulation of another agency of this state, any
33 subdivisions thereof, or the federal government.

34 (2) "Another agency of this state, any subdivision thereof, or the
35 federal government" does not include the Washington health benefit
36 exchange under chapter 43.71 RCW or P.L. 111-148 of 2010, as amended.

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

7 (a) Ensure that the plan covers the ten essential health benefits
8 categories specified in section 1302 of P.L. 111-148 of 2010, as
9 amended; and

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

15 (4) Beginning December 15, 2012, and every year thereafter, the
16 commissioner shall submit to the legislature a list of state-mandated
17 health benefits, the enforcement of which will result in federally
18 imposed costs to the state related to the plans sold through the
19 exchange because the benefits are not included in the essential health
20 benefits designated under federal law. The list must include the
21 anticipated costs to the state of each state-mandated health benefit on
22 the list and any statutory changes needed if funds are not appropriated
23 to defray the state costs for the listed mandate. The commissioner may
24 enforce a mandate on the list for the entire market only if funds are
25 appropriated in an omnibus appropriations act specifically to pay the
26 state portion of the identified costs.

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

31 **PART VI**
32 **THE BASIC HEALTH OPTION**

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

35 (1) On or before December 1, 2012, the director of the health care

1 authority shall submit a report to the legislature on whether to
2 proceed with implementation of a federal basic health option, under
3 section 1331 of P.L. 111-148 of 2010, as amended. The report shall
4 address whether:

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

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

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

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

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

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

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

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

35 (5) To the extent funding is available specifically for this
36 purpose in the operating budget, the health care authority shall assume
37 the federal basic health plan option will be implemented in Washington
38 state, and initiate the necessary design and development work. If the

1 legislature determines under subsection (1) of this section not to
2 proceed with implementation, the authority may cease activities related
3 to basic health program implementation.

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

6 (a) Meeting the minimum state certification standards in section
7 1331 of the federal patient protection and affordable care act;

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

14 (c) Achieving an appropriate balance between:

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

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

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

23 (d) Transparency in program administration, including active and
24 ongoing consultation with basic health program enrollees and interested
25 organizations, and ensuring adequate enrollee notice and appeal rights.

26 PART VII

27 RISK ADJUSTMENT AND REINSURANCE

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

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

33 (b) The commissioner must include in deliberations related to
34 reinsurance rule making an analysis of an invisible high risk pool
35 option, in which the full premium and risk associated with certain
36 high-risk or high-cost enrollees would be ceded to the transitional

1 reinsurance program. The analysis must include a determination as to
2 whether that option is authorized under the federal reinsurance program
3 regulations, whether the option would provide sufficiently
4 comprehensive coverage for current nonmedicare high risk pool
5 enrollees, and how an invisible high risk pool option could be designed
6 to ensure that carriers ceding risk provide effective care management
7 to high-risk or high-cost enrollees.

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

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

11 (b) A reinsurance payment formula; and

12 (c) A mechanism to disburse reinsurance payments.

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

16 (b) The rules adopted under this section must identify and may
17 require submission of the data needed to support operation of the
18 reinsurance and risk adjustment programs established under this
19 section. The commissioner must identify by rule the sources of the
20 data, and other requirements related to the collection, validation,
21 correction, interpretation, transmission or exchange, and retention of
22 the data.

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

25 (5) Contribution amounts for the transitional reinsurance program
26 under section 1341 of P.L. 111-148 of 2010, as amended, may be
27 increased to include amounts sufficient to cover the costs of
28 administration of the reinsurance program including reasonable costs
29 incurred for preoperational and planning activities related to the
30 reinsurance program.

31 PART VIII

32 THE WASHINGTON STATE HEALTH INSURANCE POOL

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

35 (1) The board shall review populations that may need ongoing access
36 to coverage through the pool, with specific attention to those persons

1 who may be excluded from or may receive inadequate coverage beginning
2 January 1, 2014, such as persons with end-stage renal disease or
3 HIV/AIDS, or persons not eligible for coverage in the exchange.

4 (2) If the review under subsection (1) of this section indicates a
5 continued need for coverage through the pool after December 31, 2013,
6 the board shall submit recommendations regarding any modifications to
7 pool eligibility requirements for new and ongoing enrollment after
8 December 31, 2013. The recommendations must address any needed
9 modifications to the standard health questionnaire or other eligibility
10 screening tool that could be used in a manner consistent with federal
11 law to determine eligibility for enrollment in the pool.

12 (3) The board shall complete an analysis of current pool assessment
13 requirements in relation to assessments that will fund the reinsurance
14 program and recommend changes to pool assessments or any credits
15 against assessments that may be considered for the reinsurance program.
16 The analysis shall recommend whether the categories of members paying
17 assessments should be adjusted to make the assessment fair and
18 equitable among all payers.

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

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

23 (1) The pool is authorized to contract with the commissioner to
24 administer risk management functions if necessary, consistent with
25 section 16 of this act, and consistent with P.L. 111-148 of 2010, as
26 amended. Prior to entering into a contract, the pool may conduct
27 preoperational and planning activities related to these programs,
28 including defining and implementing an appropriate legal structure or
29 structures to administer and coordinate the reinsurance or risk
30 adjustment programs.

31 (2) The reasonable costs incurred by the pool for preoperational
32 and planning activities related to the reinsurance program may be
33 reimbursed from federal funds or from the additional contributions
34 authorized under section 16 of this act to pay the administrative costs
35 of the reinsurance program.

36 (3) If the pool contracts to administer and coordinate the

1 reinsurance or risk adjustment program, the board must submit
2 recommendations to the legislature with suggestions for additional
3 consumer representatives or other representative members to the board.

4 (4) The pool shall report on these activities to the appropriate
5 committees of the senate and house of representatives by December 15,
6 2012, and December 15, 2013.

7 **PART IX**
8 **EXCHANGE EMPLOYEES**

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

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

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

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

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

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

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

24 The definitions in this section apply throughout this chapter
25 unless the context clearly requires otherwise.

26 (1) "Authority" means the Washington state health care authority.

27 (2) "Board" means the public employees' benefits board established
28 under RCW 41.05.055.

29 (3) "Dependent care assistance program" means a benefit plan
30 whereby state and public employees may pay for certain employment
31 related dependent care with pretax dollars as provided in the salary
32 reduction plan under this chapter pursuant to 26 U.S.C. Sec. 129 or
33 other sections of the internal revenue code.

1 (4) "Director" means the director of the authority.

2 (5) "Emergency service personnel killed in the line of duty" means
3 law enforcement officers and firefighters as defined in RCW 41.26.030,
4 members of the Washington state patrol retirement fund as defined in
5 RCW 43.43.120, and reserve officers and firefighters as defined in RCW
6 41.24.010 who die as a result of injuries sustained in the course of
7 employment as determined consistent with Title 51 RCW by the department
8 of labor and industries.

9 (6) "Employee" includes all employees of the state, whether or not
10 covered by civil service; elected and appointed officials of the
11 executive branch of government, including full-time members of boards,
12 commissions, or committees; justices of the supreme court and judges of
13 the court of appeals and the superior courts; and members of the state
14 legislature. Pursuant to contractual agreement with the authority,
15 "employee" may also include: (a) Employees of a county, municipality,
16 or other political subdivision of the state and members of the
17 legislative authority of any county, city, or town who are elected to
18 office after February 20, 1970, if the legislative authority of the
19 county, municipality, or other political subdivision of the state seeks
20 and receives the approval of the authority to provide any of its
21 insurance programs by contract with the authority, as provided in RCW
22 41.04.205 and 41.05.021(1)(g); (b) employees of employee organizations
23 representing state civil service employees, at the option of each such
24 employee organization, and, effective October 1, 1995, employees of
25 employee organizations currently pooled with employees of school
26 districts for the purpose of purchasing insurance benefits, at the
27 option of each such employee organization; (c) employees of a school
28 district if the authority agrees to provide any of the school
29 districts' insurance programs by contract with the authority as
30 provided in RCW 28A.400.350; ~~((and))~~ (d) employees of a tribal
31 government, if the governing body of the tribal government seeks and
32 receives the approval of the authority to provide any of its insurance
33 programs by contract with the authority, as provided in RCW
34 41.05.021(1) (f) and (g); and (e) employees of the Washington health
35 benefit exchange if the governing board of the exchange established in
36 RCW 43.71.020 seeks and receives approval of the authority to provide
37 any of its insurance programs by contract with the authority, as
38 provided in RCW 41.05.021(1) (g) and (n). "Employee" does not include:

1 Adult family homeowners; unpaid volunteers; patients of state
2 hospitals; inmates; employees of the Washington state convention and
3 trade center as provided in RCW 41.05.110; students of institutions of
4 higher education as determined by their institution; and any others not
5 expressly defined as employees under this chapter or by the authority
6 under this chapter.

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

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

13 (9) "Faculty" means an academic employee of an institution of
14 higher education whose workload is not defined by work hours but whose
15 appointment, workload, and duties directly serve the institution's
16 academic mission, as determined under the authority of its enabling
17 statutes, its governing body, and any applicable collective bargaining
18 agreement.

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

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

26 (12) "Medical flexible spending arrangement" means a benefit plan
27 whereby state and public employees may reduce their salary before taxes
28 to pay for medical expenses not reimbursed by insurance as provided in
29 the salary reduction plan under this chapter pursuant to 26 U.S.C. Sec.
30 125 or other sections of the internal revenue code.

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

33 (14) "Plan year" means the time period established by the
34 authority.

35 (15) "Premium payment plan" means a benefit plan whereby state and
36 public employees may pay their share of group health plan premiums with
37 pretax dollars as provided in the salary reduction plan under this

1 chapter pursuant to 26 U.S.C. Sec. 125 or other sections of the
2 internal revenue code.

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

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

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

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

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

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

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

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

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

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

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

29 and who are at least age fifty-five and have at least ten years of
30 service under the teachers' retirement system plan 3 as defined in RCW
31 41.32.010(33), the Washington school employees' retirement system plan
32 3 as defined in RCW 41.35.010, or the public employees' retirement
33 system plan 3 as defined in RCW 41.40.010.

34 (21) "State purchased health care" or "health care" means medical
35 and health care, pharmaceuticals, and medical equipment purchased with
36 state and federal funds by the department of social and health
37 services, the department of health, the basic health plan, the state

1 health care authority, the department of labor and industries, the
2 department of corrections, the department of veterans affairs, and
3 local school districts.

4 (22) "Tribal government" means an Indian tribal government as
5 defined in section 3(32) of the employee retirement income security act
6 of 1974, as amended, or an agency or instrumentality of the tribal
7 government, that has government offices principally located in this
8 state.

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

11 (1) The Washington state health care authority is created within
12 the executive branch. The authority shall have a director appointed by
13 the governor, with the consent of the senate. The director shall serve
14 at the pleasure of the governor. The director may employ a deputy
15 director, and such assistant directors and special assistants as may be
16 needed to administer the authority, who shall be exempt from chapter
17 41.06 RCW, and any additional staff members as are necessary to
18 administer this chapter. The director may delegate any power or duty
19 vested in him or her by law, including authority to make final
20 decisions and enter final orders in hearings conducted under chapter
21 34.05 RCW. The primary duties of the authority shall be to:
22 Administer state employees' insurance benefits and retired or disabled
23 school employees' insurance benefits; administer the basic health plan
24 pursuant to chapter 70.47 RCW; administer the children's health program
25 pursuant to chapter 74.09 RCW; study state-purchased health care
26 programs in order to maximize cost containment in these programs while
27 ensuring access to quality health care; implement state initiatives,
28 joint purchasing strategies, and techniques for efficient
29 administration that have potential application to all state-purchased
30 health services; and administer grants that further the mission and
31 goals of the authority. The authority's duties include, but are not
32 limited to, the following:

33 (a) To administer health care benefit programs for employees and
34 retired or disabled school employees as specifically authorized in RCW
35 41.05.065 and in accordance with the methods described in RCW
36 41.05.075, 41.05.140, and other provisions of this chapter;

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

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

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

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

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

18 (v) Development of data systems to obtain utilization data from
19 state-purchased health care programs in order to identify cost centers,
20 utilization patterns, provider and hospital practice patterns, and
21 procedure costs, utilizing the information obtained pursuant to RCW
22 41.05.031; and

23 (vi) In collaboration with other state agencies that administer
24 state purchased health care programs, private health care purchasers,
25 health care facilities, providers, and carriers:

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

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

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

36 (B) Through state health purchasing, reimbursement, or pilot
37 strategies, promote and increase the adoption of health information

1 technology systems, including electronic medical records, by hospitals
2 as defined in RCW 70.41.020(4), integrated delivery systems, and
3 providers that:

- 4 (I) Facilitate diagnosis or treatment;
- 5 (II) Reduce unnecessary duplication of medical tests;
- 6 (III) Promote efficient electronic physician order entry;
- 7 (IV) Increase access to health information for consumers and their
8 providers; and
- 9 (V) Improve health outcomes;

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

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

14 (d) To provide information and technical and administrative
15 assistance to the board;

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

22 (f) To review and approve or deny the application when the
23 governing body of a tribal government applies to transfer their
24 employees to an insurance or self-insurance program administered under
25 this chapter. In the event of an employee transfer pursuant to this
26 subsection (1)(f), members of the governing body are eligible to be
27 included in such a transfer if the members are authorized by the tribal
28 government to participate in the insurance program being transferred
29 from and subject to payment by the members of all costs of insurance
30 for the members. The authority shall: (i) Establish the conditions
31 for participation; (ii) have the sole right to reject the application;
32 and (iii) set the premium contribution for approved groups as outlined
33 in RCW 41.05.050. Approval of the application by the authority
34 transfers the employees and dependents involved to the insurance,
35 self-insurance, or health care program approved by the authority;

36 (g) To ensure the continued status of the employee insurance or
37 self-insurance programs administered under this chapter as a
38 governmental plan under section 3(32) of the employee retirement income

1 security act of 1974, as amended, the authority shall limit the
2 participation of employees of a county, municipal, school district,
3 educational service district, or other political subdivision, the
4 Washington health benefit exchange, or a tribal government, including
5 providing for the participation of those employees whose services are
6 substantially all in the performance of essential governmental
7 functions, but not in the performance of commercial activities;

8 (h) To establish billing procedures and collect funds from school
9 districts in a way that minimizes the administrative burden on
10 districts;

11 (i) To publish and distribute to nonparticipating school districts
12 and educational service districts by October 1st of each year a
13 description of health care benefit plans available through the
14 authority and the estimated cost if school districts and educational
15 service district employees were enrolled;

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

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

23 (l) To adopt rules consistent with this chapter as described in RCW
24 41.05.160 including, but not limited to:

25 (i) Setting forth the criteria established by the board under RCW
26 41.05.065 for determining whether an employee is eligible for benefits;

27 (ii) Establishing an appeal process in accordance with chapter
28 34.05 RCW by which an employee may appeal an eligibility determination;

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

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

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

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

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

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

29 (n) To review and approve or deny the application from the
30 governing board of the Washington health benefit exchange to provide
31 state-sponsored insurance or self-insurance programs to employees of
32 the exchange. The authority shall (i) establish the conditions for
33 participation; (ii) have the sole right to reject an application; and
34 (iii) set the premium contribution for approved groups as outlined in
35 RCW 41.05.050.

36 (2) On and after January 1, 1996, the public employees' benefits
37 board may implement strategies to promote managed competition among

1 employee health benefit plans. Strategies may include but are not
2 limited to:

3 (a) Standardizing the benefit package;

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

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

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

13 **PART X**

14 **MISCELLANEOUS**

15 NEW SECTION. **Sec. 24.** The health care authority shall pursue an
16 application for the state to participate in the individual market
17 wellness program demonstration as described in section 2705 of P.L.
18 111-148 of 2010, as amended. The health care authority shall pursue
19 activities that will prepare the state to apply for the demonstration
20 project once announced by the United States department of health and
21 human services.

22 NEW SECTION. **Sec. 25.** A new section is added to chapter 43.71 RCW
23 to read as follows:

24 A person or entity functioning as a navigator consistent with the
25 requirements of section 1311(i) of P.L. 111-148 of 2010, as amended,
26 shall not be considered soliciting or negotiating insurance as stated
27 under chapter 48.17 RCW.

28 NEW SECTION. **Sec. 26.** A new section is added to chapter 43.71 RCW
29 to read as follows:

30 If at any time the exchange is no longer self-sustaining as defined
31 in RCW 43.71.010, the operations of the exchange shall be suspended.

32 NEW SECTION. **Sec. 27.** If any provision of this act or its

1 application to any person or circumstance is held invalid, the
2 remainder of the act or the application of the provision to other
3 persons or circumstances is not affected.

4 NEW SECTION. **Sec. 28.** Sections 4, 16, 18, and 19 through 23 of
5 this act are necessary for the immediate preservation of the public
6 peace, health, or safety, or support of the state government and its
7 existing public institutions, and take effect immediately.

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