H-2294.1

SUBSTITUTE HOUSE BILL 2098

State of Washington 60th Legislature 2007 Regular Session

By House Committee on Health Care & Wellness (originally sponsored by Representatives Cody, Upthegrove, Morrell, Kenney, Conway, Simpson, Hudgins and Ormsby; by request of Governor Gregoire)

READ FIRST TIME 02/21/07.

AN ACT Relating to providing high quality, affordable health care to Washingtonians based on the recommendations of the blue ribbon commission on health care costs and access; amending RCW 41.05.220, 48.41.110, and 41.05.065; adding new sections to chapter 41.05 RCW; adding a new section to chapter 74.09 RCW; adding a new section to chapter 43.70 RCW; adding a new section to chapter 48.20 RCW; adding a new section to chapter 48.21 RCW; adding a new section to chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; adding a new section to chapter 48.43 RCW; creating new sections; and providing an effective date.

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

USE STATE PURCHASING TO IMPROVE HEALTH CARE QUALITY

NEW SECTION. **Sec. 1.** The health care authority and the department of social and health services shall, by September 1, 2007, develop a five-year plan to change reimbursement within state purchased health care programs to:

(1) Reward quality health outcomes rather than simply paying for the receipt of particular services or procedures;

(2) Pay for care that reflects patient preference and is of proven value;

(3) Require the use of evidence-based standards of care where available;

(4) Tie provider rate increases to measurable improvements in access to quality care;

(5) Direct enrollees to quality care systems;

(6) Better support primary care and provide a medical home to all enrollees; and

(7) Pay for e-mail consultations, telemedicine, and telehealth where doing so reduces the overall cost of care.

The plan shall identify any existing barriers and opportunities to support implementation, including needed changes to state or federal law and be submitted to the governor and the legislature upon completion.

NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05 RCW to read as follows:

(1) The health care authority shall implement a pilot for shared decision making for common medical decisions. The authority shall select or create not more than two patient decision aids in collaboration with the state agency medical directors group. Criteria for selection of the patient decision aids shall include common medical decisions which have no more than five treatment options, and where there exists sound evidence about medical effectiveness.

(2) The authority shall seek up to two contracts with provider organizations or health carriers to pilot the use of patient decision aids. These contracts shall require an evaluation of the resulting outcomes of utilizing the patient decision aids. The authority shall provide a report to the governor and the legislature on the pilot results by June 30, 2009.

(3) For purposes of this section:

(a) "Patient decision aid" means: (i) High quality, up-to-date information about the condition, including risk and benefits of available options and, if appropriate, a discussion of the limits of scientific knowledge about outcomes; (ii) values clarification to help patients sort out their values and preferences; and (iii) guidance or

coaching in deliberation, designed to improve the patient's involvement in the decision process; and

(b) "Shared decision making" means a process in which the physician discloses to the patient the risks and benefits associated with all treatment alternatives, including no treatment, that a reasonable person in the patient's situation could consider significant in selecting a particular path of medical care. The patient then shares with the physician all relevant personal information that might make one treatment or side effect more or less desirable than others.

PREVENTION AND MANAGEMENT OF CHRONIC ILLNESS

NEW SECTION. **Sec. 3.** A new section is added to chapter 74.09 RCW to read as follows:

(1) The department of social and health services, in collaboration with the department of health, shall:

(a) Design and implement medical homes for its aged, blind, and disabled clients in conjunction with chronic care management programs to improve health outcomes, access, and cost-effectiveness. Programs must be evidence based, facilitating the use of information technology to improve quality of care, and must improve coordination of primary, acute, and long-term care for those clients with multiple chronic conditions. The department shall consider expansion of existing medical home and chronic care management programs and build on the Washington state collaborative initiative. The department shall use best practices in identifying those clients best served under a chronic care management model using predictive modeling through claims or other health risk information; and

(b) Evaluate the effectiveness of the intensive chronic care management pilot project that manages the needs of long-term care clients with multiple chronic conditions and the department's chronic care management program to determine if the models support medical home infrastructure and improved client outcomes.

(2) For purposes of this section:

(a) "Medical home" means a site of care that provides comprehensive preventive and coordinated care centered on the patient needs and assures high quality, accessible, and efficient care.

(b) "Chronic care management" means the department's program that provides care management and coordination activities for medical assistance clients determined to be at risk for high medical costs. "Chronic care management" provides education and training and/or coordination that assist program participants in improving self-management skills to improve health outcomes and reduce medical costs by educating clients to better utilize services.

NEW SECTION. **Sec. 4.** A new section is added to chapter 43.70 RCW to read as follows:

(1) The department shall conduct a program of training and technical assistance regarding care of people with chronic conditions for providers of primary care. The program shall emphasize evidence-based high quality preventive and chronic disease care. The department may designate one or more chronic conditions to be the subject of the program.

(2) The training and technical assistance program shall include the following elements:

(a) Clinical information systems and sharing and organization of patient data;

(b) Decision support to promote evidence-based care;

(c) Clinical delivery system design;

(d) Support for patients managing their own conditions; and

(e) Identification and use of community resources that are available in the community for patients and their families.

(3) In selecting primary care providers to participate in the program, the department shall consider the number and type of patients with chronic conditions the provider serves, and the provider's participation in the medicaid and medicare programs.

COST AND QUALITY INFORMATION FOR CONSUMERS AND PROVIDERS

NEW SECTION. **Sec. 5.** A new section is added to chapter 41.05 RCW to read as follows:

The Washington state quality forum is established within the authority. The forum shall collaborate with the Puget Sound health alliance and other local organizations and shall:

(1) Collect and disseminate research regarding health care quality, evidence-based medicine, and patient safety to promote best practices, in collaboration with the technology assessment program and the prescription drug program;

(2) Coordinate the collection of health care quality data among state health care purchasing agencies;

(3) Adopt a set of measures to evaluate and compare health care cost and quality and provider performance;

(4) Identify and disseminate information regarding variations in clinical practice patterns across the state; and

(5) Produce an annual quality report detailing clinical practice patterns identified to purchasers, providers, insurers, and policy makers.

NEW SECTION. **Sec. 6.** A new section is added to chapter 41.05 RCW to read as follows:

(1) The administrator shall design and pilot a consumer-centric health information infrastructure and the first health record banks that will facilitate the secure exchange of health information when and where needed and shall:

(a) Complete the plan of initial implementation, including but not limited to determining the technical infrastructure for health record banks and the account locator service, setting criteria and standards for health record banks, and determining oversight of health record banks;

(b) Implement the first health record banks in pilot sites as funding allows;

(c) Involve health care consumers in meaningful ways in the design, implementation, oversight, and dissemination of information on the health record bank system; and

(d) Promote adoption of electronic medical records and health information exchange through continuation of the Washington health information collaborative, and by working with private payors and other organizations in restructuring reimbursement to provide incentives for providers to adopt electronic medical records in their practices.

(2) The administrator may establish an advisory board, a stakeholder committee, and subcommittees to assist in carrying out the duties under this section. The administrator may reappoint health

information infrastructure advisory board members to assure continuity and shall appoint any additional representatives that may be required for their expertise and experience.

(a) The administrator shall appoint the chair of the advisory board, chairs, and cochairs of the stakeholder committee, if formed;

(b) Meetings of the board, stakeholder committee, and any advisory group are subject to chapter 42.30 RCW, the open public meetings act, including RCW 42.30.110(1)(l), which authorizes an executive session during a regular or special meeting to consider proprietary or confidential nonpublished information; and

(c) The members of the board, stakeholder committee, and any advisory group:

(i) Shall agree to the terms and conditions imposed by the administrator regarding conflicts of interest as a condition of appointment;

(ii) Are immune from civil liability for any official acts performed in good faith as members of the board, stakeholder committee, or any advisory group.

(3) Members of the board may be compensated in accordance with a personal services contract to be executed after appointment and before commencement of activities related to the work of the board. Members of the stakeholder committee shall not receive compensation but shall be reimbursed under RCW 43.03.050 and 43.03.060.

(4) The administrator may work with public and private entities to develop and encourage the use of personal health records which are portable, interoperable, secure, and respectful of patients' privacy.

(5) The administrator may enter into contracts to issue, distribute, and administer grants that are necessary or proper to carry out this section.

REDUCING UNNECESSARY EMERGENCY ROOM USE

Sec. 7. RCW 41.05.220 and 1998 c 245 s 38 are each amended to read as follows:

(1) State general funds appropriated to the department of health for the purposes of funding community health centers to provide primary health and dental care services, migrant health services, and maternity health care services shall be transferred to the state health care

authority. Any related administrative funds expended by the department of health for this purpose shall also be transferred to the health care authority. The health care authority shall exclusively expend these funds through contracts with community health centers to provide primary health and dental care services, migrant health services, and maternity health care services. The administrator of the health care authority shall establish requirements necessary to assure community health centers provide quality health care services that are appropriate and effective and are delivered in a cost-efficient manner. The administrator shall further assure that community health centers have appropriate referral arrangements for acute care and medical specialty services not provided by the community health centers.

(2) The authority, in consultation with the department of health, shall work with community and migrant health clinics and other providers of care to underserved populations, to ensure that the number of people of color and underserved people receiving access to managed care is expanded in proportion to need, based upon demographic data.

(3) In contracting with community health centers to provide primary health and dental services, migrant health services, and maternity health care services under subsection (1) of this section the authority shall give priority to those community health centers working with local hospitals to successfully reduce unnecessary emergency room use.

NEW SECTION. **Sec. 8.** The Washington state health care authority and the department of social and health services shall report to the legislature by December 1, 2007, on recent trends in unnecessary emergency room use by enrollees in state purchased health care programs, and then partner with community organizations and local health care providers to design a demonstration pilot to reduce such unnecessary visits.

REDUCE HEALTH CARE ADMINISTRATIVE COSTS

NEW SECTION. **Sec. 9.** By September 1, 2007, the insurance commissioner shall provide a report to the governor and the legislature that identifies the key contributors to health care administrative costs and evaluates opportunities to reduce them, including suggested

changes to state law. The report shall be completed in collaboration with health care providers, carriers, state health purchasing agencies, the Washington healthcare forum, and other interested parties.

COVERAGE FOR DEPENDENTS TO AGE TWENTY-FIVE

NEW SECTION. **Sec. 10.** A new section is added to chapter 41.05 RCW to read as follows:

(1) Any plan offered to public employees under this chapter must offer each public employee the option of covering any unmarried dependent of the employee under the age of twenty-five regardless of whether the dependent is enrolled in an educational institution.

(2) Any employee choosing under subsection (1) of this section to cover a dependent who is: (a) Age twenty through twenty-three and not a registered student at an accredited secondary school, college, university, vocational school, or school of nursing; or (b) age twenty-four, shall be required to pay the full cost of such coverage.

NEW SECTION. **Sec. 11.** A new section is added to chapter 48.20 RCW to read as follows:

Any disability insurance contract that provides coverage for a subscriber's dependent must offer the option of covering any unmarried dependent under the age of twenty-five regardless of whether the dependent is enrolled in an educational institution.

NEW SECTION. **Sec. 12.** A new section is added to chapter 48.21 RCW to read as follows:

Any group disability insurance contract or blanket disability insurance contract that provides coverage for a participating member's dependent must offer each participating member the option of covering any unmarried dependent under the age of twenty-five regardless of whether the dependent is enrolled in an educational institution.

NEW SECTION. **Sec. 13.** A new section is added to chapter 48.44 RCW to read as follows:

(1) Any individual health care service plan contract that provides coverage for a subscriber's dependent must offer the option of covering

any unmarried dependent under the age of twenty-five regardless of whether the dependent is enrolled in an educational institution.

(2) Any group health care service plan contract that provides coverage for a participating member's dependent must offer each participating member the option of covering any unmarried dependent under the age of twenty-five regardless of whether the dependent is enrolled in an educational institution.

NEW SECTION. **Sec. 14.** A new section is added to chapter 48.46 RCW to read as follows:

(1) Any individual health maintenance agreement that provides coverage for a subscriber's dependent must offer the option of covering any unmarried dependent under the age of twenty-five regardless of whether the dependent is enrolled in an educational institution.

(2) Any group health maintenance agreement that provides coverage for a participating member's dependent must offer each participating member the option of covering any unmarried dependent under the age of twenty-five regardless of whether the dependent is enrolled in an educational institution.

SUSTAINABILITY AND ACCESS TO PUBLIC PROGRAMS

NEW SECTION. **Sec. 15.** (1) The department of social and health services shall seek necessary federal waivers and state plan amendments to expand coverage and leverage federal and state resources for the state's basic health program, for the medical assistance program, as codified at Title XIX of the federal social security act, and the state's children's health insurance program, as codified at Title XXI of the federal social security act. The department shall propose options including but not limited to:

(a) Offering alternative benefit designs to promote high quality care, improve health outcomes, and encourage cost-effective treatment options, including benefit designs that discourage the use of emergency rooms for nonemergent care, and redirect savings to finance additional coverage; and

(b) Promoting private health insurance plans and premium subsidies to purchase employer-sponsored insurance wherever possible, including

federal approval to expand the department's employer-sponsored insurance premium assistance program to enrollees covered through the state's children's health insurance program.

(2) The department of social and health services, in collaboration with the Washington state health care authority, shall ensure that enrollees are not simultaneously enrolled in the state's basic health program and the medical assistance program or the state's children's health insurance program to ensure coverage for the maximum number of people within available funds. Priority enrollment in the basic health program shall be given to those who disenrolled from the program in order to enroll in medicaid, and subsequently became ineligible for medicaid coverage.

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

When the department of social and health services determines that it is cost-effective to enroll a person eligible for medical assistance under chapter 74.09 RCW in an employer-sponsored health plan, a carrier shall permit the enrollment of the person in the health plan for which he or she is otherwise eligible without regard to any open enrollment period restrictions.

REINSURANCE

NEW SECTION. **Sec. 17.** (1) The office of financial management, in collaboration with the office of the insurance commissioner, shall design a state-supported reinsurance program to address the impact of high cost enrollees in the individual and small group health insurance markets, and submit implementing legislation and supporting information, including financing options, to the governor and the legislature by December 1, 2007. In designing the program, the office of financial management shall:

(a) Estimate the quantitative impact on premium savings, premium stability over time and across groups of enrollees, individual and employer take-up, number of uninsured, and government costs associated with a government-funded stop-loss insurance program, including distinguishing between one-time premium savings and savings in subsequent years;

(b) Identify all relevant design issues and alternative options for each issue. Where quantitative impacts cannot be estimated, the office of financial management shall assess qualitative impacts of design issues and their options, including potential disincentives for reducing premiums, achieving premium stability, sustaining/increasing take-up, decreasing the number of uninsured, and managing government's stop-loss insurance costs;

(c) Identify market and regulatory changes needed to maximize the chance of the program achieving its policy goals, including how the program will relate to other coverage programs and markets;

(d) Address conditions under which overall expenditures could increase as a result of a government-funded stop-loss program and options to mitigate those conditions, such as passive versus aggressive use of disease and care management programs by insurers;

(e) Evaluate, and quantify where possible, the behavioral responses of insurers to the program including impacts on insurer premiums and practices for settling legal disputes around large claims; and

(f) Provide alternatives for transitioning from the status quo and, where applicable, alternatives for phasing in some design elements, such as threshold or corridor levels, to balance government costs and premium savings.

(2) Within funds specifically appropriated for this purpose, the office of financial management may contract with actuaries and other experts as necessary to meet the requirements of this section.

THE WASHINGTON STATE HEALTH INSURANCE POOL

Sec. 18. RCW 48.41.110 and 2001 c 196 s 4 are each amended to read as follows:

(1) The pool shall offer one or more care management plans of coverage. Such plans may, but are not required to, include point of service features that permit participants to receive in-network benefits or out-of-network benefits subject to differential cost shares. ((~~Covered persons enrolled in the pool on January 1, 2001, may continue coverage under the pool plan in which they are enrolled on that date. However,~~)) <u>T</u>he pool may incorporate managed care features <u>and requirements to participate in chronic care and disease management and evidence-based protocols</u> into ((~~such~~)) existing plans.

(2) The administrator shall prepare a brochure outlining the benefits and exclusions of ((~~the~~)) pool ((~~policy~~)) policies in plain language. After approval by the board, such brochure shall be made reasonably available to participants or potential participants.

(3) The health insurance ((~~policy~~)) policies issued by the pool shall pay only reasonable amounts for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of covered illnesses, injuries, and conditions ((~~which are not otherwise limited or excluded~~)). Eligible expenses are the reasonable amounts for the health care services and items for which benefits are extended under ((~~the~~)) a pool policy. ((~~Such benefits shall at minimum include, but not be limited to, the following services or related items~~))

(4) The pool shall offer at least one policy which at a minimum includes, but is not limited to, the following services or related items:

(a) Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, but limited to a total of one hundred eighty inpatient days in a calendar year, and limited to thirty days inpatient care for mental and nervous conditions, or alcohol, drug, or chemical dependency or abuse per calendar year;

(b) Professional services including surgery for the treatment of injuries, illnesses, or conditions, other than dental, which are rendered by a health care provider, or at the direction of a health care provider, by a staff of registered or licensed practical nurses, or other health care providers;

(c) The first twenty outpatient professional visits for the diagnosis or treatment of one or more mental or nervous conditions or alcohol, drug, or chemical dependency or abuse rendered during a calendar year by one or more physicians, psychologists, or community mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners, in the case of mental or nervous conditions, and rendered by a state certified chemical dependency program approved under chapter 70.96A RCW, in the case of alcohol, drug, or chemical dependency or abuse;

(d) Drugs and contraceptive devices requiring a prescription;

(e) Services of a skilled nursing facility, excluding custodial and convalescent care, for not more than one hundred days in a calendar year as prescribed by a physician;

(f) Services of a home health agency;

(g) Chemotherapy, radioisotope, radiation, and nuclear medicine therapy;

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

(k) Durable medical equipment which has no personal use in the absence of the condition for which prescribed;

(l) Diagnostic x-rays and laboratory tests;

(m) Oral surgery limited to the following: Fractures of facial bones; excisions of mandibular joints, lesions of the mouth, lip, or tongue, tumors, or cysts excluding treatment for temporomandibular joints; incision of accessory sinuses, mouth salivary glands or ducts; dislocations of the jaw; plastic reconstruction or repair of traumatic injuries occurring while covered under the pool; and excision of impacted wisdom teeth;

(n) Maternity care services;

(o) Services of a physical therapist and services of a speech therapist;

(p) Hospice services;

(q) Professional ambulance service to the nearest health care facility qualified to treat the illness or injury; and

(r) Other medical equipment, services, or supplies required by physician's orders and medically necessary and consistent with the diagnosis, treatment, and condition.

((~~(4)~~)) (5) The pool shall offer at least one policy which closely adheres to benefits available in the private, individual market.

(6) The board shall design and employ cost containment measures and requirements such as, but not limited to, care coordination, provider network limitations, preadmission certification, and concurrent inpatient review which may make the pool more cost-effective.

((~~(5)~~)) (7) The pool benefit policy may contain benefit limitations, exceptions, and cost shares such as copayments, coinsurance, and deductibles that are consistent with managed care products, except that differential cost shares may be adopted by the

board for nonnetwork providers under point of service plans. The pool benefit policy cost shares and limitations must be consistent with those that are generally included in health plans approved by the insurance commissioner; however, no limitation, exception, or reduction may be used that would exclude coverage for any disease, illness, or injury.

((~~(6)~~)) (8) The pool may not reject an individual for health plan coverage based upon preexisting conditions of the individual or deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that it shall impose a six-month benefit waiting period for preexisting conditions for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the effective date of coverage. The preexisting condition waiting period shall not apply to prenatal care services. The pool may not avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. Credit against the waiting period shall be as provided in subsection ((~~(7)~~)) (9) of this section.

((~~(7)~~)) (9)(a) Except as provided in (b) of this subsection, the pool shall credit any preexisting condition waiting period in its plans for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the new pool plan. For the person previously enrolled in a group health benefit plan, the pool must credit the aggregate of all periods of preceding coverage not separated by more than sixty-three days toward the waiting period of the new health plan. For the person previously enrolled in an individual health benefit plan other than a catastrophic health plan, the pool must credit the period of coverage the person was continuously covered under the immediately preceding health plan toward the waiting period of the new health plan. For the purposes of this subsection, a preceding health plan includes an employer-provided self-funded health plan.

(b) The pool shall waive any preexisting condition waiting period for a person who is an eligible individual as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)).

((~~(8)~~)) (10) If an application is made for the pool policy as a result of rejection by a carrier, then the date of application to the carrier, rather than to the pool, should govern for purposes of determining preexisting condition credit.

(11) The pool shall contract with organizations that provide care management that has been demonstrated to be effective and shall require that enrollees who are eligible for care management services participate in such programs on a continuous basis as a condition of receiving pool coverage.

PREVENTION AND HEALTH PROMOTION

NEW SECTION. **Sec. 19.** The Washington state health care authority, the department of social and health services, the department of labor and industries, and the department of health shall, by September 1, 2007, develop a five-year plan to integrate disease and accident prevention and health promotion into state health programs by:

(1) Structuring benefits and reimbursements to promote healthy choices and disease and accident prevention;

(2) Requiring enrollees in state health programs to complete a health assessment, and providing appropriate follow up;

(3) Reimbursing for cost-effective prevention activities;

(4) Developing prevention and health promotion contracting standards for state programs that contract with health carriers; and

(5) Strengthening the state's employee wellness program in partnership with the state's health and productivity committee.

The plan shall identify any existing barriers and opportunities to support implementation, including needed changes to state or federal law, and be submitted to the governor and the legislature upon completion.

Sec. 20. RCW 41.05.065 and 2006 c 299 s 2 are each amended to read as follows:

(1) The board shall study all matters connected with the provision of health care coverage, life insurance, liability insurance, accidental death and dismemberment insurance, and disability income insurance or any of, or a combination of, the enumerated types of

insurance for employees and their dependents on the best basis possible with relation both to the welfare of the employees and to the state. However, liability insurance shall not be made available to dependents.

(2) The board shall develop employee benefit plans that include comprehensive health care benefits for all employees. In developing these plans, the board shall consider the following elements:

(a) Methods of maximizing cost containment while ensuring access to quality health care;

(b) Development of provider arrangements that encourage cost containment and ensure access to quality care, including but not limited to prepaid delivery systems and prospective payment methods;

(c) Wellness incentives that focus on proven strategies, such as smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education;

(d) Utilization review procedures including, but not limited to a cost-efficient method for prior authorization of services, hospital inpatient length of stay review, requirements for use of outpatient surgeries and second opinions for surgeries, review of invoices or claims submitted by service providers, and performance audit of providers;

(e) Effective coordination of benefits;

(f) Minimum standards for insuring entities; and

(g) Minimum scope and content of public employee benefit plans to be offered to enrollees participating in the employee health benefit plans. To maintain the comprehensive nature of employee health care benefits, employee eligibility criteria related to the number of hours worked and the benefits provided to employees shall be substantially equivalent to the state employees' health benefits plan and eligibility criteria in effect on January 1, 1993. Nothing in this subsection (2)(g) shall prohibit changes or increases in employee point-of-service payments or employee premium payments for benefits or the administration of a high deductible health plan in conjunction with a health savings account.

(3) The board shall design benefits and determine the terms and conditions of employee and retired employee participation and coverage, including establishment of eligibility criteria. The same terms and

conditions of participation and coverage, including eligibility criteria, shall apply to state employees and to school district employees and educational service district employees.

(4) The board may authorize premium contributions for an employee and the employee's dependents in a manner that encourages the use of cost-efficient managed health care systems. During the 2005-2007 fiscal biennium, the board may only authorize premium contributions for an employee and the employee's dependents that are the same, regardless of an employee's status as represented or nonrepresented by a collective bargaining unit under the personnel system reform act of 2002. The board shall require participating school district and educational service district employees to pay at least the same employee premiums by plan and family size as state employees pay.

(5) The board shall develop a health savings account option for employees that conform to section 223, Part VII of subchapter B of chapter 1 of the internal revenue code of 1986. The board shall comply with all applicable federal standards related to the establishment of health savings accounts.

(6) Notwithstanding any other provision of this chapter, the board shall develop a high deductible health plan to be offered in conjunction with a health savings account developed under subsection (5) of this section.

(7) Employees shall choose participation in one of the health care benefit plans developed by the board and may be permitted to waive coverage under terms and conditions established by the board.

(8) The board shall review plans proposed by insuring entities that desire to offer property insurance and/or accident and casualty insurance to state employees through payroll deduction. The board may approve any such plan for payroll deduction by insuring entities holding a valid certificate of authority in the state of Washington and which the board determines to be in the best interests of employees and the state. The board shall promulgate rules setting forth criteria by which it shall evaluate the plans.

(9) Before January 1, 1998, the public employees' benefits board shall make available one or more fully insured long-term care insurance plans that comply with the requirements of chapter 48.84 RCW. Such programs shall be made available to eligible employees, retired employees, and retired school employees as well as eligible dependents

which, for the purpose of this section, includes the parents of the employee or retiree and the parents of the spouse of the employee or retiree. Employees of local governments and employees of political subdivisions not otherwise enrolled in the public employees' benefits board sponsored medical programs may enroll under terms and conditions established by the administrator, if it does not jeopardize the financial viability of the public employees' benefits board's long-term care offering.

(a) Participation of eligible employees or retired employees and retired school employees in any long-term care insurance plan made available by the public employees' benefits board is voluntary and shall not be subject to binding arbitration under chapter 41.56 RCW. Participation is subject to reasonable underwriting guidelines and eligibility rules established by the public employees' benefits board and the health care authority.

(b) The employee, retired employee, and retired school employee are solely responsible for the payment of the premium rates developed by the health care authority. The health care authority is authorized to charge a reasonable administrative fee in addition to the premium charged by the long-term care insurer, which shall include the health care authority's cost of administration, marketing, and consumer education materials prepared by the health care authority and the office of the insurance commissioner.

(c) To the extent administratively possible, the state shall establish an automatic payroll or pension deduction system for the payment of the long-term care insurance premiums.

(d) The public employees' benefits board and the health care authority shall establish a technical advisory committee to provide advice in the development of the benefit design and establishment of underwriting guidelines and eligibility rules. The committee shall also advise the board and authority on effective and cost-effective ways to market and distribute the long-term care product. The technical advisory committee shall be comprised, at a minimum, of representatives of the office of the insurance commissioner, providers of long-term care services, licensed insurance agents with expertise in long-term care insurance, employees, retired employees, retired school employees, and other interested parties determined to be appropriate by the board.

(e) The health care authority shall offer employees, retired employees, and retired school employees the option of purchasing long-term care insurance through licensed agents or brokers appointed by the long-term care insurer. The authority, in consultation with the public employees' benefits board, shall establish marketing procedures and may consider all premium components as a part of the contract negotiations with the long-term care insurer.

(f) In developing the long-term care insurance benefit designs, the public employees' benefits board shall include an alternative plan of care benefit, including adult day services, as approved by the office of the insurance commissioner.

(g) The health care authority, with the cooperation of the office of the insurance commissioner, shall develop a consumer education program for the eligible employees, retired employees, and retired school employees designed to provide education on the potential need for long-term care, methods of financing long-term care, and the availability of long-term care insurance products including the products offered by the board.

(h) By December 1998, the health care authority, in consultation with the public employees' benefits board, shall submit a report to the appropriate committees of the legislature, including an analysis of the marketing and distribution of the long-term care insurance provided under this section.

(10) The health savings account option for employees under subsection (5) of this section shall be offered to employees during the open enrollment period in 2008.

NEW SECTION. **Sec. 21.** Subheadings used in this act are not any part of the law.

NEW SECTION. **Sec. 22.** Sections 10 through 14 of this act take effect January 1, 2008.

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