2SHB 2319 - H AMD **1068**
By Representative Cody

ADOPTED 02/11/2012

Strike everything after the enacting clause and insert the following:

"**PART I**
DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage; and

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

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

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

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

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

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

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

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

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

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

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

((~~(34)~~)) (36) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, 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 for the purpose of improving enrollee health status and reducing health service costs.

PART II
THE WASHINGTON HEALTH BENEFIT EXCHANGE

Sec. 2. RCW 43.71.020 and 2011 c 317 s 3 are each amended to read as follows:

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

(a) By October 1, 2011, each of the two largest caucuses in both the house of representatives and the senate shall submit to the governor a list of five nominees who are not legislators or employees

of the state or its political subdivisions, with no caucus submitting the same nominee.

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

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

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

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

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

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

(c) By December 15, 2011, the governor shall appoint a ninth member to serve as chair. The chair may not be an employee of the state or its political subdivisions. The chair shall serve as a nonvoting member except in the case of a tie. Beginning on December 1, 2013, the chair shall serve at the pleasure of the governor.

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

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

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

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

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

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

(b) A voting board member may lobby on issues related to the exchange or the state's implementation of the affordable care act, but only to: (i) Provide information or communicating on matters pertaining to official board business to any elected official; or (ii) advocate the official position or interests of the board to any elected official. A voting board member may communicate with a member of the legislature, on issues related to the exchange or the state's implementation of the affordable care act, on the request of that member or communicate to the legislature, through proper board-approved channels, requests for legislative action or appropriations deemed necessary for the efficient conduct of the exchange or actually made in the proper performance of his or her duties as a voting board member. For purposes of this subsection, "lobby" has the same meaning as in RCW 42.17A.005.

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

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

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

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

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

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

Sec. 3. RCW 43.71.030 and 2011 c 317 s 4 are each amended to read as follows:

(1) The exchange may, consistent with the purposes of this chapter: (a) Sue and be sued in its own name; (b) make and execute agreements, contracts, and other instruments, with any public or private person or entity; (c) employ, contract with, or engage personnel; (d) pay administrative costs; ((~~and~~)) (e) accept grants, donations, loans of funds, and contributions in money, services, materials or otherwise, from the United States or any of its agencies, from the state of Washington and its agencies or from any other source, and use or expend those moneys, services, materials, or other contributions; (f) aggregate or delegate the aggregation of funds that comprise the

premium for a health plan; and (g) complete other duties necessary to begin open enrollment in qualified health plans through the exchange beginning October 2, 2013.

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

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

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

Sec. 4. RCW 43.71.060 and 2011 c 317 s 7 are each amended to read as follows:

(1) The health benefit exchange account is created in the custody of the state treasurer. All receipts from federal grants received under the affordable care act shall be deposited into the account. Expenditures from the account may be used only for purposes consistent with the grants. Until March 15, 2012, only the administrator of the health care authority, or his or her designee, may authorize expenditures from the account. ((~~Beginning March 15, 2012, only the board of the Washington health benefit exchange may authorize expenditures from the account.~~)) The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

(2) This section expires January 1, 2014.

PART III
MARKET RULES

NEW SECTION. **Sec. 5.** A new section is added to chapter 48.43 RCW to read as follows:

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

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

(3)(a) The commissioner shall adopt rules prohibiting a carrier from offering outside the exchange a health benefit plan that meets the definition of a bronze level qualified health plan under section 1302 of P.L. 111-148 of 2010, as amended, unless the carrier offers the same plan inside the exchange, if:

(i) The exchange is experiencing adverse selection or, based upon current and projected health plan enrollment patterns, the exchange is likely to experience adverse selection within the next twelve months; or

(ii) Consumers do not have an adequate choice of health plan options among the actuarial value tiers specified in section 1302 of P.L. 111-148 in the exchange.

(b) Any rules adopted under this subsection (3) may not go into effect until one full regular session of the legislature has passed following their adoption.

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

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

All health plans, other than catastrophic health plans, offered

outside of the exchange must conform with the actuarial value tiers specified in section 1302 of P.L. 111-148 of 2010, as amended, as bronze, silver, gold, or platinum.

PART IV
QUALIFIED HEALTH PLANS

NEW SECTION. **Sec. 7.** A new section is added to chapter 43.71 RCW to read as follows:

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

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

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

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

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

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

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

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

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

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

(2) Enrollee satisfaction;

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

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

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

(6) Protection of the privacy of patients' personal health information;

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

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

Sec. 9. RCW 48.42.010 and 1985 c 264 s 15 are each amended to read as follows:

(1) Notwithstanding any other provision of law, and except as provided in this chapter, any person or other entity which provides coverage in this state for life insurance, annuities, loss of time, medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether the coverage is by direct payment, reimbursement, the providing of services, or otherwise, shall be subject to the authority of the state insurance commissioner, unless the person or other entity shows that while providing the services it is subject to the

jurisdiction and regulation of another agency of this state, any subdivisions thereof, or the federal government.

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

Sec. 10. RCW 48.42.020 and 1983 c 36 s 2 are each amended to read as follows:

(1) A person or entity may show that it is subject to the jurisdiction and regulation of another agency of this state, any subdivision thereof, or the federal government, by providing to the insurance commissioner the appropriate certificate, license, or other document issued by the other governmental agency which permits or qualifies it to provide the coverage as defined in RCW 48.42.010.

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

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

Certification by the Washington health benefit exchange of a plan as a qualified health plan, or of a carrier as a qualified issuer, does not exempt the plan or carrier from any of the requirements of this title or rules adopted by the commissioner pursuant to chapter 34.05 RCW.

PART V
ESSENTIAL HEALTH BENEFITS

NEW SECTION. **Sec. 12.** A new section is added to chapter 48.43 RCW to read as follows:

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

(2) If the essential health benefits benchmark plan does not include all of the ten benefit categories specified by section 1302 of

P.L. 111-148, as amended, the commissioner, in consultation with the board and the health care authority, shall, by rule, supplement the benchmark plan benefits as needed to meet the requirements of section 1302.

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

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

(b) Does not have a plan benefits design that would create a risk of biased selection based on health status; and

(c) Contains meaningful scope and level of benefits in each of the ten essential health benefits categories specified by section 1302 of P.L. 111-148 of 2010, as amended.

(4) Beginning December 15, 2012, and every year thereafter, the commissioner shall submit to the legislature a list of state-mandated health benefits, the enforcement of which will result in federally imposed costs to the state related to the plans sold through the exchange because the benefits are not included in the essential health benefits designated under federal law. The list must include the anticipated costs to the state of each state-mandated health benefit on the list. The commissioner may enforce a mandate on the list for the entire market only if funds are appropriated in an omnibus appropriations act specifically to pay for the identified costs. During any period of time such funds are not appropriated, the mandate must be suspended for the entire market and may not be enforced by the commissioner.

NEW SECTION. **Sec. 13.** Nothing in this act prohibits the offering of benefits for spiritual care services deductible under section 213(d) of the internal revenue code in health plans inside and outside of the exchange.

PART VI
THE BASIC HEALTH OPTION

NEW SECTION. **Sec. 14.** A new section is added to chapter 70.47 RCW to read as follows:

(1) The director of the health care authority shall provide the necessary certifications to the secretary of the federal department of health and human services under section 1331 of P.L. 111-148 of 2010, as amended, for the purposes of Washington state's adoption of the federal basic health program option, unless, by September 1, 2012, the governor finds that:

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

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

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

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

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

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

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

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

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

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

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

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

(c) Achieving an appropriate balance between:

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

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

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

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

PART VII
RISK ADJUSTMENT AND REINSURANCE

NEW SECTION. **Sec. 15.** A new section is added to chapter 48.43 RCW to read as follows:

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

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

(a) A mechanism to collect reinsurance contribution funds;

(b) A reinsurance payment formula; and

(c) A mechanism to disburse reinsurance payments.

(3)(a) The rules for the reinsurance program may compensate carriers offering health plans in the exchange for the possibility of increased risk in the exchange and incentivize carrier participation in the exchange by making any or all of the following modifications to the reinsurance payment formula established by federal law:

(i) Establishing a lower attachment point inside the exchange than outside the exchange;

(ii) Establishing a higher reinsurance cap inside the exchange than outside the exchange or eliminating the reinsurance cap inside the exchange; or

(iii) Establishing a higher coinsurance rate inside the exchange than outside the exchange.

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

(c) The rules for the reinsurance program may also include requirements to encourage appropriate cost management measures by carriers, such as care management or care coordination, for persons with chronic illness or other health conditions that present a risk of incurring high claims cost.

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

(5) The commissioner must identify by rule the data needed to support operation of the reinsurance program established under this section, the sources of the data, and other requirements related to their collection, validation, interpretation, and retention.

PART VIII
THE WASHINGTON STATE HEALTH INSURANCE POOL

NEW SECTION. **Sec. 16.** A new section is added to chapter 48.41 RCW to read as follows:

(1) The board shall evaluate the populations that may need ongoing

access to the pool coverage with specific attention to those persons who may be excluded from coverage in 2014, such as persons with end-stage renal disease or HIV/AIDS, or persons not eligible for coverage in the exchange.

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

(3) The board shall complete an analysis of the pool assessments in relation to the assessments for the reinsurance program and recommend changes for the assessment or any credits that may be considered for the reinsurance program.

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

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

For policies renewed beginning January 1, 2014:

(1) Rates for pool coverage may be no more than the average individual standard rate charged for coverage comparable to pool coverage by the five largest members, measured in terms of individual market enrollment, offering such coverages in the state. In the event five members do not offer comparable coverage, rates for pool coverage may be no more than the standard risk rate established using reasonable actuarial techniques and must reflect anticipated experience and expenses for such coverage in the individual market.

(2) The pool shall reduce the premium obligation of an enrollee in the pool on or after January 1, 2014, as needed to provide the enrollee with premium subsidies equivalent to what he or she would have received in the exchange if the enrollee:

(a) Has a modified adjusted gross income below four hundred percent of federal poverty level;

(b) Is not enrolled in medicare; and

(c) Does not have an offer of minimum essential coverage.

(3) Premium subsidies provided under this subsection shall be funded through member assessments.

PART IX
EXCHANGE EMPLOYEES

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

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

NEW SECTION. **Sec. 19.** A new section is added to chapter 43.01 RCW to read as follows:

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

NEW SECTION. **Sec. 20.** A new section is added to chapter 43.03 RCW to read as follows:

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

Sec. 21. RCW 41.05.011 and 2011 1st sp.s. c 15 s 54 are each reenacted and amended to read as follows:

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

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

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

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

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

(5) "Emergency service personnel killed in the line of duty" means law enforcement officers and firefighters as defined in RCW 41.26.030, members of the Washington state patrol retirement fund as defined in

RCW 43.43.120, and reserve officers and firefighters as defined in RCW 41.24.010 who die as a result of injuries sustained in the course of employment as determined consistent with Title 51 RCW by the department of labor and industries.

(6) "Employee" includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021(1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; ((~~and~~)) (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021(1) (f) and (g)<u>; and (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021(1) (g) and (n)</u>. "Employee" does not include: Adult family homeowners; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of

higher education as determined by their institution; and any others not expressly defined as employees under this chapter or by the authority under this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 22. RCW 41.05.021 and 2011 1st sp.s. c 15 s 56 are each amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) Facilitate diagnosis or treatment;

(II) Reduce unnecessary duplication of medical tests;

(III) Promote efficient electronic physician order entry;

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

(V) Improve health outcomes;

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

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

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

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

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

(g) To ensure the continued status of the employee insurance or self-insurance programs administered under this chapter as a governmental plan under section 3(32) of the employee retirement income security act of 1974, as amended, the authority shall limit the participation of employees of a county, municipal, school district, educational service district, or other political subdivision, the Washington health benefit exchange, or a tribal government, including

providing for the participation of those employees whose services are substantially all in the performance of essential governmental functions, but not in the performance of commercial activities;

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

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

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

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

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

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

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

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

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

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

(iii) To enter into agreements with the department of social and health services for administration of medical care services programs under Titles XIX and XXI of the social security act. The agreements shall establish the division of responsibilities between the authority

and the department with respect to mental health, chemical dependency, and long-term care services, including services for persons with developmental disabilities. The agreements shall be revised as necessary, to comply with the final implementation plan adopted under section 116, chapter 15, Laws of 2011 1st sp. sess.;

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

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

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

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

(a) Standardizing the benefit package;

(b) Soliciting competitive bids for the benefit package;

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

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

PART X

MISCELLANEOUS

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

NEW SECTION. **Sec. 24.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 25.** Section 3 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately."

Correct the title.

EFFECT: Requires the Washington Health Benefit Exchange (Exchange) to be self-sustaining and requires the Exchange to develop a methodology to ensure that it is self-sustaining. Names the Exchange "the Evergreen Health Marketplace." Delays the date after which the chair of the Exchange Board (Board) will serve at the pleasure of the

Governor to December 1, 2013. Limits the lobbying restrictions to voting members of the Board. Requires the Board to establish policies permitting sponsorship of exchange enrollees. Allows the Exchange to serve as a premium aggregator. Requires the Exchange to complete other duties necessary to begin open enrollment on October 2, 2013. Allows the Exchange to charge and equitably apportion administrative costs and expenses. Removes the ability of the Board to expend funds from the Health Benefit Exchange Account and expires the account on January 1, 2014. Requires a carrier that offers a Bronze plan outside the Exchange to also offer a Gold and Silver plan outside the Exchange. Prohibits a catastrophic plan from being offered outside the Exchange. Allows the Insurance Commissioner to adopt rules to assure substantial equivalence of prescription drug benefits if he or she finds that variation in prescription drug benefits is resulting in adverse selection. Allows integrated delivery systems to be exempt from the requirement to include all essential community providers in the provider network if consistent with federal law. Requires dental benefits offered in the Exchange to be priced separately to assure transparency for consumers. Adds the following rating factors to the qualified health plan rating system: High standards for covered services, including language spoken or transportation assistance, coverage of tax-deductible spiritual care services, and enrollee satisfaction. Designates the largest small group plan in the state by enrollment as the benchmark plan for purposes of determining the essential health benefits. Adds the following to the factors the Insurance Commissioner must consider when determining whether a plan is substantially equivalent to the benchmark: Whether a plan design creates a risk (instead of a substantial risk) of biased selection based on health status and whether the plan contains meaningful scope and level of benefits (as opposed to meaningful benefits). Requires the Insurance Commissioner to submit an annual list of state-mandated benefits that will result in federally imposed costs to the state. Suspends any mandate on the list if funding is not appropriated to pay the costs. Clarifies that the act does not prohibit the offering of tax-deductible spiritual care services. Delays the date by which the Governor must make the findings necessary to not establish the federal basic health program to September 1, 2012 (from July 1, 2012). Requires payment rates in a federal basic health program to exceed 2012 Medicaid rates. Requires the Insurance Commissioner to establish rules establishing the federal risk adjustment program (in addition to the federal reinsurance program). Allows, instead of requires, the Insurance Commissioner to alter the federal reinsurance payment formula. Allows the reinsurance program rules to include requirements to encourage appropriate cost-management measures by carriers. Requires the Insurance Commissioner to contract with one or more nonprofit entities to administer the risk adjustment and reinsurance programs. Requires the commissioner to identify by rule the data needed to support operation of the reinsurance program, the sources of the data, and other requirements related to their collection, validation, interpretation, and retention. Removes provisions that closed the WSHIP to new enrollment after January 1, 2014 (but keeps provisions establishing premium rates after January 1, 2014, and requiring WSHIP enrollees to be provided Exchange-like subsidies funded by WSHIP member assessments). Requires the Washington Health Insurance Pool (WSHIP) board to evaluate the populations that may need ongoing access to the WSHIP, recommendations to pool eligibility to allow the WSHIP to continue past January 1, 2014, and changes to the assessment

or any credits that may be considered for the reinsurance programs. Allows Exchange employees to participate in state health benefit and retirement systems. Requires the Health Care Authority to pursue an application to participate in the individual market wellness program demonstration created in the federal Affordable Care Act. Makes a variety of technical corrections.

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