

E2SHB 2319 - S AMD 190

By Senators Hargrove, Kastama, Pflug

ADOPTED 03/01/2012

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

4 "PART I
5
6 DEFINITIONS

7
8 **Sec. 1.** RCW 48.43.005 and 2011 c 315 s 2 and 2011 c 314 s 3 are
9 each reenacted and amended to read as follows:

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

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

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

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

4 (4) "Basic health plan" means the plan described under chapter
5 70.47 RCW, as revised from time to time.

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

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

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

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

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

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

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

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

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

14 (i) A health benefit plan that meets the definition of
15 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
16 2010, as amended; or

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

22 ~~((+8))~~ (9) "Certification" means a determination by a review
23 organization that an admission, extension of stay, or other health
24 care service or procedure has been reviewed and, based on the
25 information provided, meets the clinical requirements for medical
26 necessity, appropriateness, level of care, or effectiveness under the
27 auspices of the applicable health benefit plan.

28 ~~((+9))~~ (10) "Concurrent review" means utilization review
29 conducted during a patient's hospital stay or course of treatment.

30 ~~((+10))~~ (11) "Covered person" or "enrollee" means a person
31 covered by a health plan including an enrollee, subscriber,
32 policyholder, beneficiary of a group plan, or individual covered by
33 any other health plan.

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1 (~~(11)~~) (12) "Dependent" means, at a minimum, the enrollee's
2 legal spouse and dependent children who qualify for coverage under the
3 enrollee's health benefit plan.

4 (~~(12)~~) (13) "Emergency medical condition" means a medical
5 condition manifesting itself by acute symptoms of sufficient severity,
6 including severe pain, such that a prudent layperson, who possesses an
7 average knowledge of health and medicine, could reasonably expect the
8 absence of immediate medical attention to result in a condition (a)
9 placing the health of the individual, or with respect to a pregnant
10 woman, the health of the woman or her unborn child, in serious
11 jeopardy, (b) serious impairment to bodily functions, or (c) serious
12 dysfunction of any bodily organ or part.

13 (~~(13)~~) (14) "Emergency services" means a medical screening
14 examination, as required under section 1867 of the social security act
15 (42 U.S.C. 1395dd), that is within the capability of the emergency
16 department of a hospital, including ancillary services routinely
17 available to the emergency department to evaluate that emergency
18 medical condition, and further medical examination and treatment, to
19 the extent they are within the capabilities of the staff and
20 facilities available at the hospital, as are required under section
21 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the
22 patient. Stabilize, with respect to an emergency medical condition,
23 has the meaning given in section 1867(e)(3) of the social security act
24 (42 U.S.C. 1395dd(e)(3)).

25 (~~(14)~~) (15) "Employee" has the same meaning given to the term,
26 as of January 1, 2008, under section 3(6) of the federal employee
27 retirement income security act of 1974.

28 (~~(15)~~) (16) "Enrollee point-of-service cost-sharing" means
29 amounts paid to health carriers directly providing services, health
30 care providers, or health care facilities by enrollees and may include
31 copayments, coinsurance, or deductibles.

32 (~~(16)~~) (17) "Exchange" means the Washington health benefit
33 exchange established under chapter 43.71 RCW.

34 (18) "Final external review decision" means a determination by an

1 independent review organization at the conclusion of an external
2 review.

3 ~~((17))~~ (19) "Final internal adverse benefit determination" means
4 an adverse benefit determination that has been upheld by a health plan
5 or carrier at the completion of the internal appeals process, or an
6 adverse benefit determination with respect to which the internal
7 appeals process has been exhausted under the exhaustion rules
8 described in RCW 48.43.530 and 48.43.535.

9 ~~((18))~~ (20) "Grandfathered health plan" means a group health
10 plan or an individual health plan that under section 1251 of the
11 patient protection and affordable care act, P.L. 111-148 (2010) and as
12 amended by the health care and education reconciliation act, P.L.
13 111-152 (2010) is not subject to subtitles A or C of the act as
14 amended.

15 ~~((19))~~ (21) "Grievance" means a written complaint submitted by
16 or on behalf of a covered person regarding: (a) Denial of payment for
17 medical services or nonprovision of medical services included in the
18 covered person's health benefit plan, or (b) service delivery issues
19 other than denial of payment for medical services or nonprovision of
20 medical services, including dissatisfaction with medical care, waiting
21 time for medical services, provider or staff attitude or demeanor, or
22 dissatisfaction with service provided by the health carrier.

23 ~~((20))~~ (22) "Health care facility" or "facility" means hospices
24 licensed under chapter 70.127 RCW, hospitals licensed under chapter
25 70.41 RCW, rural health care facilities as defined in RCW 70.175.020,
26 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes
27 licensed under chapter 18.51 RCW, community mental health centers
28 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment
29 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,
30 treatment, or surgical facilities licensed under chapter 70.41 RCW,
31 drug and alcohol treatment facilities licensed under chapter 70.96A
32 RCW, and home health agencies licensed under chapter 70.127 RCW, and
33 includes such facilities if owned and operated by a political
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1 subdivision or instrumentality of the state and such other facilities
2 as required by federal law and implementing regulations.

3 ~~((+21))~~ (23) "Health care provider" or "provider" means:

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

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

9 ~~((+22))~~ (24) "Health care service" means that service offered or
10 provided by health care facilities and health care providers relating
11 to the prevention, cure, or treatment of illness, injury, or disease.

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

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

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

24 (b) Medicare supplemental health insurance governed by chapter
25 48.66 RCW;

26 (c) Coverage supplemental to the coverage provided under chapter
27 55, Title 10, United States Code;

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

30 (e) Disability income;

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

34 (g) Workers' compensation coverage;

1 (h) Accident only coverage;

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

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

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

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

15 (~~(25)~~) (27) "Material modification" means a change in the
16 actuarial value of the health plan as modified of more than five
17 percent but less than fifteen percent.

18 (~~(26)~~) (28) "Open enrollment" means a period of time as defined
19 in rule to be held at the same time each year, during which applicants
20 may enroll in a carrier's individual health benefit plan without being
21 subject to health screening or otherwise required to provide evidence
22 of insurability as a condition for enrollment.

23 (~~(27)~~) (29) "Preexisting condition" means any medical condition,
24 illness, or injury that existed any time prior to the effective date
25 of coverage.

26 (~~(28)~~) (30) "Premium" means all sums charged, received, or
27 deposited by a health carrier as consideration for a health plan or
28 the continuance of a health plan. Any assessment or any "membership,"
29 "policy," "contract," "service," or similar fee or charge made by a
30 health carrier in consideration for a health plan is deemed part of
31 the premium. "Premium" shall not include amounts paid as enrollee
32 point- of-service cost-sharing.

33 (~~(29)~~) (31) "Review organization" means a disability insurer
34 regulated under chapter 48.20 or 48.21 RCW, health care service

1 contractor as defined in RCW 48.44.010, or health maintenance
2 organization as defined in RCW 48.46.020, and entities affiliated
3 with, under contract with, or acting on behalf of a health carrier to
4 perform a utilization review.

5 ~~((+30+))~~ (32) "Small employer" or "small group" means any person,
6 firm, corporation, partnership, association, political subdivision,
7 sole proprietor, or self-employed individual that is actively engaged
8 in business that employed an average of at least one but no more than
9 fifty employees, during the previous calendar year and employed at
10 least one employee on the first day of the plan year, is not formed
11 primarily for purposes of buying health insurance, and in which a bona
12 fide employer-employee relationship exists. In determining the number
13 of employees, companies that are affiliated companies, or that are
14 eligible to file a combined tax return for purposes of taxation by
15 this state, shall be considered an employer. Subsequent to the
16 issuance of a health plan to a small employer and for the purpose of
17 determining eligibility, the size of a small employer shall be
18 determined annually. Except as otherwise specifically provided, a
19 small employer shall continue to be considered a small employer until
20 the plan anniversary following the date the small employer no longer
21 meets the requirements of this definition. A self-employed individual
22 or sole proprietor who is covered as a group of one must also: (a)
23 Have been employed by the same small employer or small group for at
24 least twelve months prior to application for small group coverage, and
25 (b) verify that he or she derived at least seventy-five percent of his
26 or her income from a trade or business through which the individual or
27 sole proprietor has attempted to earn taxable income and for which he
28 or she has filed the appropriate internal revenue service form 1040,
29 schedule C or F, for the previous taxable year, except a self-employed
30 individual or sole proprietor in an agricultural trade or business,
31 must have derived at least fifty-one percent of his or her income from
32 the trade or business through which the individual or sole proprietor
33 has attempted to earn taxable income and for which he or she has filed
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1 the appropriate internal revenue service form 1040, for the previous
2 taxable year.

3 ~~((+31))~~ (33) "Special enrollment" means a defined period of time
4 of not less than thirty-one days, triggered by a specific qualifying
5 event experienced by the applicant, during which applicants may enroll
6 in the carrier's individual health benefit plan without being subject
7 to health screening or otherwise required to provide evidence of
8 insurability as a condition for enrollment.

9 ~~((+32))~~ (34) "Standard health questionnaire" means the standard
10 health questionnaire designated under chapter 48.41 RCW.

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

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

23

PART II

24

THE WASHINGTON HEALTH BENEFIT EXCHANGE

25

26

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

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

34

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

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

7 (3) "Board" means the governing board established in RCW
8 43.71.020.

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

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

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

17

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

20 (1) The Washington health benefit exchange is established and
21 constitutes a self-sustaining public-private partnership separate and
22 distinct from the state, exercising functions delineated in chapter
23 317, Laws of 2011. By January 1, 2014, the exchange shall operate
24 consistent with the affordable care act subject to statutory
25 authorization. The exchange shall have a governing board consisting
26 of persons with expertise in the Washington health care system and
27 private and public health care coverage. The initial membership of
28 the board shall be appointed as follows:

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

34

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16
17 **Sec. 4.** RCW 43.71.030 and 2011 c 317 s 4 are each amended to read
18 as follows:

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

32 ~~((The powers and duties of the exchange and the board are~~
33 ~~limited to those necessary to apply for and administer grants,~~
34 ~~establish information technology infrastructure, and undertake~~

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

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

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

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

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

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

33 (1) The health benefit exchange account is created in the custody of
34 the state treasurer. All receipts from federal grants received under

1 the affordable care act (~~shall~~) may be deposited into the account.
2 Expenditures from the account may be used only for purposes consistent
3 with the grants. Until March 15, 2012, only the administrator of the
4 health care authority, or his or her designee, may authorize
5 expenditures from the account. Beginning March 15, 2012, only the
6 board of the Washington health benefit exchange or designee may
7 authorize expenditures from the account. The account is subject to
8 allotment procedures under chapter 43.88 RCW, but an appropriation is
9 not required for expenditures.

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

11
12 **PART III**

13 **MARKET RULES**

14
15 NEW SECTION. **Sec. 6.** A new section is added to chapter 48.43 RCW
16 to read as follows:

17 (1) For plan or policy years beginning January 1, 2014, a carrier
18 must offer individual or small group health benefit plans that meet
19 the definition of silver and gold level plans in section 1302 of P.L.
20 111-148 of 2010, as amended, in any market outside the exchange in
21 which it offers a plan that meets the definition of bronze level in
22 section 1302 of P.L. 111-148 of 2010, as amended.

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

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

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

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

3
4 NEW SECTION. **Sec. 7.** A new section is added to chapter 48.43 RCW
5 to read as follows:

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

10 **PART IV**

11 **QUALIFIED HEALTH PLANS**

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13
14 NEW SECTION. **Sec. 8.** A new section is added to chapter 43.71 RCW
15 to read as follows:

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

18 (a) Insurance commissioner to meet the requirements of Title 48
19 RCW and rules adopted by the commissioner pursuant to chapter 34.05
20 RCW to implement the requirements of Title 48 RCW;

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

23 (c) Board to include tribal clinics and urban Indian clinics as
24 essential community providers in the plan's provider network
25 consistent with federal law. If consistent with federal law,
26 integrated delivery systems shall be exempt from the requirement to
27 include essential community providers in the provider network.

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

33
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1 (3) The board may permit direct primary care medical home plans,
2 consistent with section 1301 of P.L. 111-148 of 2010, as amended, to
3 be offered in the exchange beginning January 1, 2014.

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

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

15
16 NEW SECTION. **Sec. 9.** A new section is added to chapter 43.71 RCW
17 to read as follows:

18 The board shall establish a rating system consistent with section
19 1311 of P.L. 111-148 of 2010, as amended, for qualified health plans
20 to assist consumers in evaluating plan choices in the exchange.
21 Rating factors established by the board may include, but are not
22 limited to:

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

25 (2) Enrollee satisfaction;

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

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

31 (5) High standards for provider network adequacy, including
32 consumer choice of providers and service locations and robust provider
33 participation intended to improve access to underserved populations

34

1 through participation of essential community providers, family
2 planning providers and pediatric providers;

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

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

7
8 **Sec. 10.** RCW 48.42.010 and 1985 c 264 s 15 are each amended to
9 read as follows:

10 (1) Notwithstanding any other provision of law, and except as provided
11 in this chapter, any person or other entity which provides coverage in
12 this state for life insurance, annuities, loss of time, medical,
13 surgical, chiropractic, physical therapy, speech pathology, audiology,
14 professional mental health, dental, hospital, or optometric expenses,
15 whether the coverage is by direct payment, reimbursement, the
16 providing of services, or otherwise, shall be subject to the authority
17 of the state insurance commissioner, unless the person or other entity
18 shows that while providing the services it is subject to the
19 jurisdiction and regulation of another agency of this state, any
20 subdivisions thereof, or the federal government.

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

24
25 **Sec. 11.** RCW 48.42.020 and 1983 c 36 s 2 are each amended to read
26 as follows:

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

33
34

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

4
5 NEW SECTION. **Sec. 12.** A new section is added to chapter 48.43
6 RCW to read as follows:

7 Certification by the Washington health benefit exchange of a plan
8 as a qualified health plan, or of a carrier as a qualified issuer,
9 does not exempt the plan or carrier from any of the requirements of
10 this title or rules adopted by the commissioner pursuant to chapter
11 34.05 RCW to implement this title.

12
13 **PART V**
14 **ESSENTIAL HEALTH BENEFITS**

15
16 NEW SECTION. **Sec. 13.** A new section is added to chapter 48.43
17 RCW to read as follows:

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

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

30 (3) A health plan required to offer the essential health benefits,
31 other than a health plan offered through the federal basic health
32 program or medicaid, under P.L. 111-148 of 2010, as amended, may not
33 be offered in the state unless the commissioner finds that it is
34

1 substantially equal to the benchmark plan. When making this
2 determination, the commissioner must:

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

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

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

23
24 NEW SECTION. **Sec. 14.** Nothing in this act prohibits the offering
25 of benefits for spiritual care services deductible under section
26 213(d) of the internal revenue code in health plans inside and outside
27 of the exchange.

28
29 **PART VI**

30 **THE BASIC HEALTH OPTION**

31
32 NEW SECTION. **Sec. 15.** A new section is added to chapter 70.47
33 RCW to read as follows:

1 (1) On or before December 1, 2012, the director of the health care
2 authority shall submit a report to the legislature on whether to
3 proceed with implementation of a federal basic health option, under
4 section 1331 of P.L. 111-148 of 2010, as amended. The report shall
5 address whether:

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

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

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

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

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

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

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

34

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

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

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

13 (a) Meeting the minimum state certification standards in section
14 1331 of the federal patient protection and affordable care act;

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

21 (c) Achieving an appropriate balance between:

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

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

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

30 (d) Transparency in program administration, including active and
31 ongoing consultation with basic health program enrollees and
32 interested organizations, and ensuring adequate enrollee notice and
33 appeal rights.

34

PART VII

RISK ADJUSTMENT AND REINSURANCE

1
2
3
4 NEW SECTION. **Sec. 16.** A new section is added to chapter 48.43
5 RCW to read as follows:

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

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

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

- 22 (a) A mechanism to collect reinsurance contribution funds;
23 (b) A reinsurance payment formula; and
24 (c) A mechanism to disburse reinsurance payments.

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

28 (b) The rules adopted under this section must identify and may
29 require submission of the data needed to support operation of the
30 reinsurance and risk adjustment programs established under this
31 section. The commissioner must identify by rule the sources of the
32 data, and other requirements related to the collection, validation,
33

1 correction, interpretation, transmission or exchange, and retention of
2 the data.

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

5 (5) Contribution amounts for the transitional reinsurance program
6 under section 1341 of P.L. 111-148 of 2010, as amended, may be
7 increased to include amounts sufficient to cover the costs of
8 administration of the reinsurance program including reasonable costs
9 incurred for preoperational and planning activities related to the
10 reinsurance program.

11
12 **PART VIII**

13 **THE WASHINGTON STATE HEALTH INSURANCE POOL**

14
15 NEW SECTION. **Sec. 17.** A new section is added to chapter 48.41
16 RCW to read as follows:

17 (1) The board shall review populations that may need ongoing
18 access to coverage through the pool, with specific attention to those
19 persons who may be excluded from or may receive inadequate coverage
20 beginning January 1, 2014, such as persons with end-stage renal
21 disease or HIV/AIDS, or persons not eligible for coverage in the
22 exchange.

23 (2) If the review under subsection (1) of this section indicates a
24 continued need for coverage through the pool after December 31, 2013,
25 the board shall submit recommendations regarding any modifications to
26 pool eligibility requirements for new and ongoing enrollment after
27 December 31, 2013. The recommendations must address any needed
28 modifications to the standard health questionnaire or other
29 eligibility screening tool that could be used in a manner consistent
30 with federal law to determine eligibility for enrollment in the pool.

31 (3) The board shall complete an analysis of current pool
32 assessment requirements in relation to assessments that will fund the
33 reinsurance program and recommend changes to pool assessments or any
34 credits against assessments that may be considered for the reinsurance

1 program. The analysis shall recommend whether the categories of
2 members paying assessments should be adjusted to make the assessment
3 fair and equitable among all payers.

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

6
7 NEW SECTION. **Sec. 18.** A new section is added to chapter 48.41
8 RCW to read as follows:

9 (1) The pool is authorized to contract with the commissioner to
10 administer risk management functions if necessary, consistent with
11 section 16 of this act, and consistent with P.L. 111-148 of 2010, as
12 amended. Prior to entering into a contract, the pool may conduct
13 preoperational and planning activities related to these programs,
14 including defining and implementing an appropriate legal structure or
15 structures to administer and coordinate the reinsurance or risk
16 adjustment programs.

17 (2) The reasonable costs incurred by the pool for preoperational
18 and planning activities related to the reinsurance program may be
19 reimbursed from federal funds or from the additional contributions
20 authorized under section 16 of this act to pay the administrative
21 costs of the reinsurance program.

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

26 (4) The pool shall report on these activities to the appropriate
27 committees of the senate and house of representatives by December 15,
28 2012, and December 15, 2013.

29
30 **PART IX**
31 **EXCHANGE EMPLOYEES**
32

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

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

4
5 NEW SECTION. **Sec. 20.** A new section is added to chapter 43.01
6 RCW to read as follows:

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

9
10 NEW SECTION. **Sec. 21.** A new section is added to chapter 43.03
11 RCW to read as follows:

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

14
15 **Sec. 22.** RCW 41.05.011 and 2011 1st sp.s. c 15 s 54 are each
16 reenacted and amended to read as follows:

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

19 (1) "Authority" means the Washington state health care authority.
20 (2) "Board" means the public employees' benefits board established
21 under RCW 41.05.055.

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

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

28 (5) "Emergency service personnel killed in the line of duty" means
29 law enforcement officers and firefighters as defined in RCW 41.26.030,
30 members of the Washington state patrol retirement fund as defined in
31 RCW 43.43.120, and reserve officers and firefighters as defined in RCW
32 41.24.010 who die as a result of injuries sustained in the course of
33 employment as determined consistent with Title 51 RCW by the
34 department of labor and industries.

1 (6) "Employee" includes all employees of the state, whether or not
2 covered by civil service; elected and appointed officials of the
3 executive branch of government, including full-time members of boards,
4 commissions, or committees; justices of the supreme court and judges
5 of the court of appeals and the superior courts; and members of the
6 state legislature. Pursuant to contractual agreement with the
7 authority, "employee" may also include: (a) Employees of a county,
8 municipality, or other political subdivision of the state and members
9 of the legislative authority of any county, city, or town who are
10 elected to office after February 20, 1970, if the legislative
11 authority of the county, municipality, or other political subdivision
12 of the state seeks and receives the approval of the authority to
13 provide any of its insurance programs by contract with the authority,
14 as provided in RCW 41.04.205 and 41.05.021(1)(g); (b) employees of
15 employee organizations representing state civil service employees, at
16 the option of each such employee organization, and, effective October
17 1, 1995, employees of employee organizations currently pooled with
18 employees of school districts for the purpose of purchasing insurance
19 benefits, at the option of each such employee organization; (c)
20 employees of a school district if the authority agrees to provide any
21 of the school districts' insurance programs by contract with the
22 authority as provided in RCW 28A.400.350; (~~and~~) (d) employees of a
23 tribal government, if the governing body of the tribal government
24 seeks and receives the approval of the authority to provide any of its
25 insurance programs by contract with the authority, as provided in RCW
26 41.05.021(1) (f) and (g); and (e) employees of the Washington health
27 benefit exchange if the governing board of the exchange established in
28 RCW 43.71.020 seeks and receives approval of the authority to provide
29 any of its insurance programs by contract with the authority, as
30 provided in RCW 41.05.021(1) (g) and (n). "Employee" does not
31 include: Adult family homeowners; unpaid volunteers; patients of
32 state hospitals; inmates; employees of the Washington state convention
33 and trade center as provided in RCW 41.05.110; students of
34 institutions of higher education as determined by their institution;

1 and any others not expressly defined as employees under this chapter
2 or by the authority under this chapter.

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

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

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

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

19 (11) "Insuring entity" means an insurer as defined in chapter
20 48.01 RCW, a health care service contractor as defined in chapter
21 48.44 RCW, or a health maintenance organization as defined in chapter
22 48.46 RCW.

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

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

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

33 (15) "Premium payment plan" means a benefit plan whereby state and
34 public employees may pay their share of group health plan premiums

1 with pretax dollars as provided in the salary reduction plan under
2 this chapter pursuant to 26 U.S.C. Sec. 125 or other sections of the
3 internal revenue code.

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

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

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

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

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

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

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

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

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

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

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

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

34

1 3 as defined in RCW 41.35.010, or the public employees' retirement
2 system plan 3 as defined in RCW 41.40.010.

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

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

15

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

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

1 initiatives, joint purchasing strategies, and techniques for efficient
2 administration that have potential application to all state-purchased
3 health services; and administer grants that further the mission and
4 goals of the authority. The authority's duties include, but are not
5 limited to, the following:

6 (a) To administer health care benefit programs for employees and
7 retired or disabled school employees as specifically authorized in RCW
8 41.05.065 and in accordance with the methods described in RCW
9 41.05.075, 41.05.140, and other provisions of this chapter;

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

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

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

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

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

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

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

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

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

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

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

16 (I) Facilitate diagnosis or treatment;

17 (II) Reduce unnecessary duplication of medical tests;

18 (III) Promote efficient electronic physician order entry;

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

21 (V) Improve health outcomes;

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

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

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

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

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

16 (g) To ensure the continued status of the employee insurance or
17 self-insurance programs administered under this chapter as a
18 governmental plan under section 3(32) of the employee retirement
19 income security act of 1974, as amended, the authority shall limit the
20 participation of employees of a county, municipal, school district,
21 educational service district, or other political subdivision, the
22 Washington health benefit exchange, or a tribal government, including
23 providing for the participation of those employees whose services are
24 substantially all in the performance of essential governmental
25 functions, but not in the performance of commercial activities;

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

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

34

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

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

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

10 (i) Setting forth the criteria established by the board under RCW
11 41.05.065 for determining whether an employee is eligible for
12 benefits;

13 (ii) Establishing an appeal process in accordance with chapter
14 34.05 RCW by which an employee may appeal an eligibility
15 determination;

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

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

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

26 (iii) To enter into agreements with the department of social and
27 health services for administration of medical care services programs
28 under Titles XIX and XXI of the social security act. The agreements
29 shall establish the division of responsibilities between the authority
30 and the department with respect to mental health, chemical dependency,
31 and long-term care services, including services for persons with
32 developmental disabilities. The agreements shall be revised as
33 necessary, to comply with the final implementation plan adopted under
34 section 116, chapter 15, Laws of 2011 1st sp. sess.;

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

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

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

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

33 (a) Standardizing the benefit package;

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

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

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

9

10 **PART X**

11 **MISCELLANEOUS**

12

13

14

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

22

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

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

29

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

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

35

36

1 NEW SECTION. **Sec. 27.** If any provision of this act or its
2 application to any person or circumstance is held invalid, the
3 remainder of the act or the application of the provision to other
4 persons or circumstances is not affected.

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

11 **E2SHB 2319** - S COMM AMD

12 By Committee on Health & Long-Term Care

13
14 On page 1, line 2 of the title, after "act;" strike the remainder of
15 the title and insert "amending RCW 43.71.010, 43.71.020, 43.71.030,
16 43.71.060, 48.42.010, 48.42.020, and 41.05.021; reenacting and
17 amending RCW 48.43.005 and 41.05.011; adding new sections to chapter
18 48.43 RCW; adding new sections to chapter 43.71 RCW; adding a new
19 section to chapter 70.47 RCW; adding new sections to chapter 48.41
20 RCW; adding a new section to chapter 41.04 RCW; adding a new section
21 to chapter 43.01 RCW; adding a new section to chapter 43.03 RCW;
22 creating new sections; providing an expiration date; and declaring an
23 emergency."

EFFECT:

Definitions: Modified definition of "self-sustaining" to remove
the word "participating."

Exchange Board: Removed reference to "Evergreen Health
Marketplace."

Modified methodology to make Exchange self-sustaining to
require input from carriers and to assure final authority for
determining the methodology rests with the Legislature.

Employers offering coverage in the SHOP may specify a
level of coverage so that employees may enroll in any qualified
health plan offered at the specified level of coverage.

Market Rules: Removes requirement that carriers offer the
identical small group plan in and out of Exchange.

Removes option for OIC to require carriers to offer
bronze plans outside the Exchange if they offer one within the

Exchange.

Removes the offer of a public option if the Board finds there are not sufficient plans participating in the Exchange.

Qualified Health Plans: Clarifies that OIC is to enforce rules to Title 48 RCW regulating carriers (i.e., this section does not broaden the scope of OIC authority to introduce new sets of rules). Adds a reference to allow the Board to make direct primary care practices available through the Exchange. Modifies the consumer rating guide to reference section 1311 of the ACA and allows the Board to modify the rating factors.

Essential Health Benefits: Adds sentence requiring OIC to report on any statutory changes that would be needed if the Legislature decides not to fund a mandate. Removes sentence relating to suspension of mandates.

Basic Health Option: Requires the Health Care Authority to submit recommendations to the Legislature on whether to implement a BHP by December 1, 2012. The HCA proceeds with certification if the Legislature decides to proceed with implementation.

Restates references to health plan reimbursement that must be sufficient to ensure robust provider networks and health homes as described in SB 5394 (Laws of 2011).

If funding is provided in the operating budget, the HCA must continue work on developing BHP eligibility and enrollment systems until the Legislature determines there is sufficient funding for the operations of the program.

Reinsurance and Risk Adjustment: As requested by WSHIP, permits OIC to increase assessments to fund preoperational and planning activities for reinsurance.

WSHIP: References potential increased assessments to fund preoperational and planning activities for reinsurance.

Producers: Adds a new section clarifying that: Activities of navigators that are consistent with the ACA shall not be considered soliciting or negotiating insurance as stated under chapter 48.17 RCW.

Adds a new section that says that if the Exchange is not self-sustaining as defined in the bill, the operations shall be suspended.

Emergency clause: Adds sections to the emergency clause to allow for development of the reinsurance and risk adjustment programs.

--- END ---