

HB 1000 - H AMD 3014

By Representative Barkis

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

2 **"PART I**

3 **DEFINITIONS**

4
5 **Sec. 1.** RCW 48.43.005 and 2011 c 315 s 2 and 2011 c 314 s 3 are
6 each reenacted and amended to read as follows:

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

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

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

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

1 (4) "Basic health plan" means the plan described under chapter
2 70.47 RCW, as revised from time to time.

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

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

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

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

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

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

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

33 (b) In July 2008, and in each July thereafter, the insurance
34 commissioner shall adjust the minimum deductible and out-of-pocket

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

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

10 (i) A health benefit plan that meets the definition of
11 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
12 2010, as amended; or

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

18 ~~((+8))~~ (9) "Certification" means a determination by a review
19 organization that an admission, extension of stay, or other health
20 care service or procedure has been reviewed and, based on the
21 information provided, meets the clinical requirements for medical
22 necessity, appropriateness, level of care, or effectiveness under the
23 auspices of the applicable health benefit plan.

24 ~~((+9))~~ (10) "Concurrent review" means utilization review
25 conducted during a patient's hospital stay or course of treatment.

26 ~~((+10))~~ (11) "Covered person" or "enrollee" means a person
27 covered by a health plan including an enrollee, subscriber,
28 policyholder, beneficiary of a group plan, or individual covered by
29 any other health plan.

30 ~~((+11))~~ (12) "Dependent" means, at a minimum, the enrollee's
31 legal spouse and dependent children who qualify for coverage under the
32 enrollee's health benefit plan.

33 ~~((+12))~~ (13) "Emergency medical condition" means a medical
34 condition manifesting itself by acute symptoms of sufficient severity,

1 including severe pain, such that a prudent layperson, who possesses an
2 average knowledge of health and medicine, could reasonably expect the
3 absence of immediate medical attention to result in a condition (a)
4 placing the health of the individual, or with respect to a pregnant
5 woman, the health of the woman or her unborn child, in serious
6 jeopardy, (b) serious impairment to bodily functions, or (c) serious
7 dysfunction of any bodily organ or part.

8 ~~((+13+))~~ (14) "Emergency services" means a medical screening
9 examination, as required under section 1867 of the social security act
10 (42 U.S.C. 1395dd), that is within the capability of the emergency
11 department of a hospital, including ancillary services routinely
12 available to the emergency department to evaluate that emergency
13 medical condition, and further medical examination and treatment, to
14 the extent they are within the capabilities of the staff and
15 facilities available at the hospital, as are required under section
16 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the
17 patient. Stabilize, with respect to an emergency medical condition,
18 has the meaning given in section 1867(e)(3) of the social security act
19 (42 U.S.C. 1395dd(e)(3)).

20 ~~((+14+))~~ (15) "Employee" has the same meaning given to the term,
21 as of January 1, 2008, under section 3(6) of the federal employee
22 retirement income security act of 1974.

23 ~~((+15+))~~ (16) "Enrollee point-of-service cost-sharing" means
24 amounts paid to health carriers directly providing services, health
25 care providers, or health care facilities by enrollees and may include
26 copayments, coinsurance, or deductibles.

27 ~~((+16+))~~ (17) "Exchange" means the Washington health benefit
28 exchange established under chapter 43.71 RCW.

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

32 ~~((+17+))~~ (19) "Final internal adverse benefit determination" means
33 an adverse benefit determination that has been upheld by a health plan
34 or carrier at the completion of the internal appeals process, or an

1 adverse benefit determination with respect to which the internal
2 appeals process has been exhausted under the exhaustion rules
3 described in RCW 48.43.530 and 48.43.535.

4 ~~((+18+))~~ (20) "Grandfathered health plan" means a group health
5 plan or an individual health plan that under section 1251 of the
6 patient protection and affordable care act, P.L. 111148 (2010) and as
7 amended by the health care and education reconciliation act, P.L.
8 111152 (2010) is not subject to subtitles A or C of the act as
9 amended.

10 ~~((+19+))~~ (21) "Grievance" means a written complaint submitted by
11 or on behalf of a covered person regarding: (a) Denial of payment for
12 medical services or nonprovision of medical services included in the
13 covered person's health benefit plan, or (b) service delivery issues
14 other than denial of payment for medical services or nonprovision of
15 medical services, including dissatisfaction with medical care, waiting
16 time for medical services, provider or staff attitude or demeanor, or
17 dissatisfaction with service provided by the health carrier.

18 ~~((+20+))~~ (22) "Health care facility" or "facility" means hospices
19 licensed under chapter 70.127 RCW, hospitals licensed under chapter
20 70.41 RCW, rural health care facilities as defined in RCW 70.175.020,
21 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes
22 licensed under chapter 18.51 RCW, community mental health centers
23 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment
24 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,
25 treatment, or surgical facilities licensed under chapter 70.41 RCW,
26 drug and alcohol treatment facilities licensed under chapter 70.96A
27 RCW, and home health agencies licensed under chapter 70.127 RCW, and
28 includes such facilities if owned and operated by a political
29 subdivision or instrumentality of the state and such other facilities
30 as required by federal law and implementing regulations.

31 ~~((+21+))~~ (23) "Health care provider" or "provider" means:

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

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

3 ~~((+22))~~ (24) "Health care service" means that service offered or
4 provided by health care facilities and health care providers relating
5 to the prevention, cure, or treatment of illness, injury, or disease.

6 ~~((+23))~~ (25) "Health carrier" or "carrier" means a disability
7 insurer regulated under chapter 48.20 or 48.21 RCW, a health care
8 service contractor as defined in RCW 48.44.010, or a health
9 maintenance organization as defined in RCW 48.46.020, and includes
10 "issuers" as that term is used in the patient protection and
11 affordable care act (P.L. 111-148).

12 ~~((+24))~~ (26) "Health plan" or "health benefit plan" means any
13 policy, contract, or agreement offered by a health carrier to provide,
14 arrange, reimburse, or pay for health care services except the
15 following:

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

18 (b) Medicare supplemental health insurance governed by chapter
19 48.66 RCW;

20 (c) Coverage supplemental to the coverage provided under chapter
21 55, Title 10, United States Code;

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

24 (e) Disability income;

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

28 (g) Workers' compensation coverage;

29 (h) Accident only coverage;

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

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

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

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

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

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

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

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

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

32 ((+30+)) (32) "Small employer" or "small group" means any person,
33 firm, corporation, partnership, association, political subdivision,
34 sole proprietor, or self-employed individual that is actively engaged

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

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

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

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

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

9

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30 (3) A member of the board whose term has expired or who otherwise
31 leaves the board shall be replaced by gubernatorial appointment. When
32 the person leaving was nominated by one of the caucuses of the house
33 of representatives or the senate, his or her replacement shall be
34 appointed from a list of five nominees submitted by that caucus within

1 thirty days after the person leaves. If the member to be replaced is
2 the chair, the governor shall appoint a new chair within thirty days
3 after the vacancy occurs. A person appointed to replace a member who
4 leaves the board prior to the expiration of his or her term shall
5 serve only the duration of the unexpired term. Members of the board
6 may be reappointed to multiple terms.

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

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

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

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

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

28 (8) Members of the board are not civilly or criminally liable and
29 may not have any penalty or cause of action of any nature arise
30 against them for any action taken or not taken, including any
31 discretionary decision or failure to make a discretionary decision,
32 when the action or inaction is done in good faith and in the
33 performance of the powers and duties under chapter 317, Laws of 2011.

34

1 Nothing in this section prohibits legal actions against the board to
2 enforce the board's statutory or contractual duties or obligations.

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

7

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

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

23 ~~((The powers and duties of the exchange and the board are~~
24 ~~limited to those necessary to apply for and administer grants,~~
25 ~~establish information technology infrastructure, and undertake~~
26 ~~additional administrative functions necessary to begin operation of~~
27 ~~the exchange by January 1, 2014. Any actions relating to substantive~~
28 ~~issues included in RCW 43.71.040 must be consistent with statutory~~
29 ~~direction on those issues.)) The board shall develop a methodology to
30 ensure the exchange is self-sustaining after December 31, 2014. The
31 board shall seek input from health carriers to develop funding
32 mechanisms that fairly and equitably apportion among carriers the
33 reasonable administrative costs and expenses incurred to implement the
34 provisions of this chapter. The board shall submit its~~

1 recommendations to the legislature by December 1, 2012. If the
2 legislature does not enact legislation during the 2013 regular session
3 to modify or reject the board's recommendations, the board may proceed
4 with implementation of the recommendations.

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

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

12 (5) Qualified employers may access coverage for their employees
13 through the exchange for small groups under section 1311 of P.L.
14 111-148 of 2010, as amended. The exchange shall enable any qualified
15 employer to specify a level of coverage so that any of its employees
16 may enroll in any qualified health plan offered through the small
17 group exchange at the specified level of coverage.

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

21
22 **Sec. 5.** RCW 43.71.060 and 2011 c 317 s 7 are each amended to read
23 as follows:

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

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

2
3 **PART III**

4 **MARKET RULES**

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

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

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

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

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

28
29 NEW SECTION. **Sec. 7.** A new section is added to chapter 48.43 RCW
30 to read as follows:

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

1
2 **PART IV**

3 **QUALIFIED HEALTH PLANS**

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

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

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

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

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

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

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

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

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

4
5 NEW SECTION. **Sec. 9.** A new section is added to chapter 43.71 RCW
6 to read as follows:

7 The board shall establish a rating system consistent with section
8 1311 of P.L. 111-148 of 2010, as amended, for qualified health plans
9 to assist consumers in evaluating plan choices in the exchange.
10 Rating factors established by the board may include, but are not
11 limited to:

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

14 (2) Enrollee satisfaction;

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

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

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

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

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

29
30 **Sec. 10.** RCW 48.42.010 and 1985 c 264 s 15 are each amended to
31 read as follows:

32 (1) Notwithstanding any other provision of law, and except as provided
33 in this chapter, any person or other entity which provides coverage in
34 this state for life insurance, annuities, loss of time, medical,

1 surgical, chiropractic, physical therapy, speech pathology, audiology,
2 professional mental health, dental, hospital, or optometric expenses,
3 whether the coverage is by direct payment, reimbursement, the
4 providing of services, or otherwise, shall be subject to the authority
5 of the state insurance commissioner, unless the person or other entity
6 shows that while providing the services it is subject to the
7 jurisdiction and regulation of another agency of this state, any
8 subdivisions thereof, or the federal government.

9 (2) "Another agency of this state, any subdivision thereof, or the
10 federal government" does not include the Washington health benefit
11 exchange under chapter 43.71 RCW or P.L. 111-148 of 2010, as amended.
12

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

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

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

27 Certification by the Washington health benefit exchange of a plan
28 as a qualified health plan, or of a carrier as a qualified issuer,
29 does not exempt the plan or carrier from any of the requirements of
30 this title or rules adopted by the commissioner pursuant to chapter
31 34.05 RCW to implement this title.
32

33 PART V

34 ESSENTIAL HEALTH BENEFITS

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NEW SECTION. **Sec. 13.** 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 the individual and small group market 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 for the individual and small group market 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 minimum 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:

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

(b) May consider whether the health plan has a benefit design that would create a risk of biased selection based on health status and whether the health plan contains meaningful scope and level of benefits in each of the ten essential health benefit 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

1 benefits designated under federal law. The list must include the
2 anticipated costs to the state of each state-mandated health benefit
3 on the list and any statutory changes needed if funds are not
4 appropriated to defray the state costs for the listed mandate. The
5 commissioner may enforce a mandate on the list for the entire market
6 only if funds are appropriated in an omnibus appropriations act
7 specifically to pay the state portion of the identified costs.

8
9 NEW SECTION. **Sec. 14.** Nothing in this act prohibits the offering
10 of benefits for spiritual care services deductible under section
11 213(d) of the internal revenue code in health plans inside and outside
12 of the exchange.

13
14 **PART VI**

15 **THE BASIC HEALTH OPTION**

16
17 NEW SECTION. **Sec. 15.** A new section is added to chapter 70.47
18 RCW to read as follows:

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

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

27 (b) Anticipated federal funding under section 1331 will be
28 sufficient, absent any additional state funding, to cover the
29 provision of essential health benefits and costs for administering the
30 basic health plan. Enrollee premium levels will be below the levels
31 that would apply to persons with income between one hundred
32 thirty-four and two hundred percent of the federal poverty level
33 through the exchange; and

34

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

4 (2) If the legislature determines to proceed with implementation
5 of a federal basic health option, the director shall provide the
6 necessary certifications to the secretary of the federal department of
7 health and human services under section 1331 of P.L. 111-148 of 2010,
8 as amended, to proceed with adoption of the federal basic health
9 program option.

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

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

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

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

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

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

31 (a) Meeting the minimum state certification standards in section
32 1331 of the federal patient protection and affordable care act;

33 (b) To the extent allowed by the federal department of health and
34 human services, twelve-month continuous eligibility for the basic

1 health program, and corresponding twelve-month continuous enrollment
2 in standard health plans by enrollees; or, in lieu of twelve-month
3 continuous eligibility, financing mechanisms that enable enrollees to
4 remain with a plan for the entire plan year;

5 (c) Achieving an appropriate balance between:

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

8 (ii) Standard health plan contracting requirements that minimize
9 plan and provider administrative costs, while incentivizing
10 improvements in quality and enrollee health outcomes; and

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

14 (d) Transparency in program administration, including active and
15 ongoing consultation with basic health program enrollees and
16 interested organizations, and ensuring adequate enrollee notice and
17 appeal rights.

18
19 **PART VII**

20 **RISK ADJUSTMENT AND REINSURANCE**

21
22 NEW SECTION. **Sec. 16.** A new section is added to chapter 48.43
23 RCW to read as follows:

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

27 (b) The commissioner must include in deliberations related to
28 reinsurance rule making an analysis of an invisible high risk pool
29 option, in which the full premium and risk associated with certain
30 high-risk or high-cost enrollees would be ceded to the transitional
31 reinsurance program. The analysis must include a determination as to
32 whether that option is authorized under the federal reinsurance
33 program regulations, whether the option would provide sufficiently
34 comprehensive coverage for current nonmedicare high risk pool

1 enrollees, and how an invisible high risk pool option could be
2 designed to ensure that carriers ceding risk provide effective care
3 management to high-risk or high-cost enrollees.

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

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

7 (b) A reinsurance payment formula; and

8 (c) A mechanism to disburse reinsurance payments.

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

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

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

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

27

28 PART VIII

29

30 THE WASHINGTON STATE HEALTH INSURANCE POOL

31

32

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

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

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

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

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

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

22

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

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

33 (2) The reasonable costs incurred by the pool for preoperational
34 and planning activities related to the reinsurance program may be

1 reimbursed from federal funds or from the additional contributions
2 authorized under section 16 of this act to pay the administrative
3 costs of the reinsurance program.

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

8 (4) The pool shall report on these activities to the appropriate
9 committees of the senate and house of representatives by December 15,
10 2012, and December 15, 2013.

11
12 **PART IX**

13 **EXCHANGE EMPLOYEES**

14
15 NEW SECTION. **Sec. 19.** A new section is added to chapter 41.04
16 RCW to read as follows:

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

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

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

25
26 NEW SECTION. **Sec. 21.** A new section is added to chapter 43.03
27 RCW to read as follows:

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

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

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

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

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

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

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

10 (5) "Emergency service personnel killed in the line of duty" means
11 law enforcement officers and firefighters as defined in RCW 41.26.030,
12 members of the Washington state patrol retirement fund as defined in
13 RCW 43.43.120, and reserve officers and firefighters as defined in RCW
14 41.24.010 who die as a result of injuries sustained in the course of
15 employment as determined consistent with Title 51 RCW by the
16 department of labor and industries.

17 (6) "Employee" includes all employees of the state, whether or not
18 covered by civil service; elected and appointed officials of the
19 executive branch of government, including full-time members of boards,
20 commissions, or committees; justices of the supreme court and judges
21 of the court of appeals and the superior courts; and members of the
22 state legislature. Pursuant to contractual agreement with the
23 authority, "employee" may also include: (a) Employees of a county,
24 municipality, or other political subdivision of the state and members
25 of the legislative authority of any county, city, or town who are
26 elected to office after February 20, 1970, if the legislative
27 authority of the county, municipality, or other political subdivision
28 of the state seeks and receives the approval of the authority to
29 provide any of its insurance programs by contract with the authority,
30 as provided in RCW 41.04.205 and 41.05.021(1)(g); (b) employees of
31 employee organizations representing state civil service employees, at
32 the option of each such employee organization, and, effective October
33 1, 1995, employees of employee organizations currently pooled with
34 employees of school districts for the purpose of purchasing insurance

1 benefits, at the option of each such employee organization; (c)
2 employees of a school district if the authority agrees to provide any
3 of the school districts' insurance programs by contract with the
4 authority as provided in RCW 28A.400.350; (~~and~~) (d) employees of a
5 tribal government, if the governing body of the tribal government
6 seeks and receives the approval of the authority to provide any of its
7 insurance programs by contract with the authority, as provided in RCW
8 41.05.021(1) (f) and (g); and (e) employees of the Washington health
9 benefit exchange if the governing board of the exchange established in
10 RCW 43.71.020 seeks and receives approval of the authority to provide
11 any of its insurance programs by contract with the authority, as
12 provided in RCW 41.05.021(1) (g) and (n). "Employee" does not
13 include: Adult family homeowners; unpaid volunteers; patients of
14 state hospitals; inmates; employees of the Washington state convention
15 and trade center as provided in RCW 41.05.110; students of
16 institutions of higher education as determined by their institution;
17 and any others not expressly defined as employees under this chapter
18 or by the authority under this chapter.

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

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

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

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

1 (11) "Insuring entity" means an insurer as defined in chapter
2 48.01 RCW, a health care service contractor as defined in chapter
3 48.44 RCW, or a health maintenance organization as defined in chapter
4 48.46 RCW.

5 (12) "Medical flexible spending arrangement" means a benefit plan
6 whereby state and public employees may reduce their salary before
7 taxes to pay for medical expenses not reimbursed by insurance as
8 provided in the salary reduction plan under this chapter pursuant to
9 26 U.S.C. Sec. 125 or other sections of the internal revenue code.

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

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

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

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

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

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

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

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

33 (18) "Salary reduction plan" means a benefit plan whereby state
34 and public employees may agree to a reduction of salary on a pretax

1 basis to participate in the dependent care assistance program, medical
2 flexible spending arrangement, or premium payment plan offered
3 pursuant to 26 U.S.C. Sec. 125 or other sections of the internal
4 revenue code.

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

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

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

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

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

13 and who are at least age fifty-five and have at least ten years of
14 service under the teachers' retirement system plan 3 as defined in RCW
15 41.32.010(33), the Washington school employees' retirement system plan
16 3 as defined in RCW 41.35.010, or the public employees' retirement
17 system plan 3 as defined in RCW 41.40.010.

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

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

30

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

33 (1) The Washington state health care authority is created within
34 the executive branch. The authority shall have a director appointed

1 by the governor, with the consent of the senate. The director shall
2 serve at the pleasure of the governor. The director may employ a
3 deputy director, and such assistant directors and special assistants
4 as may be needed to administer the authority, who shall be exempt from
5 chapter 41.06 RCW, and any additional staff members as are necessary
6 to administer this chapter. The director may delegate any power or
7 duty vested in him or her by law, including authority to make final
8 decisions and enter final orders in hearings conducted under chapter
9 34.05 RCW. The primary duties of the authority shall be to:

10 Administer state employees' insurance benefits and retired or disabled
11 school employees' insurance benefits; administer the basic health plan
12 pursuant to chapter 70.47 RCW; administer the children's health
13 program pursuant to chapter 74.09 RCW; study state-purchased health
14 care programs in order to maximize cost containment in these programs
15 while ensuring access to quality health care; implement state
16 initiatives, joint purchasing strategies, and techniques for efficient
17 administration that have potential application to all state-purchased
18 health services; and administer grants that further the mission and
19 goals of the authority. The authority's duties include, but are not
20 limited to, the following:

21 (a) To administer health care benefit programs for employees and
22 retired or disabled school employees as specifically authorized in RCW
23 41.05.065 and in accordance with the methods described in RCW
24 41.05.075, 41.05.140, and other provisions of this chapter;

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

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

33 (ii) Utilization of provider arrangements that encourage cost
34 containment, including but not limited to prepaid delivery systems,

1 utilization review, and prospective payment methods, and that ensure
2 access to quality care, including assuring reasonable access to local
3 providers, especially for employees residing in rural areas;

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

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

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

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

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

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

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

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

31 (I) Facilitate diagnosis or treatment;

32 (II) Reduce unnecessary duplication of medical tests;

33 (III) Promote efficient electronic physician order entry;

34

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

3 (V) Improve health outcomes;

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

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

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

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

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

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

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

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

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

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

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

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

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

28 (ii) Establishing an appeal process in accordance with chapter
29 34.05 RCW by which an employee may appeal an eligibility
30 determination;

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

1 (m)(i) To administer the medical services programs established
2 under chapter 74.09 RCW as the designated single state agency for
3 purposes of Title XIX of the federal social security act;
4 (ii) To administer the state children's health insurance program
5 under chapter 74.09 RCW for purposes of Title XXI of the federal
6 social security act;
7 (iii) To enter into agreements with the department of social and
8 health services for administration of medical care services programs
9 under Titles XIX and XXI of the social security act. The agreements
10 shall establish the division of responsibilities between the authority
11 and the department with respect to mental health, chemical dependency,
12 and long-term care services, including services for persons with
13 developmental disabilities. The agreements shall be revised as
14 necessary, to comply with the final implementation plan adopted under
15 section 116, chapter 15, Laws of 2011 1st sp. sess.;
16 (iv) To adopt rules to carry out the purposes of chapter 74.09
17 RCW;
18 (v) To appoint such advisory committees or councils as may be
19 required by any federal statute or regulation as a condition to the
20 receipt of federal funds by the authority. The director may appoint
21 statewide committees or councils in the following subject areas: (A)
22 Health facilities; (B) children and youth services; (C) blind
23 services; (D) medical and health care; (E) drug abuse and alcoholism;
24 (F) rehabilitative services; and (G) such other subject matters as are
25 or come within the authority's responsibilities. The statewide
26 councils shall have representation from both major political parties
27 and shall have substantial consumer representation. Such committees
28 or councils shall be constituted as required by federal law or as the
29 director in his or her discretion may determine. The members of the
30 committees or councils shall hold office for three years except in the
31 case of a vacancy, in which event appointment shall be only for the
32 remainder of the unexpired term for which the vacancy occurs. No
33 member shall serve more than two consecutive terms. Members of such
34 state advisory committees or councils may be paid their travel

1 expenses in accordance with RCW 43.03.050 and 43.03.060 as now
2 existing or hereafter amended;

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

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

14 (a) Standardizing the benefit package;

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

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

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

24

PART X

25

MISCELLANEOUS

26

27

28 NEW SECTION. Sec. 24. The health care authority shall pursue an
29 application for the state to participate in the individual market
30 wellness program demonstration as described in section 2705 of P.L.
31 111-148 of 2010, as amended. The health care authority shall pursue
32 activities that will prepare the state to apply for the demonstration
33 project once announced by the United States department of health and
34 human services.

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

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

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

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

NEW SECTION. **Sec. 27.** 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. 28.** Sections 4, 16, 18, and 19 through 23 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect immediately."

E2SHB 2319 - S COMM AMD
By Committee on Health & Long-Term Care

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

EFFECT:

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 ---