
ENGROSSED SENATE BILL 6589

State of Washington

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By Senators Kastama and Tom

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1 AN ACT Relating to direct patient-provider primary care practice
2 services for public employees; amending RCW 41.05.065 and 48.150.030;
3 and reenacting and amending RCW 48.150.010.

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

5 **Sec. 1.** RCW 41.05.065 and 2011 1st sp.s. c 8 s 1 are each amended
6 to read as follows:

7 (1) The board shall study all matters connected with the provision
8 of health care coverage, life insurance, liability insurance,
9 accidental death and dismemberment insurance, and disability income
10 insurance or any of, or a combination of, the enumerated types of
11 insurance for employees and their dependents on the best basis possible
12 with relation both to the welfare of the employees and to the state.
13 However, liability insurance shall not be made available to dependents.

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

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

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

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

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

15 (e) Effective coordination of benefits; and

16 (f) Minimum standards for insuring entities.

17 (3) To maintain the comprehensive nature of employee health care
18 benefits, benefits provided to employees shall be substantially
19 equivalent to the state employees' health benefits plan in effect on
20 January 1, 1993. Nothing in this subsection shall prohibit changes or
21 increases in employee point-of-service payments or employee premium
22 payments for benefits or the administration of a high deductible health
23 plan in conjunction with a health savings account. This subsection
24 does not prohibit the board from offering a plan incorporating primary
25 care services through a direct patient-provider primary care practice
26 as provided in subsection (6) of this section. The board may establish
27 employee eligibility criteria which are not substantially equivalent to
28 employee eligibility criteria in effect on January 1, 1993.

29 (4) Except if bargained for under chapter 41.80 RCW, the board
30 shall design benefits and determine the terms and conditions of
31 employee and retired employee participation and coverage, including
32 establishment of eligibility criteria subject to the requirements of
33 this chapter. Employer groups obtaining benefits through contractual
34 agreement with the authority for employees defined in RCW 41.05.011(6)
35 (a) through (d) may contractually agree with the authority to benefits
36 eligibility criteria which differs from that determined by the board.
37 The eligibility criteria established by the board shall be no more
38 restrictive than the following:

1 (a) Except as provided in (b) through (e) of this subsection, an
2 employee is eligible for benefits from the date of employment if the
3 employing agency anticipates he or she will work an average of at least
4 eighty hours per month and for at least eight hours in each month for
5 more than six consecutive months. An employee determined ineligible
6 for benefits at the beginning of his or her employment shall become
7 eligible in the following circumstances:

8 (i) An employee who works an average of at least eighty hours per
9 month and for at least eight hours in each month and whose anticipated
10 duration of employment is revised from less than or equal to six
11 consecutive months to more than six consecutive months becomes eligible
12 when the revision is made.

13 (ii) An employee who works an average of at least eighty hours per
14 month over a period of six consecutive months and for at least eight
15 hours in each of those six consecutive months becomes eligible at the
16 first of the month following the six-month averaging period.

17 (b) A seasonal employee is eligible for benefits from the date of
18 employment if the employing agency anticipates that he or she will work
19 an average of at least eighty hours per month and for at least eight
20 hours in each month of the season. A seasonal employee determined
21 ineligible at the beginning of his or her employment who works an
22 average of at least half-time, as defined by the board, per month over
23 a period of six consecutive months and at least eight hours in each of
24 those six consecutive months becomes eligible at the first of the month
25 following the six-month averaging period. A benefits-eligible seasonal
26 employee who works a season of less than nine months shall not be
27 eligible for the employer contribution during the off season, but may
28 continue enrollment in benefits during the off season by self-paying
29 for the benefits. A benefits-eligible seasonal employee who works a
30 season of nine months or more is eligible for the employer contribution
31 through the off season following each season worked.

32 (c) Faculty are eligible as follows:

33 (i) Faculty who the employing agency anticipates will work
34 half-time or more for the entire instructional year or equivalent nine-
35 month period are eligible for benefits from the date of employment.
36 Eligibility shall continue until the beginning of the first full month
37 of the next instructional year, unless the employment relationship is

1 terminated, in which case eligibility shall cease the first month
2 following the notice of termination or the effective date of the
3 termination, whichever is later.

4 (ii) Faculty who the employing agency anticipates will not work for
5 the entire instructional year or equivalent nine-month period are
6 eligible for benefits at the beginning of the second consecutive
7 quarter or semester of employment in which he or she is anticipated to
8 work, or has actually worked, half-time or more. Such an employee
9 shall continue to receive uninterrupted employer contributions for
10 benefits if the employee works at least half-time in a quarter or
11 semester. Faculty who the employing agency anticipates will not work
12 for the entire instructional year or equivalent nine-month period, but
13 who actually work half-time or more throughout the entire instructional
14 year, are eligible for summer or off-quarter coverage. Faculty who
15 have met the criteria of this subsection (4)(c)(ii), who work at least
16 two quarters of the academic year with an average academic year
17 workload of half-time or more for three quarters of the academic year,
18 and who have worked an average of half-time or more in each of the two
19 preceding academic years shall continue to receive uninterrupted
20 employer contributions for benefits if he or she works at least half-
21 time in a quarter or semester or works two quarters of the academic
22 year with an average academic workload each academic year of half-time
23 or more for three quarters. Eligibility under this section ceases
24 immediately if this criteria is not met.

25 (iii) Faculty may establish or maintain eligibility for benefits by
26 working for more than one institution of higher education. When
27 faculty work for more than one institution of higher education, those
28 institutions shall prorate the employer contribution costs, or if
29 eligibility is reached through one institution, that institution will
30 pay the full employer contribution. Faculty working for more than one
31 institution must alert his or her employers to his or her potential
32 eligibility in order to establish eligibility.

33 (iv) The employing agency must provide written notice to faculty
34 who are potentially eligible for benefits under this subsection (4)(c)
35 of their potential eligibility.

36 (v) To be eligible for maintenance of benefits through averaging
37 under (c)(ii) of this subsection, faculty must provide written

1 notification to his or her employing agency or agencies of his or her
2 potential eligibility.

3 (d) A legislator is eligible for benefits on the date his or her
4 term begins. All other elected and full-time appointed officials of
5 the legislative and executive branches of state government are eligible
6 for benefits on the date his or her term begins or they take the oath
7 of office, whichever occurs first.

8 (e) A justice of the supreme court and judges of the court of
9 appeals and the superior courts become eligible for benefits on the
10 date he or she takes the oath of office.

11 (f) Except as provided in (c)(i) and (ii) of this subsection,
12 eligibility ceases for any employee the first of the month following
13 termination of the employment relationship.

14 (g) In determining eligibility under this section, the employing
15 agency may disregard training hours, standby hours, or temporary
16 changes in work hours as determined by the authority under this
17 section.

18 (h) Insurance coverage for all eligible employees begins on the
19 first day of the month following the date when eligibility for benefits
20 is established. If the date eligibility is established is the first
21 working day of a month, insurance coverage begins on that date.

22 (i) Eligibility for an employee whose work circumstances are
23 described by more than one of the eligibility categories in (a) through
24 (e) of this subsection shall be determined solely by the criteria of
25 the category that most closely describes the employee's work
26 circumstances.

27 (j) Except for an employee eligible for benefits under (b) or
28 (c)(ii) of this subsection, an employee who has established eligibility
29 for benefits under this section shall remain eligible for benefits each
30 month in which he or she is in pay status for eight or more hours, if
31 (i) he or she remains in a benefits-eligible position and (ii) leave
32 from the benefits-eligible position is approved by the employing
33 agency. A benefits-eligible seasonal employee is eligible for the
34 employer contribution in any month of his or her season in which he or
35 she is in pay status eight or more hours during that month.
36 Eligibility ends if these conditions are not met, the employment
37 relationship is terminated, or the employee voluntarily transfers to a
38 noneligible position.

1 (k) For the purposes of this subsection:

2 (i) "Academic year" means summer, fall, winter, and spring quarters
3 or semesters;

4 (ii) "Half-time" means one-half of the full-time academic workload
5 as determined by each institution, except that half-time for community
6 and technical college faculty employees shall have the same meaning as
7 "part-time" under RCW 28B.50.489;

8 (iii) "Benefits-eligible position" shall be defined by the board.

9 (5) The board may authorize premium contributions for an employee
10 and the employee's dependents in a manner that encourages the use of
11 cost-efficient managed health care systems.

12 (6)(a)(i) For any open enrollment period following August 24, 2011,
13 the board shall offer a health savings account option for employees
14 that conforms to section 223, Part VII of subchapter B of chapter 1 of
15 the internal revenue code of 1986. The board shall comply with all
16 applicable federal standards related to the establishment of health
17 savings accounts.

18 (ii) As a pilot project, during the 2013 and 2014 plan years the
19 board shall offer employees enrolled in a self-insured health plan the
20 option to receive primary care services from a direct patient-provider
21 primary care practice as provided in chapter 48.150 RCW. For any
22 member enrolled in the option offered under this subsection (6)(a)(ii),
23 the direct fee under RCW 48.150.010 shall be paid by the member's
24 health plan at no additional cost to the member. For any plan year,
25 the option offered under this subsection (6)(a)(ii) shall be limited by
26 the board to enrollees who utilized at least twice the median value of
27 care for a member during the first nine months of the prior plan year,
28 except that a member who is already enrolled in the option may remain
29 enrolled in subsequent years if the option is offered by the board.
30 The board shall negotiate a direct fee that reflects the intensity of
31 such care. Additionally, enrollment in the option offered under this
32 subsection (6)(a)(ii) shall be limited to no more than two thousand
33 members living in King and Pierce counties. The board shall use best
34 efforts to inform and educate prospective plan enrollees on the
35 existence and benefits of the option offered under this subsection
36 (6)(a)(ii). These efforts shall include, but not be limited to, an
37 invitation to direct patient-provider primary care practices eligible
38 to participate in any plan offered under this subsection to participate

1 in open enrollment meetings and other beneficiary communication
2 methods. No later than November 1, 2014, the board shall submit a
3 report to the legislature on the direct practice option offered under
4 this subsection, describing the impact of the option on plan costs and
5 the health of the members enrolled in the option.

6 (b) By November 30, 2015, and each year thereafter, the authority
7 shall submit a report to the relevant legislative policy and fiscal
8 committees that includes the following:

9 (i) Public employees' benefits board health plan cost and service
10 utilization trends for the previous three years, in total and for each
11 health plan offered to employees;

12 (ii) For each health plan offered to employees, the number and
13 percentage of employees and dependents enrolled in the plan, and the
14 age and gender demographics of enrollees in each plan;

15 (iii) Any impact of enrollment in alternatives to the most
16 comprehensive plan, including the high deductible health plan with a
17 health savings account, upon the cost of health benefits for those
18 employees who have chosen to remain enrolled in the most comprehensive
19 plan.

20 (7) Notwithstanding any other provision of this chapter, for any
21 open enrollment period following August 24, 2011, the board shall offer
22 a high deductible health plan in conjunction with a health savings
23 account developed under subsection (6) of this section.

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

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

35 (10) Before January 1, 1998, the public employees' benefits board
36 shall make available one or more fully insured long-term care insurance
37 plans that comply with the requirements of chapter 48.84 RCW. Such
38 programs shall be made available to eligible employees, retired

1 employees, and retired school employees as well as eligible dependents
2 which, for the purpose of this section, includes the parents of the
3 employee or retiree and the parents of the spouse of the employee or
4 retiree. Employees of local governments, political subdivisions, and
5 tribal governments not otherwise enrolled in the public employees'
6 benefits board sponsored medical programs may enroll under terms and
7 conditions established by the administrator, if it does not jeopardize
8 the financial viability of the public employees' benefits board's long-
9 term care offering.

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

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

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

28 (d) The public employees' benefits board and the health care
29 authority shall establish a technical advisory committee to provide
30 advice in the development of the benefit design and establishment of
31 underwriting guidelines and eligibility rules. The committee shall
32 also advise the board and authority on effective and cost-effective
33 ways to market and distribute the long-term care product. The
34 technical advisory committee shall be comprised, at a minimum, of
35 representatives of the office of the insurance commissioner, providers
36 of long-term care services, licensed insurance agents with expertise in
37 long-term care insurance, employees, retired employees, retired school

1 employees, and other interested parties determined to be appropriate by
2 the board.

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

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

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

21 (11) The board may establish penalties to be imposed by the
22 authority when the eligibility determinations of an employing agency
23 fail to comply with the criteria under this chapter.

24 **Sec. 2.** RCW 48.150.010 and 2009 c 552 s 1 are each reenacted and
25 amended to read as follows:

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

28 (1) "Direct agreement" means a written agreement entered into
29 between a direct practice and an individual direct patient, or the
30 parent or legal guardian of the direct patient or a family of direct
31 patients, whereby the direct practice charges a direct fee as
32 consideration for being available to provide and providing primary care
33 services to the individual direct patient. "Direct agreement" also
34 means an agreement entered into by a direct practice to provide primary
35 care services to members enrolled in the option offered under RCW
36 41.05.065(6)(a)(ii) in exchange for a direct fee. A direct agreement

1 must (a) describe the specific health care services the direct practice
2 will provide; and (b) be terminable at will upon written notice by the
3 direct patient.

4 (2) "Direct fee" means a fee charged by a direct practice as
5 consideration for being available to provide and providing primary care
6 services as specified in a direct agreement.

7 (3) "Direct patient" means a person who is party to a direct
8 agreement and is entitled to receive primary care services under the
9 direct agreement from the direct practice.

10 (4) "Direct patient-provider primary care practice" and "direct
11 practice" means a provider, group, or entity that meets the following
12 criteria in (a), (b), (c), and (d) of this subsection:

13 (a)(i) A health care provider who furnishes primary care services
14 through a direct agreement;

15 (ii) A group of health care providers who furnish primary care
16 services through a direct agreement; or

17 (iii) An entity that sponsors, employs, or is otherwise affiliated
18 with a group of health care providers who furnish only primary care
19 services through a direct agreement, which entity is wholly owned by
20 the group of health care providers or is a nonprofit corporation exempt
21 from taxation under section 501(c)(3) of the internal revenue code, and
22 is not otherwise regulated as a health care service contractor, health
23 maintenance organization, or disability insurer under Title 48 RCW.
24 Such entity is not prohibited from sponsoring, employing, or being
25 otherwise affiliated with other types of health care providers not
26 engaged in a direct practice;

27 (b) Enters into direct agreements with direct patients or parents
28 or legal guardians of direct patients;

29 (c) Does not accept payment for health care services provided to
30 direct patients from any entity subject to regulation under Title 48
31 RCW or plans administered under chapter 41.05, 70.47, or 70.47A RCW,
32 except for direct fees paid on behalf of direct patients enrolled in
33 the option offered under RCW 41.05.065(6)(a)(ii); and

34 (d) Does not provide, in consideration for the direct fee,
35 services, procedures, or supplies such as prescription drugs,
36 hospitalization costs, major surgery, dialysis, high level radiology
37 (CT, MRI, PET scans or invasive radiology), rehabilitation services,

1 procedures requiring general anesthesia, or similar advanced
2 procedures, services, or supplies.

3 (5) "Health care provider" or "provider" means a person regulated
4 under Title 18 RCW or chapter 70.127 RCW to practice health or health-
5 related services or otherwise practicing health care services in this
6 state consistent with state law.

7 (6) "Health carrier" or "carrier" has the same meaning as in RCW
8 48.43.005.

9 (7) "Network" means the group of participating providers and
10 facilities providing health care services to a particular health
11 carrier's health plan or to plans administered under chapter 41.05,
12 70.47, or 70.47A RCW.

13 (8) "Primary care" means routine health care services, including
14 screening, assessment, diagnosis, and treatment for the purpose of
15 promotion of health, and detection and management of disease or injury.

16 **Sec. 3.** RCW 48.150.030 and 2007 c 267 s 5 are each amended to read
17 as follows:

18 (1) A direct practice must charge a direct fee on a monthly basis.
19 The fee must represent the total amount due for all primary care
20 services specified in the direct agreement and may be paid by the
21 direct patient or on his or her behalf by others.

22 (2) A direct practice must:

23 (a) Maintain appropriate accounts and provide data regarding
24 payments made and services received to direct patients upon request;
25 and

26 (b) Either:

27 (i) Bill patients at the end of each monthly period; or

28 (ii) If the patient pays the monthly fee in advance, promptly
29 refund to the direct patient all unearned direct fees following receipt
30 of written notice of termination of the direct agreement from the
31 direct patient. The amount of the direct fee considered earned shall
32 be a proration of the monthly fee as of the date the notice of
33 termination is received.

34 (3) If the patient chooses to pay more than one monthly direct fee
35 in advance, the funds must be held in a trust account and paid to the
36 direct practice as earned at the end of each month. Any unearned
37 direct fees held in trust following receipt of termination of the

1 direct agreement shall be promptly refunded to the direct patient. The
2 amount of the direct fee earned shall be a proration of the monthly fee
3 for the then current month as of the date the notice of termination is
4 received.

5 (4) The direct fee schedule applying to an existing direct patient
6 may not be increased over the annual negotiated amount more frequently
7 than annually. A direct practice shall provide advance notice to
8 existing patients of any change within the fee schedule applying to
9 those existing direct patients. A direct practice shall provide at
10 least sixty days' advance notice of any change in the fee.

11 (5) A direct practice must designate a contact person to receive
12 and address any patient complaints.

13 (6) Direct fees for comparable services within a direct practice
14 shall not vary from patient to patient based on health status or sex.
15 Direct fees paid on behalf of direct patients enrolled in the option
16 offered under RCW 41.05.065(6)(a)(ii) in which enrollment is limited to
17 enrollees who utilize substantially more health care services than
18 average may vary to reflect the intensity of services used.

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