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**SENATE BILL 5653**

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**State of Washington 65th Legislature 2017 Regular Session**

**By** Senators Becker, Braun, Brown, Bailey, Padden, Zeiger, King, Wilson, O'Ban, Rossi, Walsh, Hawkins, and Fain

AN ACT Relating to administration of the public employees' benefits program; amending RCW 41.50.030, 41.05.013, 41.05.014, 41.05.015, 41.05.017, 41.05.019, 41.05.021, 41.05.022, 41.05.023, 41.05.026, 41.05.033, 41.05.035, 41.05.036, 41.05.039, 41.05.046, 41.05.055, 41.05.065, 41.05.074, 41.05.075, 41.05.085, 41.05.123, 41.05.130, 41.05.143, 41.05.160, 41.05.175, 41.05.177, 41.05.180, 41.05.183, 41.05.220, 41.05.310, 41.05.400, 41.05.520, 41.05.540, 41.05.550, 41.05.600, 41.05.601, 41.05.630, 41.05.655, and 41.05.660; reenacting and amending RCW 41.05.011 and 41.05.120; adding a new section to chapter 41.50 RCW; adding a new chapter to Title 43 RCW; creating a new section; recodifying RCW 41.05.014, 41.05.015, 41.05.036, 41.05.037, 41.05.220, 41.05.230, 41.05.400, 41.05.520, 41.05.530, 41.05.550, 41.05.600, 41.05.601, 41.05.650, 41.05.651, 41.05.660, 41.05.670, 41.05.680, 41.05.690, 41.05.730, 41.05.735, and 41.05.800; repealing RCW 41.05.006 and 41.05.295; and providing an effective date.

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

NEW SECTION. **Sec.**  The legislature finds that the nature of the work outside the public employees' benefits program at the health care authority is very different than providing benefits to public employees and this difference has caused inefficiencies in the way services are provided. The legislature further finds that customers and services of the public employees' benefits board and the department of retirement systems are similar in that both provide benefits to public employees and retirees.

Therefore, it is the intent of the legislature that administration of the public employees' benefits board is moved to be managed by the department of retirement systems.

NEW SECTION. **Sec.**  A new section is added to chapter 41.50 RCW to read as follows:

(1) All powers, duties, and functions of the health care authority pertaining to the public employees' benefits board are transferred to the department of retirement systems.

(2)(a) All reports, documents, surveys, books, records, files, papers, or written material in the possession of the health care authority pertaining to the powers, functions, and duties transferred shall be delivered to the custody of the department of retirement systems. All funds, credits, or other assets held in connection with the powers, functions, and duties transferred shall be assigned to the department of retirement systems.

(b) Whenever any question arises as to the transfer of any funds, books, documents, records, papers, files, or other tangible property used or held in the exercise of the powers and the performance of the duties and functions transferred, the director of financial management shall make a determination as to the proper allocation and certify the same to the state agencies concerned.

(3) All rules and all pending business before the health care authority pertaining to the powers, functions, and duties transferred shall be continued and acted upon by the department of retirement systems. All existing contracts and obligations shall remain in full force and shall be performed by the department of retirement systems.

(4) The transfer of the powers, duties, and functions of the health care authority shall not affect the validity of any act performed before the effective date of this section.

(5) Nothing contained in this section may be construed to alter any existing collective bargaining unit or the provisions of any existing collective bargaining agreement until the agreement has expired or until the bargaining unit has been modified by action of the public employment relations commission as provided by law.

**Sec.**  RCW 41.50.030 and 2011 1st sp.s. c 47 s 20 are each amended to read as follows:

(1) As soon as possible but not more than one hundred and eighty days after March 19, 1976, there is transferred to the department of retirement systems, except as otherwise provided in this chapter, all powers, duties, and functions of:

(a) The Washington public employees' retirement system;

(b) The Washington state teachers' retirement system;

(c) The Washington law enforcement officers' and firefighters' retirement system;

(d) The Washington state patrol retirement system;

(e) The Washington judicial retirement system; and

(f) The state treasurer with respect to the administration of the judges' retirement fund imposed pursuant to chapter 2.12 RCW.

(2) On July 1, 1996, there is transferred to the department all powers, duties, and functions of the deferred compensation committee.

(3) The department shall administer chapter 41.34 RCW.

(4) The department shall administer the Washington school employees' retirement system created under chapter 41.35 RCW.

(5) The department shall administer the Washington public safety employees' retirement system created under chapter 41.37 RCW.

(6) The department shall administer the collection of employer contributions and initial prefunding of the higher education retirement plan supplemental benefits, also referred to as the annuity or retirement income plans created under chapter 28B.10 RCW.

(7) The department shall administer the public employees' benefits board under chapter 41.05 RCW.

**Sec.**  RCW 41.05.011 and 2016 c 241 s 136 and 2016 c 67 s 2 are each reenacted and amended to read as follows:

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

(1) "Authority" or "department" means the ((~~Washington state health care authority~~)) department of retirement systems.

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

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

(4) "Director" means the director of ((~~the authority~~)) retirement systems.

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

(6) "Employee" includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021(1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021(1) (f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021(1)(g) ((~~and (n)~~)); and (f) employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under this chapter or by the authority under this chapter.

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

(8) "Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, and educational service districts, and employee organizations representing state civil service employees, obtaining employee benefits through a contractual agreement with the authority.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(23)~~)) "Tribal government" means an Indian tribal government as defined in section 3(32) of the employee retirement income security act of 1974, as amended, or an agency or instrumentality of the tribal government, that has government offices principally located in this state.

**Sec.**  RCW 41.05.013 and 2006 c 307 s 8 are each amended to read as follows:

(1) The authority shall coordinate state agency efforts to develop and implement uniform policies across state purchased health care programs that will ensure prudent, cost-effective health services purchasing, maximize efficiencies in administration of state purchased health care programs, improve the quality of care provided through state purchased health care programs, and reduce administrative burdens on health care providers participating in state purchased health care programs. The policies adopted should be based, to the extent possible, upon the best available scientific and medical evidence and shall endeavor to address:

(a) Methods of formal assessment, such as a health technology assessment under RCW 70.14.080 through 70.14.130. Consideration of the best available scientific evidence does not preclude consideration of experimental or investigational treatment or services under a clinical investigation approved by an institutional review board;

(b) Monitoring of health outcomes, adverse events, quality, and cost-effectiveness of health services;

(c) Development of a common definition of medical necessity; and

(d) Exploration of common strategies for disease management and demand management programs, including asthma, diabetes, heart disease, and similar common chronic diseases. Strategies to be explored include individual asthma management plans. On January 1, 2007, and January 1, 2009, the authority shall issue a status report to the legislature summarizing any results it attains in exploring and coordinating strategies for asthma, diabetes, heart disease, and other chronic diseases.

(2) The ((~~administrator~~)) director may invite health care provider organizations, carriers, other health care purchasers, and consumers to participate in efforts undertaken under this section.

(3) For the purposes of this section "best available scientific and medical evidence" means the best available clinical evidence derived from systematic research.

**Sec.**  RCW 41.05.014 and 2009 c 201 s 2 are each amended to read as follows:

(1) The ((~~administrator~~)) director may require applications, enrollment forms, and eligibility certification documents for benefits that are administered by the authority under this chapter and chapters 70.47 and 70.47A RCW to be signed by the person submitting them. The ((~~administrator~~)) director may accept electronic signatures.

(2) For the purpose of this section, "electronic signature" means a signature in electronic form attached to or logically associated with an electronic record including, but not limited to, a digital signature.

**Sec.**  RCW 41.05.015 and 2011 1st sp.s. c 15 s 55 are each amended to read as follows:

The director shall designate a medical director who is licensed under chapter 18.57 or 18.71 RCW. ((~~The director shall also appoint such professional personnel and other assistants and employees, including professional medical screeners, as may be reasonably necessary to carry out the provisions of this chapter and chapter 74.09 RCW. The medical screeners must be supervised by one or more physicians whom the director or the director's designee shall appoint.~~))

**Sec.**  RCW 41.05.017 and 2016 c 139 s 4 are each amended to read as follows:

Each health plan that provides medical insurance offered under this chapter or chapter 43.--- RCW (the new chapter created in section 50 of this act), including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, are subject to the provisions of RCW 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545, 48.43.550, 70.02.110, 70.02.900, 48.43.190, and 48.43.083.

**Sec.**  RCW 41.05.019 and 2011 1st sp.s. c 8 s 2 are each amended to read as follows:

(1) The ((~~Washington state health care~~)) authority shall develop a plan to incorporate direct patient-provider primary care practices as provided in chapter 48.150 RCW into one or more of the choices of health benefit programs made available to participants in the public employees' benefits board system beginning no later than the open enrollment period beginning November 1, 2012.

(2) The plan will be developed in consultation with the board and interested parties, will identify statutory barriers to implementation, and will include proposed legislation to address those barriers and implement the plan. The plan will be submitted to the board and to the house of representatives and senate health care committees by December 1, 2011.

**Sec.**  RCW 41.05.021 and 2012 c 87 s 23 are each amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

(B) Through state health purchasing, reimbursement, or pilot strategies, promote and increase the adoption of health information technology systems, including electronic medical records, by hospitals as defined in RCW 70.41.020((~~(4)~~)) (7), integrated delivery systems, and providers that:

(I) Facilitate diagnosis or treatment;

(II) Reduce unnecessary duplication of medical tests;

(III) Promote efficient electronic physician order entry;

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

(V) Improve health outcomes;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Standardizing the benefit package;

(b) Soliciting competitive bids for the benefit package;

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

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

**Sec.**  RCW 41.05.022 and 1995 1st sp.s. c 6 s 3 are each amended to read as follows:

(1) The ((~~health care authority~~)) board is hereby designated as the single state agent for purchasing health services for public employees.

(2) On and after January 1, 1995, at least the following state-purchased health services programs shall be merged into a single, community-rated risk pool: Health benefits for groups of employees of school districts and educational service districts that voluntarily purchase health benefits as provided in RCW 41.05.011; health benefits for state employees; health benefits for eligible retired or disabled school employees not eligible for parts A and B of medicare; and health benefits for eligible state retirees not eligible for parts A and B of medicare.

(3) When purchasing health services, at a minimum, and regardless of other legislative enactments, the ((~~state health services purchasing agent~~)) board shall:

(a) Require that a public agency that provides subsidies for a substantial portion of services now covered under the basic health plan use uniform eligibility processes, insofar as may be possible, and ensure that multiple eligibility determinations are not required;

(b) Require that a health care provider or a health care facility that receives funds from a public program provide care to state residents receiving a state subsidy who may wish to receive care from them, and that an insuring entity that receives funds from a public program accept enrollment from state residents receiving a state subsidy who may wish to enroll with them;

(c) ((~~Strive~~)) Work with the authority to integrate purchasing for all publicly sponsored health services in order to maximize the cost control potential and promote the most efficient methods of financing and coordinating services;

(d) Consult regularly with the governor, the legislature, and state agency directors whose operations are affected by the implementation of this section; and

(e) Ensure the control of benefit costs under managed competition by adopting rules to prevent employers from entering into an agreement with employees or employee organizations when the agreement would result in increased utilization in public employees' benefits board plans or reduce the expected savings of managed competition.

NEW SECTION. **Sec.**  The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

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

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

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

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

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

NEW SECTION. **Sec.**  The director shall appoint such professional personnel and other assistants and employees, including professional medical screeners, as may be reasonably necessary to carry out the provisions of this chapter and chapter 74.09 RCW. The medical screeners must be supervised by one or more physicians whom the director or the director's designee shall appoint.

NEW SECTION. **Sec.**  (1) The Washington state health care authority is created within the executive branch. The authority shall have a director appointed by the governor, with the consent of the senate. The director shall serve at the pleasure of the governor. The director may employ a deputy director, and such assistant directors and special assistants as may be needed to administer the authority, who shall be exempt from chapter 41.06 RCW, and any additional staff members as are necessary to administer this chapter. The director may delegate any power or duty vested in him or her by law, including authority to make final decisions and enter final orders in hearings conducted under chapter 34.05 RCW.

(2) The primary duties of the authority shall be to: Administer the basic health plan pursuant to chapter 70.47 RCW; administer the children's health program pursuant to chapter 74.09 RCW; consult with the public employees' benefits board on studies and joint purchasing strategies in order to maximize cost containment in these programs while ensuring access to quality health care; implement state initiatives and techniques for efficient administration; and administer grants that further the mission and goals of the authority.

(3) The authority's duties include, but are not limited to, the following:

(a) To coordinate with the public employees' benefits board on analysis, pilots, strategies, and measures as described under RCW 41.05.021;

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

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

(d) To adopt rules consistent with this chapter including, but not limited to:

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

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

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

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

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

(vi) Reviewing and approving or denying the application from the governing board of the Washington health benefit exchange to provide state-sponsored insurance or self-insurance programs to employees of the exchange. The authority shall (A) establish the conditions for participation; (B) have the sole right to reject an application; and (C) set the premium contribution for approved groups as outlined in RCW 41.05.050.

NEW SECTION. **Sec.**  When purchasing health services, at a minimum, and regardless of other legislative enactments, the authority shall:

(1) Require that a health care provider or a health care facility that receives funds from a public program provide care to state residents receiving a state subsidy who may wish to receive care from them, and that an insuring entity that receives funds from a public program accept enrollment from state residents receiving a state subsidy who may wish to enroll with them; and

(2) Work with the public employees' benefits board to integrate purchasing for all publicly sponsored health services in order to maximize the cost control potential and promote the most efficient methods of financing and coordinating services.

**Sec.**  RCW 41.05.023 and 2007 c 259 s 6 are each amended to read as follows:

(1) The ((~~health care~~)) authority, in collaboration with the department of health, shall design and implement a chronic care management program for state employees enrolled in the state's self-insured uniform medical plan. Programs must be evidence based, facilitating the use of information technology to improve quality of care and must improve coordination of primary, acute, and long-term care for those enrollees with multiple chronic conditions. The authority shall consider expansion of existing medical home and chronic care management programs. The authority shall use best practices in identifying those employees best served under a chronic care management model using predictive modeling through claims or other health risk information.

(2) For purposes of this section:

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

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

**Sec.**  RCW 41.05.026 and 2005 c 274 s 277 are each amended to read as follows:

(1) When soliciting proposals for the purpose of awarding contracts for goods or services, the ((~~administrator~~)) director shall, upon written request by the bidder, exempt from public inspection and copying such proprietary data, trade secrets, or other information contained in the bidder's proposal that relate to the bidder's unique methods of conducting business or of determining prices or premium rates to be charged for services under terms of the proposal.

(2) When soliciting information for the development, acquisition, or implementation of state purchased health care services, the ((~~administrator~~)) director shall, upon written request by the respondent, exempt from public inspection and copying such proprietary data, trade secrets, or other information submitted by the respondent that relate to the respondent's unique methods of conducting business, data unique to the product or services of the respondent, or to determining prices or rates to be charged for services.

(3) Actuarial formulas, statistics, cost and utilization data, or other proprietary information submitted upon request of the ((~~administrator~~)) director, board, or a technical review committee created to facilitate the development, acquisition, or implementation of state purchased health care under this chapter by a contracting insurer, health care service contractor, health maintenance organization, vendor, or other health services organization may be withheld at any time from public inspection when necessary to preserve trade secrets or prevent unfair competition.

(4) The board, or a technical review committee created to facilitate the development, acquisition, or implementation of state purchased health care under this chapter, may hold an executive session in accordance with chapter 42.30 RCW during any regular or special meeting to discuss information submitted in accordance with subsections (1) through (3) of this section.

(5) A person who challenges a request for or designation of information as exempt under this section is entitled to seek judicial review pursuant to chapter 42.56 RCW.

**Sec.**  RCW 41.05.033 and 2007 c 259 s 2 are each amended to read as follows:

(1) The legislature finds that there is growing evidence that, for preference-sensitive care involving elective surgery, patient-practitioner communication is improved through the use of high‑quality decision aids that detail the benefits, harms, and uncertainty of available treatment options. Improved communication leads to more fully informed patient decisions. The legislature intends to increase the extent to which patients make genuinely informed, preference-based treatment decisions, by promoting public/private collaborative efforts to broaden the development, certification, use, and evaluation of effective decision aids and by recognition of shared decision making and patient decision aids in the state's laws on informed consent.

(2) The ((~~health care~~)) authority shall implement a shared decision‑making demonstration project. The demonstration project shall be conducted at one or more multispecialty group practice sites providing state purchased health care in the state of Washington, and may include other practice sites providing state purchased health care. The demonstration project shall include the following elements:

(a) Incorporation into clinical practice of one or more decision aids for one or more identified preference-sensitive care areas combined with ongoing training and support of involved practitioners and practice teams, preferably at sites with necessary supportive health information technology;

(b) An evaluation of the impact of the use of shared decision making with decision aids, including the use of preference-sensitive health care services selected for the demonstration project and expenditures for those services, the impact on patients, including patient understanding of the treatment options presented and concordance between patient values and the care received, and patient and practitioner satisfaction with the shared decision-making process; and

(c) As a condition of participating in the demonstration project, a participating practice site must bear the cost of selecting, purchasing, and incorporating the chosen decision aids into clinical practice.

(3) The ((~~health care~~)) authority may solicit and accept funding and in-kind contributions to support the demonstration and evaluation, and may scale the evaluation to fall within resulting resource parameters.

**Sec.**  RCW 41.05.035 and 2007 c 259 s 10 are each amended to read as follows:

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

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

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

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

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

(2) The ((~~administrator~~)) director may establish an advisory board, a stakeholder committee, and subcommittees to assist in carrying out the duties under this section. The ((~~administrator~~)) director may reappoint health information infrastructure advisory board members to assure continuity and shall appoint any additional representatives that may be required for their expertise and experience.

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

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

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

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

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

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

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

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

**Sec.**  RCW 41.05.036 and 2011 1st sp.s. c 15 s 57 are each amended to read as follows:

The definitions in this section apply throughout ((~~RCW 41.05.039 through 41.05.046~~)) this chapter unless the context clearly requires otherwise.

(1) "Director" means the director of the state health care authority under this chapter.

(2) "Exchange" means the methods or medium by which health care information may be electronically and securely exchanged among authorized providers, payors, and patients within Washington state.

(3) "Health care provider" or "provider" has the same meaning as in RCW 48.43.005.

(4) "Health data provider" means an organization that is a primary source for health-related data for Washington residents, including but not limited to:

(a) The children's health immunizations linkages and development profile immunization registry provided by the department of health pursuant to chapter 43.70 RCW;

(b) Commercial laboratories providing medical laboratory testing results;

(c) Prescription drugs clearinghouses, such as the national patient health information network; and

(d) Diagnostic imaging centers.

(5) "Lead organization" means a private sector organization or organizations designated by the director to lead development of processes, guidelines, and standards under chapter 300, Laws of 2009.

(6) "Payor" means public purchasers, as defined in this section, carriers licensed under chapters 48.20, 48.21, 48.44, 48.46, and 48.62 RCW, and the Washington state health insurance pool established in chapter 48.41 RCW.

(7) "Public purchaser" means the department of social and health services, the department of labor and industries, and the health care authority.

(8) "Secretary" means the secretary of the department of health.

**Sec.**  RCW 41.05.039 and 2009 c 300 s 3 are each amended to read as follows:

(1) By August 1, 2009, the ((~~administrator~~)) director shall designate one or more lead organizations to coordinate development of processes, guidelines, and standards to:

(a) Improve patient access to and control of their own health care information and thereby enable their active participation in their own care; and

(b) Implement methods for the secure exchange of clinical data as a means to promote:

(i) Continuity of care;

(ii) Quality of care;

(iii) Patient safety; and

(iv) Efficiency in medical practices.

(2) The lead organization designated by the ((~~administrator~~)) director under this section shall:

(a) Be representative of health care privacy advocates, providers, and payors across the state;

(b) Have expertise and knowledge in the major disciplines related to the secure exchange of health data;

(c) Be able to support the costs of its work without recourse to state funding. The ((~~administrator~~)) director and the lead organization are authorized and encouraged to seek federal funds, including funds from the federal American recovery and reinvestment act, as well as solicit, receive, contract for, collect, and hold grants, donations, and gifts to support the implementation of this section and RCW 41.05.042;

(d) In collaboration with the ((~~administrator~~)) director, identify and convene work groups, as needed, to accomplish the goals of this section and RCW 41.05.042;

(e) Conduct outreach and communication efforts to maximize the adoption of the guidelines, standards, and processes developed by the lead organization;

(f) Submit regular updates to the ((~~administrator~~)) director on the progress implementing the requirements of this section and RCW 41.05.042; and

(g) With the ((~~administrator~~)) director, report to the legislature December 1, 2009, and on December 1st of each year through December 1, 2012, on progress made, the time necessary for completing tasks, and identification of future tasks that should be prioritized for the next improvement cycle.

(3) Within available funds as specified in subsection (2)(c) of this section, the ((~~administrator~~)) director shall:

(a) Participate in and review the work and progress of the lead organization, including the establishment and operation of work groups for this section and RCW 41.05.042; and

(b) Consult with the office of the attorney general to determine whether:

(i) An antitrust safe harbor is necessary to enable licensed carriers and providers to develop common rules and standards; and, if necessary, take steps, such as implementing rules or requesting legislation, to establish a safe harbor; and

(ii) Legislation is needed to limit provider liability if their health records are missing health information despite their participation in the exchange of health information.

(4) The lead organization or organizations shall take steps to minimize the costs that implementation of the processes, guidelines, and standards may have on participating entities, including providers.

**Sec.**  RCW 41.05.046 and 2009 c 300 s 5 are each amended to read as follows:

If any provision in RCW 41.05.036 (as recodified by this act), 41.05.039, and 41.05.042 conflicts with existing or new federal requirements, the ((~~administrator~~)) director shall recommend modifications, as needed, to assure compliance with the aims of RCW 41.05.036 (as recodified by this act), 41.05.039, and 41.05.042 and federal requirements.

**Sec.**  RCW 41.05.055 and 2009 c 537 s 6 are each amended to read as follows:

(1) The public employees' benefits board is created within the authority. The function of the board is to design and approve insurance benefit plans for employees and to establish eligibility criteria for participation in insurance benefit plans.

(2) The board shall be composed of nine members appointed by the governor as follows:

(a) Two representatives of state employees, one of whom shall represent an employee union certified as exclusive representative of at least one bargaining unit of classified employees, and one of whom is retired, is covered by a program under the jurisdiction of the board, and represents an organized group of retired public employees;

(b) Two representatives of school district employees, one of whom shall represent an association of school employees and one of whom is retired, and represents an organized group of retired school employees;

(c) Four members with experience in health benefit management and cost containment; and

(d) The ((~~administrator~~)) director.

(3) The member who represents an association of school employees and one member appointed pursuant to subsection (2)(c) of this section shall be nonvoting members until such time that there are no less than twelve thousand school district employee subscribers enrolled with the authority for health care coverage.

(4) The governor shall appoint the initial members of the board to staggered terms not to exceed four years. Members appointed thereafter shall serve two-year terms. Members of the board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060. The board shall prescribe rules for the conduct of its business. The ((~~administrator~~)) director shall serve as chair of the board. Meetings of the board shall be at the call of the chair.

**Sec.**  RCW 41.05.065 and 2015 c 116 s 3 are each amended to read as follows:

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

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

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

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

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

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

(e) Effective coordination of benefits; and

(f) Minimum standards for insuring entities.

(3) To maintain the comprehensive nature of employee health care benefits, benefits provided to employees shall be substantially equivalent to the state employees' health benefit((~~s~~)) plan in effect on January 1, 1993. Nothing in this subsection shall prohibit changes or increases in employee point-of-service payments or employee premium payments for benefits or the administration of a high deductible health plan in conjunction with a health savings account. The board may establish employee eligibility criteria which are not substantially equivalent to employee eligibility criteria in effect on January 1, 1993.

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

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

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

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

(b) A seasonal employee is eligible for benefits from the date of employment if the employing agency anticipates that he or she will work an average of at least eighty hours per month and for at least eight hours in each month of the season. A seasonal employee determined ineligible at the beginning of his or her employment who works an average of at least eighty hours per month over a period of six consecutive months and at least eight hours in each of those six consecutive months becomes eligible at the first of the month following the six-month averaging period. A benefits-eligible seasonal employee who works a season of less than nine months shall not be eligible for the employer contribution during the off season, but may continue enrollment in benefits during the off season by self-paying for the benefits. A benefits-eligible seasonal employee who works a season of nine months or more is eligible for the employer contribution through the off season following each season worked.

(c) Faculty are eligible as follows:

(i) Faculty who the employing agency anticipates will work half–time or more for the entire instructional year or equivalent nine-month period are eligible for benefits from the date of employment. Eligibility shall continue until the beginning of the first full month of the next instructional year, unless the employment relationship is terminated, in which case eligibility shall cease the first month following the notice of termination or the effective date of the termination, whichever is later.

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

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

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

(v) To be eligible for maintenance of benefits through averaging under (c)(ii) of this subsection, faculty must provide written notification to his or her employing agency or agencies of his or her potential eligibility.

(vi) For the purposes of this subsection (4)(c):

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

(B) "Half-time" means one-half of the full-time academic workload as determined by each institution; except that for community and technical college faculty, half-time academic workload is calculated according to RCW 28B.50.489.

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

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

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

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

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

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

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

(k) For the purposes of this subsection, the board shall define "benefits-eligible position."

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

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

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

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

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

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

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

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

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

(10) Before January 1, 1998, the public employees' benefits board shall make available one or more fully insured long-term care insurance plans that comply with the requirements of chapter 48.84 RCW. Such programs shall be made available to eligible employees, retired employees, and retired school employees as well as eligible dependents which, for the purpose of this section, includes the parents of the employee or retiree and the parents of the spouse of the employee or retiree. Employees of local governments, political subdivisions, and tribal governments not otherwise enrolled in the public employees' benefits board sponsored medical programs may enroll under terms and conditions established by the ((~~administrator~~)) director, if it does not jeopardize the financial viability of the public employees' benefits board's long-term care offering.

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

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

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

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

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

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

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

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

**Sec.**  RCW 41.05.074 and 2015 c 251 s 1 are each amended to read as follows:

(1) A health plan offered to public employees and their covered dependents under this chapter that imposes different prior authorization standards and criteria for a covered service among tiers of contracting providers of the same licensed profession in the same health plan shall inform an enrollee which tier an individual provider or group of providers is in by posting the information on its web site in a manner accessible to both enrollees and providers.

(2) The health plan may not require prior authorization for an evaluation and management visit or an initial treatment visit with a contracting provider in a new episode of chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapies. Notwithstanding RCW 48.43.515(5) this section may not be interpreted to limit the ability of a health plan to require a referral or prescription for the therapies listed in this section.

(3) The ((~~health care~~)) authority shall post on its web site and provide upon the request of a covered person or contracting provider any prior authorization standards, criteria, or information the health plan uses for medical necessity decisions.

(4) A health care provider with whom the administrator of the health plan consults regarding a decision to deny, limit, or terminate a person's covered health care services must hold a license, certification, or registration, in good standing and must be in the same or related health field as the health care provider being reviewed or of a specialty whose practice entails the same or similar covered health care service.

(5) The health plan may not require a provider to provide a discount from usual and customary rates for health care services not covered under the health plan, policy, or other agreement, to which the provider is a party.

(6) For purposes of this section:

(a) "New episode of care" means treatment for a new or recurrent condition for which the enrollee has not been treated by the provider within the previous ninety days and is not currently undergoing any active treatment.

(b) "Contracting provider" does not include providers employed within an integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW.

**Sec.**  RCW 41.05.075 and 2007 c 259 s 34 are each amended to read as follows:

(1) The ((~~administrator~~)) director shall provide benefit plans designed by the board through a contract or contracts with insuring entities, through self-funding, self-insurance, or other methods of providing insurance coverage authorized by RCW 41.05.140.

(2) The ((~~administrator~~)) director shall establish a contract bidding process that:

(a) Encourages competition among insuring entities;

(b) Maintains an equitable relationship between premiums charged for similar benefits and between risk pools including premiums charged for retired state and school district employees under the separate risk pools established by RCW 41.05.022 and 41.05.080 such that insuring entities may not avoid risk when establishing the premium rates for retirees eligible for medicare;

(c) Is timely to the state budgetary process; and

(d) Sets conditions for awarding contracts to any insuring entity.

(3) The ((~~administrator~~)) director shall establish a requirement for review of utilization and financial data from participating insuring entities on a quarterly basis.

(4) The ((~~administrator~~)) director shall centralize the enrollment files for all employee and retired or disabled school employee health plans offered under chapter 41.05 RCW and develop enrollment demographics on a plan-specific basis.

(5) All claims data shall be the property of the state. The ((~~administrator~~)) director may require of any insuring entity that submits a bid to contract for coverage all information deemed necessary including:

(a) Subscriber or member demographic and claims data necessary for risk assessment and adjustment calculations in order to fulfill the ((~~administrator's~~)) director's duties as set forth in this chapter; and

(b) Subscriber or member demographic and claims data necessary to implement performance measures or financial incentives related to performance under subsection (7) of this section.

(6) All contracts with insuring entities for the provision of health care benefits shall provide that the beneficiaries of such benefit plans may use on an equal participation basis the services of practitioners licensed pursuant to chapters 18.22, 18.25, 18.32, 18.53, 18.57, 18.71, 18.74, 18.83, and 18.79 RCW, as it applies to registered nurses and advanced registered nurse practitioners. However, nothing in this subsection may preclude the ((~~administrator~~)) director from establishing appropriate utilization controls approved pursuant to RCW 41.05.065(2) (a), (b), and (d).

(7) The ((~~administrator~~)) director shall, in collaboration with other state agencies that administer state purchased health care programs, private health care purchasers, health care facilities, providers, and carriers:

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

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

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

(b) Through state health purchasing, reimbursement, or pilot strategies, promote and increase the adoption of health information technology systems, including electronic medical records, by hospitals as defined in RCW 70.41.020((~~(4)~~)) (7), integrated delivery systems, and providers that:

(i) Facilitate diagnosis or treatment;

(ii) Reduce unnecessary duplication of medical tests;

(iii) Promote efficient electronic physician order entry;

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

(v) Improve health outcomes;

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

(8) The ((~~administrator~~)) director may permit the Washington state health insurance pool to contract to utilize any network maintained by the authority or any network under contract with the authority.

**Sec.**  RCW 41.05.085 and 2005 c 195 s 3 are each amended to read as follows:

(1) Beginning with the appropriations act for the 2005-2007 biennium, the legislature shall establish as part of both the state employees' and the school and educational service district employees' insurance benefit allocation the portion of the allocation to be used to provide a prescription drug subsidy to reduce the health care insurance premiums charged to retired or disabled school district and educational service district employees, or retired state employees, who are eligible for parts A and B of medicare. The legislature may also establish a separate health care subsidy to reduce insurance premiums charged to individuals who select a medicare supplemental insurance policy option established in RCW 41.05.195.

(2) The amount of any premium reduction shall be established by the board. The amount established shall not result in a premium reduction of more than fifty percent, except as provided in subsection (3) of this section. The board may also determine the amount of any subsidy to be available to spouses and dependents.

(3) The amount of the premium reduction in subsection (2) of this section may exceed fifty percent, if the ((~~administrator~~)) director, in consultation with the office of financial management, determines that it is necessary in order to meet eligibility requirements to participate in the federal employer incentive program as provided in RCW 41.05.068.

**Sec.**  RCW 41.05.120 and 2005 c 518 s 921 and 2005 c 143 s 3 are each reenacted and amended to read as follows:

(1) The public employees' and retirees' insurance account is hereby established in the custody of the state treasurer, to be used by the ((~~administrator~~)) director for the deposit of contributions, the remittance paid by school districts and educational service districts under RCW 28A.400.410, reserves, dividends, and refunds, for payment of premiums for employee and retiree insurance benefit contracts and subsidy amounts provided under RCW 41.05.085, and transfers from the ((~~medical~~)) flexible spending administrative account as authorized in RCW 41.05.123. Moneys from the account shall be disbursed by the state treasurer by warrants on vouchers duly authorized by the ((~~administrator~~)) director. Moneys from the account may be transferred to the ((~~medical~~)) flexible spending administrative account to provide reserves and start-up costs for the operation of the ((~~medical~~)) flexible spending administrative account program.

(2) The state treasurer and the state investment board may invest moneys in the public employees' and retirees' insurance account. All such investments shall be in accordance with RCW 43.84.080 or 43.84.150, whichever is applicable. The ((~~administrator~~)) director shall determine whether the state treasurer or the state investment board or both shall invest moneys in the public employees' ((~~[and retirees']~~)) and retirees' insurance account.

((~~(3) During the 2005-07 fiscal biennium, the legislature may transfer from the public employees' and retirees' insurance account such amounts as reflect the excess fund balance of the fund.~~))

**Sec.**  RCW 41.05.123 and 2008 c 229 s 6 are each amended to read as follows:

(1) The flexible spending administrative account is created in the custody of the state treasurer. All receipts from the following must be deposited in the account: (a) Revenues from employing agencies for costs associated with operating the medical flexible spending arrangement program and the dependent care assistance program provided through the salary reduction plan authorized under this chapter; (b) funds transferred from the dependent care administrative account; and (c) unclaimed moneys at the end of the plan year after all timely submitted claims for that plan year have been processed. Expenditures from the account may be used only for administrative and other expenses related to operating the medical flexible spending arrangement program and the dependent care assistance program provided through the salary reduction plan authorized under this chapter. Only the ((~~administrator~~)) director or the ((~~administrator's~~)) director's designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

(2) The salary reduction account is established in the state treasury. Employee salary reductions paid to reimburse participants or service providers for benefits provided by the medical flexible spending arrangement program and the dependent care assistance program provided through the salary reduction plan authorized under this chapter shall be paid from the salary reduction account. The funds held by the state to pay for benefits provided by the medical flexible spending arrangement program and the dependent care assistance program provided through the salary reduction plan authorized under this chapter shall be deposited in the salary reduction account. Unclaimed moneys remaining in the salary reduction account at the end of a plan year after all timely submitted claims for that plan year have been processed shall become a part of the flexible spending administrative account. Only the ((~~administrator~~)) director or the ((~~administrator's~~)) director's designee may authorize expenditures from the account. The account is not subject to allotment procedures under chapter 43.88 RCW and an appropriation is not required for expenditures.

(3) Program claims reserves and money necessary for start-up costs transferred from the public employees' and retirees' insurance account established in RCW 41.05.120 may be deposited in the flexible spending administrative account. Moneys in excess of the amount necessary for administrative and operating expenses of the medical flexible spending arrangement program may be transferred to the public employees' and retirees' insurance account.

(4) The authority may periodically bill employing agencies for costs associated with operating the medical flexible spending arrangement program and the dependent care assistance program provided through the salary reduction plan authorized under this chapter.

**Sec.**  RCW 41.05.130 and 2014 c 221 s 914 are each amended to read as follows:

The ((~~state health care~~)) authority administrative account is hereby created in the state treasury. Moneys in the account, including unanticipated revenues under RCW 43.79.270, may be spent only after appropriation by statute, and may be used only for operating expenses of the authority, and during the 2013-2015 fiscal biennium, for health care related analysis provided to the legislature by the office of the state actuary.

**Sec.**  RCW 41.05.143 and 2007 c 507 s 1 are each amended to read as follows:

(1) The uniform medical plan benefits administration account is created in the custody of the state treasurer. Only the ((~~administrator~~)) director or the ((~~administrator's~~)) director's designee may authorize expenditures from the account. Moneys in the account shall be used exclusively for contracted expenditures for uniform medical plan claims administration, data analysis, utilization management, preferred provider administration, and activities related to benefits administration where the level of services provided pursuant to a contract fluctuate as a direct result of changes in uniform medical plan enrollment. Moneys in the account may also be used for administrative activities required to respond to new and unforeseen conditions that impact the uniform medical plan, but only when the authority and the office of financial management jointly agree that such activities must be initiated prior to the next legislative session.

(2) Receipts from amounts due from or on behalf of uniform medical plan enrollees for expenditures related to benefits administration, including moneys disbursed from the public employees' and retirees' insurance account, shall be deposited into the account. The account is subject to allotment procedures under chapter 43.88 RCW, but no appropriation is required for expenditures. All proposals for allotment increases shall be provided to the house of representatives appropriations committee and to the senate ways and means committee at the same time as they are provided to the office of financial management.

(3) The uniform dental plan benefits administration account is created in the custody of the state treasurer. Only the ((~~administrator~~)) director or the ((~~administrator's~~)) director's designee may authorize expenditures from the account. Moneys in the account shall be used exclusively for contracted expenditures related to benefits administration for the uniform dental plan as established under RCW 41.05.140. Receipts from amounts due from or on behalf of uniform dental plan enrollees for expenditures related to benefits administration, including moneys disbursed from the public employees' and retirees' insurance account, shall be deposited into the account. The account is subject to allotment procedures under chapter 43.88 RCW, but no appropriation is required for expenditures.

(4) The public employees' benefits board medical benefits administration account is created in the custody of the state treasurer. Only the ((~~administrator~~)) director or the ((~~administrator's~~)) director's designee may authorize expenditures from the account. Moneys in the account shall be used exclusively for contracted expenditures related to claims administration, data analysis, utilization management, preferred provider administration, and other activities related to benefits administration for self-insured medical plans other than the uniform medical plan. Receipts from amounts due from or on behalf of enrollees for expenditures related to benefits administration, including moneys disbursed from the public employees' and retirees' insurance account, shall be deposited into the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

**Sec.**  RCW 41.05.160 and 1988 c 107 s 15 are each amended to read as follows:

The ((~~administrator~~)) director may promulgate and adopt rules consistent with this chapter to carry out the purposes of this chapter. All rules shall be adopted in accordance with chapter 34.05 RCW.

**Sec.**  RCW 41.05.175 and 2011 c 159 s 2 are each amended to read as follows:

(1) Each health plan offered to public employees and their covered dependents under this chapter, including those subject to the provision of Title 48 RCW, and is issued or renewed beginning January 1, 2012, and provides coverage for cancer chemotherapy treatment must provide coverage for prescribed, self-administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis at least comparable to cancer chemotherapy medications administered by a health care provider or facility as defined in RCW 48.43.005 ((~~(15) and (16)~~)) (22) and (23).

(2) Nothing in this section may be interpreted to prohibit a health plan from administering a formulary or preferred drug list, requiring prior authorization, or imposing other appropriate utilization controls in approving coverage for any chemotherapy.

**Sec.**  RCW 41.05.177 and 2006 c 367 s 1 are each amended to read as follows:

(1) Each plan offered to public employees and their covered dependents under this chapter that is not subject to the provisions of Title 48 RCW and is issued or renewed after December 31, 2006, shall provide coverage for prostate cancer screening, provided that the screening is delivered upon the recommendation of the patient's physician, advanced registered nurse practitioner, or physician assistant.

(2) This section shall not be construed to prevent the application of standard policy provisions applicable to other benefits, such as deductible or copayment provisions. This section does not limit the authority of the ((~~health care~~)) authority to negotiate rates and contract with specific providers for the delivery of prostate cancer screening services. This section shall not apply to medicare supplemental policies or supplemental contracts covering a specified disease or other limited benefits.

**Sec.**  RCW 41.05.180 and 1994 sp.s. c 9 s 725 are each amended to read as follows:

Each health plan offered to public employees and their covered dependents under this chapter that is not subject to the provisions of Title 48 RCW and is established or renewed after January 1, 1990, and that provides benefits for hospital or medical care shall provide benefits for screening or diagnostic mammography services, provided that such services are delivered upon the recommendation of the patient's physician or advanced registered nurse practitioner as authorized by the nursing care quality assurance commission pursuant to chapter 18.79 RCW or physician assistant pursuant to chapter 18.71A RCW.

This section shall not be construed to prevent the application of standard health plan provisions applicable to other benefits such as deductible or copayment provisions. This section does not limit the authority of the ((~~state health care~~)) authority to negotiate rates and contract with specific providers for the delivery of mammography services. This section shall not apply to medicare supplement policies or supplemental contracts covering a specified disease or other limited benefits.

**Sec.**  RCW 41.05.183 and 2001 c 321 s 1 are each amended to read as follows:

(1) Each employee benefit plan offered to public employees that provides coverage for hospital, medical, or ambulatory surgery center services must cover general anesthesia services and related facility charges in conjunction with any dental procedure performed in a hospital or ambulatory surgical center if such anesthesia services and related facility charges are medically necessary because the covered person:

(a) Is under the age of seven, or is a person who is physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or

(b) Has a medical condition that the person's physician determines would place the person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the person's physician.

(2) Each employee benefit plan offered to public employees that provides coverage for dental services must cover general anesthesia services in conjunction with any covered dental procedure performed in a dental office if the general anesthesia services are medically necessary because the covered person is under the age of seven or is a person who is physically or developmentally disabled.

(3) This section does not prohibit an employee benefit plan from:

(a) Applying cost-sharing requirements, maximum annual benefit limitations, and prior authorization requirements to the services required under this section; or

(b) Covering only those services performed by a health care provider, or in a health care facility, that is part of its provider network; nor does it limit the authority in negotiating rates and contracts with specific providers.

(4) This section does not apply to medicare supplement policies, or supplemental contracts covering a specified disease or other limited benefits.

(5) For the purpose of this section, "general anesthesia services" means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command.

(6) This section applies to employee benefit plans issued or renewed on or after January 1, 2002.

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

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

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

**Sec.**  RCW 41.05.310 and 2008 c 229 s 4 are each amended to read as follows:

The authority shall have responsibility for the formulation and adoption of a plan, policies, and procedures designed to guide, direct, and administer the salary reduction plan. For the plan year beginning January 1, 1996, the ((~~administrator~~)) director may establish a premium only plan. Expansion of the salary reduction plan or cafeteria plan during subsequent plan years shall be subject to approval by the director of the office of financial management.

(1) A plan document describing the benefits offered under the salary reduction plan shall be adopted and administered by the authority. The authority shall represent the state in all matters concerning the administration of the plan. The state, through the authority, may engage the services of a professional consultant or administrator on a contractual basis to serve as an agent to assist the authority or perform the administrative functions necessary in carrying out the purposes of RCW 41.05.123((~~,~~)) and 41.05.300 through 41.05.350((~~, and 41.05.295~~)).

(2) The authority shall formulate and establish policies and procedures for the administration of the salary reduction plan that are consistent with existing state law, the internal revenue code, and the regulations adopted by the internal revenue service as they may apply to the benefits offered to participants under the plan.

(3) Every action taken by the authority in administering RCW 41.05.123((~~,~~)) and 41.05.300 through 41.05.350((~~, and 41.05.295~~)) shall be presumed to be a fair and reasonable exercise of the authority vested in or the duties imposed upon it. The authority shall be presumed to have exercised reasonable care, diligence, and prudence and to have acted impartially as to all persons interested unless the contrary be proved by clear and convincing affirmative evidence.

**Sec.**  RCW 41.05.400 and 2000 c 80 s 7 are each amended to read as follows:

(1) The ((~~administrator~~)) director shall design and offer a plan of health care coverage as described in subsection (2) of this section, for any person eligible under subsection (3) of this section. The health care coverage shall be designed and offered only to the extent that state funds are specifically appropriated for this purpose.

(2) The plan of health care coverage shall have the following components:

(a) Services covered more limited in scope than those contained in RCW 48.41.110(3);

(b) Enrollee cost-sharing that may include but not be limited to point-of-service cost-sharing for covered services;

(c) Deductibles of three thousand dollars on a per person per calendar year basis, and four thousand dollars on a per family per calendar year basis. The deductible shall be applied to the first three thousand dollars, or four thousand dollars, of eligible expenses incurred by the covered person or family, respectively, except that the deductible shall not be applied to clinical preventive services as recommended by the United States public health service. Enrollee out-of-pocket expenses required to be paid under the plan for cost-sharing and deductibles shall not exceed five thousand dollars per person, or six thousand dollars per family;

(d) Payment methodologies for network providers may include but are not limited to resource-based relative value fee schedules, capitation payments, diagnostic related group fee schedules, and other similar strategies including risk-sharing arrangements; and

(e) Other appropriate care management and cost-containment measures determined appropriate by the ((~~administrator~~)) director, including but not limited to care coordination, provider network limitations, preadmission certification, and utilization review.

(3) Any person is eligible for coverage in the plan who resides in a county of the state where no carrier, as defined in RCW 48.43.005, or insurer regulated under chapter 48.15 RCW offers to the public an individual health benefit plan as defined in RCW 48.43.005 other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to the ((~~administrator~~)) director. Such eligibility may terminate pursuant to subsection (8) of this section.

(4) The ((~~administrator~~)) director may not reject an individual for coverage based upon preexisting conditions of the individual or deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that it shall impose a nine-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the effective date of coverage. The preexisting condition waiting period shall not apply to prenatal care services. Credit against the waiting period shall be provided pursuant to subsections (5) and (6) of this section.

(5) Except for persons to whom subsection (6) of this section applies, the ((~~administrator~~)) director shall credit any preexisting condition waiting period in the plan for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the plan in a group health benefit plan or an individual health benefit plan other than a catastrophic health plan. The ((~~administrator~~)) director must credit the period of coverage the person was continuously covered under the immediately preceding health plan toward the waiting period of the new health plan. For the purposes of this subsection, a preceding health plan includes an employer-provided self-funded health plan.

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

(7) The ((~~administrator~~)) director shall set the rates to be charged plan enrollees.

(8) When a carrier, as defined in RCW 48.43.005, or an insurer regulated under chapter 48.15 RCW, begins to offer an individual health benefit plan as defined in RCW 48.43.005 in a county where no carrier or insurer had been offering an individual health benefit plan:

(a) If the health benefit plan offered is other than a catastrophic health plan as defined in RCW 48.43.005, any person enrolled in the plan under subsection (3) of this section in that county shall no longer be eligible;

(b) The ((~~administrator~~)) director shall provide written notice to any person who is no longer eligible for coverage under the plan within thirty days of the ((~~administrator's~~)) director's determination that the person is no longer eligible. The notice shall: (i) Indicate that coverage under the plan will cease ninety days from the date that the notice is dated; (ii) describe any other coverage options available to the person; and (iii) describe the enrollment process for the available options.

**Sec.**  RCW 41.05.520 and 2003 1st sp.s. c 29 s 7 are each amended to read as follows:

(1) The ((~~administrator~~)) director shall establish and advertise a pharmacy connection program through which health care providers and members of the public can obtain information about manufacturer-sponsored prescription drug assistance programs. The ((~~administrator~~)) director shall ensure that the program has staff available who can assist persons in procuring free or discounted medications from manufacturer-sponsored prescription drug assistance programs by:

(a) Determining whether an assistance program is offered for the needed drug or drugs;

(b) Evaluating the likelihood of a person obtaining drugs from an assistance program under the guidelines formulated;

(c) Assisting persons with the application and enrollment in an assistance program;

(d) Coordinating and assisting physicians and others authorized to prescribe medications with communications, including applications, made on behalf of a person to a participating manufacturer to obtain approval of the person in an assistance program; and

(e) Working with participating manufacturers to simplify the system whereby eligible persons access drug assistance programs, including development of a single application form and uniform enrollment process.

(2) Notice regarding the pharmacy connection program shall initially target senior citizens, but the program shall be available to anyone, and shall include a toll-free telephone number, available during regular business hours, that may be used to obtain information.

(3) The ((~~administrator~~)) director may apply for and accept grants or gifts and may enter into interagency agreements or contracts with other state agencies or private organizations to assist with the implementation of this program including, but not limited to, contracts, gifts, or grants from pharmaceutical manufacturers to assist with the direct costs of the program.

(4) The ((~~administrator~~)) director shall notify pharmaceutical companies doing business in Washington of the pharmacy connection program. Any pharmaceutical company that does business in this state and that offers a pharmaceutical assistance program shall notify the ((~~administrator~~)) director of the existence of the program, the drugs covered by the program, and all information necessary to apply for assistance under the program.

(5) For purposes of this section, "manufacturer-sponsored prescription drug assistance program" means a program offered by a pharmaceutical company through which the company provides a drug or drugs to eligible persons at no charge or at a reduced cost. The term does not include the provision of a drug as part of a clinical trial.

**Sec.**  RCW 41.05.540 and 2007 c 259 s 40 are each amended to read as follows:

(1) The ((~~health care~~)) authority, in coordination with the department of health, health plans participating in public employees' benefits board programs, and the University of Washington's center for health promotion, shall establish and maintain a state employee health program focused on reducing the health risks and improving the health status of state employees, dependents, and retirees enrolled in the public employees' benefits board. The program shall use public and private sector best practices to achieve goals of measurable health outcomes, measurable productivity improvements, positive impact on the cost of medical care, and positive return on investment. The program shall establish standards for health promotion and disease prevention activities, and develop a mechanism to update standards as evidence-based research brings new information and best practices forward.

(2) The state employee health program shall:

(a) Provide technical assistance and other services as needed to wellness staff in all state agencies and institutions of higher education;

(b) Develop effective communication tools and ongoing training for wellness staff;

(c) Contract with outside vendors for evaluation of program goals;

(d) Strongly encourage the widespread completion of online health assessment tools for all state employees, dependents, and retirees. The health assessment tool must be voluntary and confidential. Health assessment data and claims data shall be used to:

(i) Engage state agencies and institutions of higher education in providing evidence-based programs targeted at reducing identified health risks;

(ii) Guide contracting with third-party vendors to implement behavior change tools for targeted high-risk populations; and

(iii) Guide the benefit structure for state employees, dependents, and retirees to include covered services and medications known to manage and reduce health risks.

(3) The ((~~health care~~)) authority shall report to the legislature in December 2008 and December 2010 on outcome goals for the employee health program.

**Sec.**  RCW 41.05.550 and 2015 c 161 s 1 are each amended to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Federal poverty level" means the official poverty level based on family size established and adjusted under section 673(2) of the omnibus budget reconciliation act of 1981 (P.L. 97-35; 42 U.S.C. Sec. 9902(2), as amended).

(b) "Foundation" means the prescription drug assistance foundation established in this section, a nonprofit corporation organized under the laws of this state to provide assistance in accessing prescription drugs to qualified uninsured individuals.

(c) "Health insurance coverage including prescription drugs" means prescription drug coverage under a private insurance plan, including a plan offered through the health benefit exchange under chapter 43.71 RCW, the medicaid program, the state children's health insurance program ("SCHIP"), the medicare program, the basic health plan, or any employer-sponsored health plan that includes a prescription drug benefit.

(d) "Qualified uninsured individual" means an uninsured person or an underinsured person who is a resident of this state and whose income meets financial criteria established by the foundation.

(e) "Underinsured" means an individual who has health insurance coverage including prescription drugs, but for whom the prescription drug coverage is inadequate for their needs.

(f) "Uninsured" means an individual who lacks health insurance coverage including prescription drugs.

(2)(a) The ((~~administrator~~)) director shall establish the foundation as a nonprofit corporation, organized under the laws of this state. The foundation shall assist qualified uninsured individuals in obtaining prescription drugs at little or no cost.

(b) The foundation shall be administered in a manner that:

(i) Begins providing assistance to qualified uninsured individuals by January 1, 2006;

(ii) Defines the population that may receive assistance in accordance with this section; and

(iii) Complies with the eligibility requirements necessary to obtain and maintain tax-exempt status under federal law.

(c) The board of directors of the foundation consists of up to eleven with a minimum of five members appointed by the governor to staggered terms of three years. The governor shall select as members of the board individuals who (i) will represent the interests of persons who lack prescription drug coverage; and (ii) have demonstrated expertise in business management and in the administration of a not-for-profit organization.

(d) The foundation shall apply for and comply with all federal requirements necessary to obtain and maintain tax-exempt status with respect to the federal tax obligations of the foundation's donors.

(e) The foundation is authorized, subject to the direction and ratification of the board, to receive, solicit, contract for, collect, and hold in trust for the purposes of this section, donations, gifts, grants, and bequests in the form of money paid or promised, services, materials, equipment, or other things tangible or intangible that may be useful for helping the foundation to achieve its purpose. The foundation may use all sources of public and private financing to support foundation activities. No general fund-state funds shall be used for the ongoing operation of the foundation.

(f) No liability on the part of, and no cause of action of any nature, shall arise against any member of the board of directors of the foundation or against an employee or agent of the foundation for any lawful action taken by them in the performance of their administrative powers and duties under this section.

**Sec.**  RCW 41.05.600 and 2005 c 6 s 2 are each amended to read as follows:

(1) For the purposes of this section, "mental health services" means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on July 24, 2005, or such subsequent date as may be provided by the ((~~administrator~~)) director by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (a) Substance related disorders; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care; and (d) court ordered treatment unless the authority's or contracted insuring entity's medical director determines the treatment to be medically necessary.

(2) All health benefit plans offered to public employees and their covered dependents under this chapter that provide coverage for medical and surgical services shall provide:

(a) For all health benefit plans established or renewed on or after January 1, 2006, coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(b) For all health benefit plans established or renewed on or after January 1, 2008, coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(c) For all health benefit plans established or renewed on or after July 1, 2010, coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(3) In meeting the requirements of subsection (2)(a) and (b) of this section, health benefit plans may not reduce the number of mental health outpatient visits or mental health inpatient days below the level in effect on July 1, 2002.

(4) This section does not prohibit a requirement that mental health services be medically necessary as determined by the medical director or designee, if a comparable requirement is applicable to medical and surgical services.

(5) ((~~Nothing in~~)) This section ((~~shall be construed to~~)) does not prevent the management of mental health services.

(6) The ((~~administrator~~)) director will consider care management techniques for mental health services, including but not limited to: (a) Authorized treatment plans; (b) preauthorization requirements based on the type of service; (c) concurrent and retrospective utilization review; (d) utilization management practices; (e) discharge coordination and planning; and (f) contracting with and using a network of participating providers.

**Sec.**  RCW 41.05.601 and 2005 c 6 s 12 are each amended to read as follows:

The ((~~administrator~~)) director may adopt rules to implement RCW 41.05.600 (as recodified by this act).

**Sec.**  RCW 41.05.630 and 2010 c 293 s 1 are each amended to read as follows:

Beginning in 2011, the ((~~state health care~~)) authority must process as a complaint an enrollee's expression of dissatisfaction about customer service or the quality or availability of a health service. The agency must require that each health plan that provides medical insurance offered under this chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140 must submit a summary of customer service complaints and appeals to the agency to be included in an annual report to the legislature. Each annual report must summarize the complaints and appeals processed by the ((~~state health care~~)) authority and contracted carriers in the preceding twelve months, and include an analysis of any trends identified. The report must be complete by September 30th of each year.

**Sec.**  RCW 41.05.655 and 2012 2nd sp.s. c 3 s 6 are each amended to read as follows:

By June 1, 2015, the ((~~health care~~)) authority must report to the governor, legislature, and joint legislative audit and review committee the following duties and analyses, based on two years of reports on school district health benefits submitted to it by the office of the insurance commissioner:

(1) The director shall establish a specific target to realize the goal of greater equity between premium costs for full family coverage and employee only coverage for the same health benefit plan. In developing this target, the director shall consider the appropriateness of the three-to-one ratio of employee premium costs between full family coverage and employee only coverage, and consider alternatives based on the data and information received from the office of the insurance commissioner.

(2) The director shall also study and report the advantages and disadvantages to the state, local school districts, and district employees:

(a) Whether better progress on the legislative goals could be achieved through consolidation of school district health insurance purchasing through a single consolidated school employee health benefits purchasing plan;

(b) Whether better progress on the legislative goals could be achieved by consolidating K-12 health insurance purchasing through the public employees' benefits board program, and whether consolidation into the public employees' benefits board program would be preferable to the creation of a consolidated school employee health benefits purchasing plan; and

(c) Whether certificated or classified employees, as separate groups, would be better served by purchasing health insurance through a single consolidated school employee health benefits purchasing plan or through participation in the public employees' benefits board program((~~; and~~)).

((~~(d)~~)) (3) Analyses shall include implications of taking any of the actions described in subsection (a) through (c) of this ((~~subsection~~)) section to include, at a minimum, the following: The costs for the state and school employees, impacts for existing purchasing programs, a proposed timeline for the implementation of any recommended actions.

**Sec.**  RCW 41.05.660 and 2009 c 299 s 2 are each amended to read as follows:

(1) The community health care collaborative grants shall be awarded on a competitive basis based on a determination of which applicant organization will best serve the purposes of the grant program established in RCW 41.05.650 (as recodified by this act). In making this determination, priority for funding shall be given to the applicants that demonstrate:

(a) The initiatives to be supported by the community health care collaborative grant are likely to address, in a measurable fashion, documented health care access and quality improvement goals aligned with state health policy priorities and needs within the region to be served;

(b) The applicant organization must document formal, active collaboration among key community partners that includes local governments, school districts, large and small businesses, nonprofit organizations, tribal governments, carriers, private health care providers, public health agencies, and community public health and safety networks, as defined in RCW 70.190.010;

(c) The applicant organization will match the community health care collaborative grant with funds from other sources. The health care authority may award grants solely to organizations providing at least two dollars in matching funds for each community health care collaborative grant dollar awarded;

(d) The community health care collaborative grant will enhance the long-term capacity of the applicant organization and its members to serve the region's documented health care access needs, including the sustainability of the programs to be supported by the community health care collaborative grant;

(e) The initiatives to be supported by the community health care collaborative grant reflect creative, innovative approaches which complement and enhance existing efforts to address the needs of the uninsured and underinsured and, if successful, could be replicated in other areas of the state; and

(f) The programs to be supported by the community health care collaborative grant make efficient and cost-effective use of available funds through administrative simplification and improvements in the structure and operation of the health care delivery system.

(2) The ((~~administrator~~)) director of the health care authority shall endeavor to disburse community health care collaborative grant funds throughout the state, supporting collaborative initiatives of differing sizes and scales, serving at-risk populations.

(3) Grants shall be disbursed over a two-year cycle, provided the grant recipient consistently provides timely reports that demonstrate the program is satisfactorily meeting the purposes of the grant and the objectives identified in the organization's application. The requirements for the performance reports shall be determined by the health care authority ((~~administrator~~)) director. The performance measures shall be aligned with the community health care collaborative grant program goals and, where possible, shall be consistent with statewide policy trends and outcome measures required by other public and private grant funders.

NEW SECTION. **Sec.**  RCW 41.05.014, 41.05.015, 41.05.036, 41.05.037, 41.05.220, 41.05.230, 41.05.400, 41.05.520, 41.05.530, 41.05.550, 41.05.600, 41.05.601, 41.05.650, 41.05.651, 41.05.660, 41.05.670, 41.05.680, 41.05.690, 41.05.730, 41.05.735, and 41.05.800 are each recodified as sections in chapter 43.--- RCW (the new chapter created in section 50 of this act).

NEW SECTION. **Sec.**  The following acts or parts of acts are each repealed:

(1)RCW 41.05.006 (Purpose) and 2006 c 299 s 1 & 1988 c 107 s 2; and

(2)RCW 41.05.295 (Dependent care assistance program—Health care authority—Powers, duties, and functions) and 2008 c 229 s 1.

NEW SECTION. **Sec.**  Sections 12 through 15 of this act constitute a new chapter in Title 43 RCW.

NEW SECTION. **Sec.**  This act takes effect January 1, 2018.

**--- END ---**