SB 6589 - S AMD **136**
By Senator Brown

ADOPTED 02/14/2012

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** RCW 41.05.065 and 2011 1st sp.s. c 8 s 1 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 benefits 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. This subsection does not prohibit the board from offering a plan incorporating primary care services through a direct patient-provider primary care practice as provided in subsection (6) of this section. 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 half-time, as defined by the board, 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 coverage. Faculty who

have met the criteria of this subsection (4)(c)(ii), who work at least two quarters of the academic year with an average academic year workload of half-time or more for three quarters 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 of the academic year with an average academic workload each academic year of half-time or more for three quarters. 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.

(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:

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

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

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

(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)(i) 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.

(ii) As a pilot project, during the 2013 and 2014 plan years the board shall offer employees enrolled in a self-insured health plan the option to receive primary care services from a direct patient-provider primary care practice as provided in chapter 48.150 RCW. For any member enrolled in the option offered under this subsection (6)(a)(ii), the direct fee under RCW 48.150.010 shall be paid by the member's health plan at no additional cost to the member. For any plan year, the option offered under this subsection (6)(a)(ii) shall be limited by the board to enrollees who utilized at least twice the median value of care for a member during the first nine months of the prior plan year, except that a member who is already enrolled in the option may remain enrolled in subsequent years if the option is offered by the board. The board shall negotiate a direct fee that reflects the intensity of such care. Additionally, enrollment in the option offered under this subsection (6)(a)(ii) shall be limited to no more than two thousand members living in King and Pierce counties. The board shall use best efforts to inform and educate prospective plan enrollees on the existence and benefits of the option offered under this subsection (6)(a)(ii). These efforts shall include, but not be limited to, an invitation to direct patient-provider primary care practices eligible to participate in any plan offered under this subsection to participate in open enrollment meetings and other beneficiary communication methods. No later than November 1, 2014, the board shall submit a report to the legislature on the direct practice option offered under this subsection, describing the impact of the option on plan costs and the health of the members enrolled in the option.

(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, 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. 2. RCW 48.150.010 and 2009 c 552 s 1 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) "Direct agreement" means a written agreement entered into between a direct practice and an individual direct patient, or the parent or legal guardian of the direct patient or a family of direct patients, whereby the direct practice charges a direct fee as consideration for being available to provide and providing primary care services to the individual direct patient. "Direct agreement" also means an agreement entered into by a direct practice to provide primary care services to members enrolled in the option offered under RCW 41.05.065(6)(a)(ii) in exchange for a direct fee. A direct agreement must (a) describe the specific health care services the direct practice will provide; and (b) be terminable at will upon written notice by the direct patient.

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

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

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

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

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

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

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

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

(d) Does not provide, in consideration for the direct fee, services, procedures, or supplies such as prescription drugs, hospitalization costs, major surgery, dialysis, high level radiology (CT, MRI, PET scans or invasive radiology), rehabilitation services, procedures requiring general anesthesia, or similar advanced procedures, services, or supplies.

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

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

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

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

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

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

(2) A direct practice must:

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

(b) Either:

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

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

(3) If the patient chooses to pay more than one monthly direct fee in advance, the funds must be held in a trust account and paid to the direct practice as earned at the end of each month. Any unearned direct fees held in trust following receipt of termination of the direct agreement shall be promptly refunded to the direct patient. The amount of the direct fee earned shall be a proration of the monthly fee for the then current month as of the date the notice of termination is received.

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

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

(6) Direct fees for comparable services within a direct practice shall not vary from patient to patient based on health status or sex. Direct fees paid on behalf of direct patients enrolled in the option

offered under RCW 41.05.065(6)(a)(ii) in which enrollment is limited to enrollees who utilize substantially more health care services than average may vary to reflect the intensity of services used."

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On page 1, line 2 of the title, after "employees;" strike the remainder of the title and insert "amending RCW 41.05.065 and 48.150.030; and reenacting and amending RCW 48.150.010."

EFFECT: Removes the requirement that employees enrolled in the direct practice plan pay a share of premium costs that is no more than 75 percent of the share paid by employees enrolled in other plans.

Allows the Public Employees' Benefits Board (PEBB) to limit enrollment in the direct practice plan to members who are heavy utilizers of services and allows a direct practice to negotiate a variable direct fee to reflect the higher level of utilization within a plan subject to such enrollment restrictions.

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