Chapter 41.05 RCW
STATE HEALTH CARE AUTHORITY

Sections

Hospitalization and health care for county, municipal and other political subdivision employees: RCW 41.04.180.

Monitoring enrollee level in basic health plan and medicaid caseload of children—Funding levels adjustment: RCW 43.41.260.

Prepaid chiropractic, pilot projects: RCW 18.25.200.

RCW 41.05.004 Intent—Use of word "board." It is the intent of the legislature that the word "board" be read to mean both the school employees' benefits board and the public employees' benefits board throughout this chapter. The use of "board" should be liberally construed to mean both boards, to the extent not in conflict with state or federal law. In no case shall either board be limited from exercising its individual authority as authorized within this chapter. [2018 c 260 s 5.]

RCW 41.05.006 Purpose. (1) The legislature recognizes that (a) the state is a major purchaser of health care services, (b) the increasing costs of such health care services are posing and will continue to pose a great financial burden on the state, (c) it is the state's policy, consistent with the best interests of the state, to

provide comprehensive health care as an employer, to public employees, officials, their dependents, and to those who are dependent on the state for necessary medical care, and (d) it is imperative that the state begin to develop effective and efficient health care delivery systems and strategies for procuring health care services in order for the state to continue to purchase the most comprehensive health care possible.

(2) It is therefore the purpose of this chapter to establish the Washington state health care authority whose purpose shall be to (a) develop health care benefit programs that provide access to at least one comprehensive benefit plan funded to the fullest extent possible by the employer, and a health savings account/high deductible health plan option as defined in section 1201 of the medicare prescription drug improvement and modernization act of 2003, as amended, for eligible public employees, officials, and their dependents, and (b) study all state purchased health care, alternative health care delivery systems, and strategies for the procurement of health care services and make recommendations aimed at minimizing the financial burden which health care poses on the state, public employees, and its charges, while at the same time allowing the state to provide the most comprehensive health care options possible. [2023 c 51 s 1; 2018 c 260 s 2; 2006 c 299 s 1; 1988 c 107 s 2.]

RCW 41.05.008 Duties of employing agencies. (1) Every employing agency shall carry out all actions required by the authority under this chapter including, but not limited to, those necessary for the operation of benefit plans, education of employees, claims administration, and appeals process.

(2) Employing agencies shall report all data relating to employees eligible to participate in benefits or plans administered by the authority in a format designed and communicated by the authority. [2009 c 537 s 1; 2005 c 143 s 4.]

Effective date—2009 c 537: "This act takes effect January 1, 2010." [2009 c 537 s 9.]

RCW 41.05.009 Determination of public employee eligibility for benefits. (1) The authority, or an employing agency at the authority's direction, shall initially determine and periodically review whether a public employee is eligible for benefits pursuant to the criteria established under this chapter.

(2) An employing agency shall inform a public employee in writing whether or not he or she is eligible for benefits when initially determined and upon any subsequent change, including notice of the public employee's right to an appeal. [2023 c 51 s 2; 2018 c 260 s 3; 2015 c 116 s 1; 2009 c 537 s 2.]

Effective date—2009 c 537: See note following RCW 41.05.008.

RCW 41.05.0091 Eligibility exists prior to January 1, 2010. An employee determined eligible for benefits prior to January 1, 2010, shall not have his or her eligibility terminated pursuant to the criteria established under chapter 537, Laws of 2009 unless the

termination is the result of: (1) A voluntary reduction in work hours; or (2) the employee's employment with an agency other than the agency by which he or she was determined eligible prior to January 1, 2010. [2009 c 537 s 10.]

Effective date—2009 c 537: See note following RCW 41.05.008.

RCW 41.05.011 Definitions. 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) "Board" means the public employees' benefits board established under RCW 41.05.055 and the school employees' benefits board established under RCW 41.05.740.

(3) "Dependent care assistance program" means a benefit plan whereby employees and school 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.

(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)(a) "Employee" for the public employees' benefits board program 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: (i) 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); (ii) employees of employee organizations representing state civil service employees, at the option of each such employee organization; (iii) through December 31, 2019, 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; (iv) 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); (v) 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 (vi) through December 31, 2019,

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; 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.

(b) Effective January 1, 2020, "school employee" for the school employees' benefits board program includes:

(i) All employees of school districts and charter schools established under chapter 28A.710 RCW;

(ii) Represented employees of educational service districts;

(iii) Effective January 1, 2024, all employees of educational service districts; and

(iv) Effective January 1, 2024, pursuant to contractual agreement with the authority, "school employee" may also include: (A) Employees of employee organizations representing school employees, at the option of each such employee organization; and (B) employees of a tribal school as defined in RCW 28A.715.010, if the governing body of the tribal school 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).

(7) "Employee group" means employees of a similar employment type, such as administrative, represented classified, nonrepresented classified excluding such employees in educational service districts until December 31, 2023, confidential, represented certificated, or nonrepresented certificated excluding such employees in educational service districts until December 31, 2023, within a school employees' benefits board organization.

(8)(a) "Employer" for the public employees' benefits board program means the state of Washington.

(b) "Employer" for the school employees' benefits board program means school districts and educational service districts and charter schools established under chapter 28A.710 RCW.

(9)(a) "Employer group" for the public employees' benefits board program means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, and employee organizations representing state civil service employees obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees' benefits board.

(b) "Employer group" for the school employees' benefits board program means an employee organization representing school employees and a tribal school as defined in RCW 28A.715.010, obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the school employees' benefits board.

(10)(a) "Employing agency" for the public employees' benefits board program means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, or other political subdivision; and a tribal government covered by this chapter.

(b) "Employing agency" for the school employees' benefits board program means school districts, educational service districts, and charter schools.

(11) "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.

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

(13) "Flexible spending arrangement" means a benefit plan whereby 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) "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.

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

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

(17) "Premium payment plan" means a benefit plan whereby 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.

(18) "Public employee" has the same meaning as employee and school employee.

(19) "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.

(20) "Salary" means a public employee's monthly salary or wages.

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

(22) "School employees' benefits board organization" means a public school district or educational service district or charter school established under chapter 28A.710 RCW that is required to participate in benefit plans provided by the school employees' benefits board.

(23) "School year" means school year as defined in RCW 28A.150.203(11).

(24) "Seasonal employee" means a state 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.

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

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

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

(iii) 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; or

(b) For the purposes of RCW 41.05.080:

(i) RCW 41.32.010 on or after January 1, 2024; or

(ii) RCW 41.35.010 on or after January 1, 2024; or

(iii) RCW 41.40.010 on or after January 1, 2024; and who are at least age 55 and have at least 20 years of service under the teachers' retirement system plan 2 as defined in RCW 41.32.010, the Washington school employees' retirement system plan 2 as defined in RCW 41.35.010, or the public employees' retirement system plan 2 as defined in RCW 41.40.010.

(26) "State purchased health care" or "health care" means medical and behavioral 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.

(27) "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. [2023 c 164 s 1; 2023 c 51 s 3; 2023 c 13 s 2; 2019 c 411 s 4; 2018 c 260 s 4; 2017 3rd sp.s. c 13 s 802. Prior: 2016 c 241 s 136; 2016 c 67 s 2; prior: 2015 c 116 s 2; 2013 c 2 s 306 (Initiative Measure No. 1240, approved November 6, 2012); 2012 c 87 s 22; prior: 2011 1st sp.s. c 15 s 54; 2009 c 537 s 3; 2008 c 229 s 2; prior: 2007 c 488 s 2; 2007 c 114 s 2; 2005 c 143 s 1; 2001 c 165 s 2; prior: 2000 c 247 s 604; 2000 c 230 s 3; 1998 c 341 s 706; 1996 c 39 s 21; 1995 1st sp.s. c 6 s 2; 1994 c 153 s 2; prior: 1993 c 492 s 214; 1993 c 386 s 5; 1990 c 222 s 2; 1988 c 107 s 3.]

Reviser's note: (1) The definitions in this section have been alphabetized pursuant to RCW 1.08.015(2)(k).

(2) This section was amended by 2023 c 13 s 2, 2023 c 51 s 3, and by 2023 c 164 s 1, without reference to one another. All amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2023 c 164: "This act takes effect January 1, 2024." [2023 c 164 s 2.]

Finding—Intent—2023 c 13: "The legislature finds that employees and employers are benefited by consistency and mobility in public employee health care.

Therefore it is the intent of the legislature to expand access to benefits provided by the school employees' benefits board to employees of tribal schools and employee organizations representing school employees." [2023 c 13 s 1.]

Intent—2017 3rd sp.s. c 13: See note following RCW 28A.150.410.

Effective date—2016 c 241: See RCW 28A.710.901.

Effective date—2012 c 87 ss 4, 16, 18, and 19-23: See note following RCW 43.71.030.

Spiritual care services—2012 c 87: See RCW 43.71.901.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Effective date—2009 c 537: See note following RCW 41.05.008.

Effective date—2008 c 229: See note following RCW 41.05.295.

Short title—2007 c 488: See note following RCW 43.43.285.

Intent—2007 c 114: "Consistent with the centennial accord, the new millennium agreement, related treaties, and federal and state law, it is the intent of the legislature to authorize tribal governments to participate in public employees' benefits board programs to the same extent that counties, municipalities, and other political subdivisions of the state are authorized to do so." [2007 c 114 s 1.]

Effective date—2007 c 114: "This act takes effect January 1, 2009." [2007 c 114 s 8.]

Effective date—2001 c 165 s 2: "Section 2 of this act takes effect March 1, 2002." [2001 c 165 s 5.]

Effective date—Application—2001 c 165: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and except for section 2 of this act takes effect immediately [May 7, 2001]. This act applies to all surviving spouses and dependent children of (1) emergency service personnel and (2) members of the law enforcement officers' and firefighters' retirement system plan 2, killed in the line of duty." [2006 c 345 s 2; 2001 c 165 s 6.]

Reviser's note: Contractual right not granted—2006 c 345: See note following RCW 41.26.510.

Effective date—2000 c 230: See note following RCW 41.35.630.

Effective date—1998 c 341: See RCW 41.35.901.

Effective dates—1996 c 39: See note following RCW 41.32.010.

Effective date—1995 1st sp.s. c 6: See note following RCW 28A.400.410.

Intent—1994 c 153: "It is the intent of the legislature to increase access to health insurance for retired and disabled state and

school district employees and to increase equity between state and school employees and between state and school retirees." [1994 c 153 s 1.]

Effective dates—1994 c 153: "This act shall take effect January 1, 1995, except section 15 of this act, which takes effect October 1, 1995." [1994 c 153 s 16.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

Intent—1993 c 386: See note following RCW 28A.400.391.

Effective date—1993 c 386 ss 1, 2, 4-6, 8-10, and 12-16: See note following RCW 28A.400.391.

RCW 41.05.013 State purchased health care programs—Uniform policies. (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.

(2) The 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. [2023 c 51 s 4; 2006 c 307 s 8; 2005 c 462 s 3; 2003 c 276 s 1.]

Captions not law—Conflict with federal requirements—2006 c 307: See notes following RCW 70.14.080.

Findings—2005 c 462: See note following RCW 28A.210.370.

Rule making—2003 c 276: "Agencies administering state purchased health care programs shall cooperatively adopt rules necessary to implement this act." [2003 c 276 s 2.]

RCW 41.05.014 Applications, enrollment forms, and eligibility certification documents—Signatures. (1) The director may require applications, enrollment forms, and eligibility certification documents for benefits that are administered by the authority under this chapter and chapter 70.47 RCW to be signed by the person submitting them. The director may accept electronic signatures.

(2) For the purpose of this section, "electronic signature" means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record. [2020 c 57 s 84; 2009 c 201 s 2.]

RCW 41.05.015 Medical director—Appointment of personnel. 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 chapters 74.09, 71.05, 71.24, and 71.34 RCW and other applicable law. The medical screeners must be supervised by one or more physicians whom the director or the director's designee shall appoint. [2023 c 51 s 5; 2018 c 201 s 7001; 2011 1st sp.s. c 15 s 55; 2000 c 5 s 16.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Intent—Purpose—2000 c 5: See RCW 48.43.500.

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 41.05.017 Provisions applicable to health plans offered under this chapter. ***(Effective until January 1, 2025.)*** 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, 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, 48.43.083, 48.43.0128, 48.43.780, 48.43.435, 48.43.815, 48.200.020 through 48.200.280, 48.200.300 through 48.200.320, and chapter 48.49 RCW. [2024 c 242 s 10. Prior: 2022 c 236 s 3; 2022 c 228 s 2; 2022 c 10 s 2; 2021 c 280 s 2; 2019 c 427 s 21; 2016 c 139 s 4; 2008 c 304 s 2; 2007 c 502 s 2; 2000 c 5 s 20.]

Short title—2021 c 280: See note following RCW 49.60.178.

Findings—Intent—Effective date—2019 c 427: See RCW 48.49.003 and 48.49.900.

Savings—Severability—Effective date—2007 c 502: See notes following RCW 48.43.083.

Intent—Purpose—2000 c 5: See RCW 48.43.500.

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 41.05.017 Provisions applicable to health plans offered under this chapter. ***(Effective January 1, 2025.)*** 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, 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, 48.43.083, 48.43.0128, 48.43.780, 48.43.435, 48.43.815, 48.200.020 through 48.200.280, 48.200.300 through 48.200.320, 48.43.440, and chapter 48.49 RCW. [2024 c 251 s 5; 2024 c 242 s 10. Prior: 2022 c 236 s 3; 2022 c 228 s 2; 2022 c 10 s 2; 2021 c 280 s 2; 2019 c 427 s 21; 2016 c 139 s 4; 2008 c 304 s 2; 2007 c 502 s 2; 2000 c 5 s 20.]

Reviser's note: This section was amended by 2024 c 242 s 10 and by 2024 c 251 s 5, without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2024 c 251: See note following RCW 70.41.495.

Short title—2021 c 280: See note following RCW 49.60.178.

Findings—Intent—Effective date—2019 c 427: See RCW 48.49.003 and 48.49.900.

Savings—Severability—Effective date—2007 c 502: See notes following RCW 48.43.083.

Intent—Purpose—2000 c 5: See RCW 48.43.500.

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 41.05.018 Transfer of certain behavioral health-related powers, duties, and functions from the department of social and health services. (1) The powers, duties, and functions of the department of social and health services pertaining to the behavioral health system and purchasing function of the behavioral health administration, except for oversight and management of state-run mental health institutions and licensing and certification activities, are hereby

transferred to the Washington state health care authority to the extent necessary to carry out the purposes of chapter 201, Laws of 2018. All references to the secretary or the department of social and health services in the Revised Code of Washington shall be construed to mean the director of the health care authority or the health care authority when referring to the functions transferred in this section.

(2)(a) All reports, documents, surveys, books, records, files, papers, or written material in the possession of the department of social and health services pertaining to the powers, duties, and functions transferred shall be delivered to the custody of the health care authority. All cabinets, furniture, office equipment, motor vehicles, and other tangible property employed by the department of social and health services in carrying out the powers, duties, and functions transferred shall be made available to the health care authority. All funds, credits, or other assets held by the department of social and health services in connection with the powers, duties, and functions transferred shall be assigned to the health care authority.

(b) Any appropriations made to the department of social and health services for carrying out the powers, functions, and duties transferred shall, on July 1, 2018, be transferred and credited to the health care authority.

(c) Whenever any question arises as to the transfer of any personnel, funds, books, documents, records, papers, files, equipment, 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 department of social and health services pertaining to the powers, duties, and functions transferred shall be continued and acted upon by the health care authority. All existing contracts and obligations shall remain in full force and shall be performed by the health care authority.

(4) The transfer of the powers, duties, functions, and personnel of the department of social and health services shall not affect the validity of any act performed before July 1, 2018.

(5) If apportionments of budgeted funds are required because of the transfers directed by this section, the director of financial management shall certify the apportionments to the agencies affected, the state auditor, and the state treasurer. Each of these shall make the appropriate transfer and adjustments in funds and appropriation accounts and equipment records in accordance with the certification.

(6) On July 1, 2018, all employees of the department of social and health services engaged in performing the powers, functions, and duties transferred to the health care authority are transferred to the health care authority. All employees classified under chapter 41.06 RCW, the state civil service law, are assigned to the health care authority to perform their usual duties upon the same terms as formerly, without any loss of rights, subject to any action that may be appropriate thereafter in accordance with the laws and rules governing state civil service law.

(7) Positions in any bargaining unit within the health care authority existing on July 1, 2018, will not be removed from an existing bargaining unit as a result of this section unless and until the existing bargaining unit is modified by the public employment relations commission pursuant to Title 391 WAC. The portions of any

bargaining units of employees at the department of social and health services existing on July 1, 2018, that are transferred to the health care authority shall be considered separate appropriate units within the health care authority unless and until modified by the public employment relations commission pursuant to Title 391 WAC. The exclusive bargaining representatives recognized as representing the portions of the bargaining units of employees at the department of social and health services existing on July 1, 2018, shall continue as the exclusive bargaining representatives of the transferred bargaining units without the necessity of an election.

(8) The public employment relations commission may review the appropriateness of the collective bargaining units that are a result of the transfer from the department of social and health services to the health care authority under chapter 201, Laws of 2018. The employer or the exclusive bargaining representative may petition the public employment relations commission to review the bargaining units in accordance with this section.

(9) On July 1, 2018, the health care authority must enter into an agreement with the department of health to ensure coordination of preventative behavioral health services or other necessary agreements to carry out the intent of chapter 201, Laws of 2018.

(10) The health care authority may enter into agreements as necessary with the department of social and health services to carry out the transfer of duties as set forth in chapter 201, Laws of 2018. [2018 c 201 s 10001.]

Findings—Intent—2018 c 201: "The legislature finds that:

(1) Washington state government must be organized to be efficient, cost-effective, and responsive to its residents.

(2) Pursuant to existing legislative direction, Washington state continues to transform how it delivers behavioral health services by integrating the financing and delivery of behavioral and physical health care by 2020. Integration will improve prevention and treatment of behavioral health conditions. Integration, leading to better whole person care, should also enable many individuals to avoid commitment at the state psychiatric hospitals or divert from jails, and support them in leading healthy, productive lives.

(3) The responsibility for oversight, purchasing, and management of Washington state's community behavioral health system is currently split between the department of social and health services, which is the state's behavioral health authority, and the health care authority, which is the single state medicaid agency responsible for state health care purchasing.

(4) The health care authority is the state's primary health care purchaser. Integrating and consolidating the oversight and purchasing of state behavioral health care into a single state agency at the health care authority will align core operations and provide better, coordinated, and more cost-effective services, with the ultimate goal of achieving whole person care.

(5) The legislature therefore intends to consolidate state behavioral health care purchasing and oversight within the health care authority, positioning the state to use its full purchasing power to get the greatest value for its investment. The department of social and health services will continue to operate the state mental health institutions, with the intent of further analyzing the future proper alignment of these services.

(6) Similar to the issues with our disparate purchasing programs, the responsibility for licensing and certification of behavioral health providers and facilities is currently spread across multiple agencies, with the department of social and health services regulating some behavioral health providers and the department of health regulating others.

(7) The department of health is responsible for the majority of licensing and certification of health care providers and facilities. The state will best be able to ensure patient safety and reduce administrative burdens of licensing and certification of behavioral health providers and facilities by consolidating those functions within a single agency at the department of health. This change will streamline processes leading to improved patient safety outcomes.

(8) The legislature therefore intends to integrate and consolidate the behavioral health licensing and certification functions within the department of health." [2018 c 201 s 1001.]

Effective date—2018 c 201: "Except as provided in section 11005 of this act, this act takes effect July 1, 2018." [2018 c 201 s 11006.]

RCW 41.05.021 State health care authority—Director—Cost control and delivery strategies—Health information technology—Managed competition—Rules. (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. The primary duties of the authority shall be to: Administer insurance benefits for employees, retired or disabled state and school employees, and school employees; 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. The authority's duties include, but are not limited to, the following:

(a) To administer health care benefit programs for employees, retired or disabled state and school employees, and school employees as specifically authorized in RCW 41.05.065 and 41.05.740 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 and school 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) 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, 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;

(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 or tribal school applies to

transfer their employees to an insurance or self-insurance program administered by the public employees' benefits board or by the school employees' benefits board. 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 or tribal school 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 administered by the public employees' benefits board or the school employees' benefits board;

(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 employer groups, 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. Charter schools established under chapter 28A.710 RCW are employers and are school employees' benefits board organizations unless:

(i) The authority receives guidance from the internal revenue service or the United States department of labor that participation jeopardizes the status of plans offered under this chapter as governmental plans under the federal employees' retirement income security act or the internal revenue code; or

(ii) The charter schools are not in compliance with regulations issued by the internal revenue service and the United States treasury department pertaining to section 414(d) of the federal internal revenue code;

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

(i) Through December 31, 2019, 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 public employees' benefits board under RCW 41.05.065, and by the school employees' benefits board under RCW 41.05.740, for determining whether a public employee is eligible for benefits;

(ii) Establishing an appeal process in accordance with chapter 34.05 RCW by which a public 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 and programs under chapters 71.05, 71.24, and 71.34 RCW. The agreements shall establish the division of responsibilities between the authority and the department with respect to mental health, substance use disorders, 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 public employees' benefits board 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) The public employees' benefits board and the school employees' benefits board may implement strategies to promote managed competition among employee and school 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. [2023 c 51 s 6; 2023 c 13 s 3. Prior: 2018 c 260 s 6; 2018 c 201 s 7002; 2017 3rd sp.s. c 13 s 803; 2012 c 87 s 23; 2011 1st sp.s. c 15 s 56; 2009 c 537 s 4; prior: 2007 c 274 s 1; 2007 c 114 s 3; 2006 c 103 s 2; 2005 c 446 s 1; 2002 c 142 s 1; 1999 c 372 s 4; 1997 c 274 s 1; 1995 1st sp.s. c 6 s 7; 1994 c 309 s 1; prior: 1993 c 492 s 215; 1993 c 386 s 6; 1990 c 222 s 3; 1988 c 107 s 4.]

Reviser's note: This section was amended by 2023 c 13 s 3 and by 2023 c 51 s 6, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Finding—Intent—2023 c 13: See note following RCW 41.05.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Intent—2017 3rd sp.s. c 13: See note following RCW 28A.150.410.

Effective date—2012 c 87 ss 4, 16, 18, and 19-23: See note following RCW 43.71.030.

Spiritual care services—2012 c 87: See RCW 43.71.901.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Effective date—2009 c 537: See note following RCW 41.05.008.

Intent—Effective date—2007 c 114: See notes following RCW 41.05.011.

Intent—2006 c 103: "(1) The legislature recognizes that improvements in the quality of health care lead to better health care outcomes for the residents of Washington state and contain health care costs. The improvements are facilitated by the adoption of electronic medical records and other health information technologies.

(2) It is the intent of the legislature to encourage all hospitals, integrated delivery systems, and providers in the state of Washington to adopt health information technologies by the year 2012." [2006 c 103 s 1.]

Effective date—1997 c 274: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 1997." [1997 c 274 s 10.]

Effective date—1995 1st sp.s. c 6: See note following RCW 28A.400.410.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

Intent—1993 c 386: See note following RCW 28A.400.391.

Effective date—1993 c 386 ss 1, 2, 4-6, 8-10, and 12-16: See note following RCW 28A.400.391.

RCW 41.05.022 State agent for purchasing health services—Single community-rated risk pool. (1) The health care authority is hereby designated as the single state agent for purchasing health services.

(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 through December 31, 2019; health benefits for 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) On and after January 1, 2020, health benefits for groups of school employees of school employees' benefits board organizations shall be merged into a single, community-rated risk pool separate and distinct from the pool described in subsection (2) of this section.

(4) By December 15, 2018, the health care authority, in consultation with the board, shall submit to the appropriate committees of the legislature a complete analysis of the most appropriate risk pool for the retired and disabled school employees, to include at a minimum an analysis of the size of the nonmedicare and medicare retiree enrollment pools, the impacts on cost for state and school district retirees of moving retirees from one pool to another, the need for and the amount of an ongoing retiree subsidy allocation from the active school employees, and the timing and suggested approach for a transition from one risk pool to another.

(5) At a minimum, and regardless of other legislative enactments, the state health services purchasing agent 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 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 an employing agency from entering into an agreement with employees or employee organizations when the agreement would result in increased utilization in board plans or reduce the expected savings of managed competition. [2018 c 260 s 7; 2017 3rd sp.s. c 13 s 804; 1995 1st sp.s. c 6 s 3; 1994 c 153 s 3; 1993 c 492 s 227.]

Intent—2017 3rd sp.s. c 13: See note following RCW 28A.150.410.

Effective date—1995 1st sp.s. c 6: See note following RCW 28A.400.410.

Intent—Effective dates—1994 c 153: See notes following RCW 41.05.011.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 41.05.023 Chronic care management program—Uniform medical plan—Definitions. (1) The health care authority, in collaboration with the department of health, shall design and implement a chronic care management program for employees and school 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 and school 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. [2018 c 260 s 8; 2007 c 259 s 6.]

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

RCW 41.05.026 Contracts—Proprietary data, trade secrets, actuarial formulas, statistics, cost and utilization data—Exemption from public inspection—Executive sessions. (1) When soliciting

proposals for the purpose of awarding contracts for goods or services, the 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 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 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. [2018 c 260 s 9; 2017 3rd sp.s. c 13 s 805; 2005 c 274 s 277; 2003 c 277 s 2; 1991 c 79 s 1; 1990 c 222 s 6.]

Intent—2017 3rd sp.s. c 13: See note following RCW 28A.150.410.

RCW 41.05.031 Health information technology office—Agencies to establish health care information systems. The Washington state health information technology office is located within the authority. The following state agencies are directed to cooperate with the authority to establish appropriate health care information systems in their programs: The department of social and health services, the department of health, the department of labor and industries, the basic health plan, the department of veterans affairs, the department of corrections, the department of children, youth, and families, and the superintendent of public instruction.

The authority, in conjunction with these agencies and in collaboration with Washington technology solutions, shall determine:

(1) Definitions of health care services;

(2) Health care data elements common to all agencies;

(3) Health care data elements unique to each agency; and

(4) A mechanism for program and budget review of health care data. [2024 c 54 s 34; 2023 c 51 s 7; 1990 c 222 s 4; 1988 c 107 s 5.]

RCW 41.05.035 Exchange of health information—Advisory board, discretionary—Director's authority. (1) The director shall design, implement, and maintain a consumer-centric health information infrastructure and the state electronic health record repositories 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 the state electronic health record repositories and the account locator service, setting criteria and standards for health record repositories, and determining oversight of the state health records service;

(b) Implement the first state health record repositories as funding allows;

(c) Involve health care consumers in meaningful ways in the design, implementation, oversight, and dissemination of information on the state health record repositories 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 director may establish an advisory board, a stakeholder committee, and subcommittees to assist in carrying out the duties under this section. The 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 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 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 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 director may enter into contracts to issue, distribute, and administer grants that are necessary or proper to carry out this section. [2023 c 51 s 8; 2007 c 259 s 10.]

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

RCW 41.05.036 Health information—Definitions. The definitions in this section apply throughout RCW 41.05.039 through 41.05.046 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. [2011 1st sp.s. c 15 s 57; 2009 c 300 s 2.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Finding—2009 c 300: "The legislature finds that:

(1) The inability to securely share critical health information between practitioners inhibits the delivery of safe, efficient care, as evidenced by:

(a) Adverse drug events that result in an average of seven hundred seventy thousand injuries and deaths each year; and

(b) Duplicative services that add to costs and jeopardize patient well-being;

(2) Consumers are unable to act as fully informed participants in their care unless they have ready access to their own health information;

(3) The blue ribbon commission on health care costs and access found that the development of a system to provide electronic access to patient information anywhere in the state was a key to improving health care; and

(4) In 2005, the legislature established a health information infrastructure advisory board to develop a strategy for the adoption and use of health information technologies that are consistent with emerging national standards and promote interoperability of health information systems." [2009 c 300 s 1.]

RCW 41.05.037 Nurse hotline, when funded. To the extent that funding is provided specifically for this purpose, the director shall provide all persons enrolled in health plans under this chapter and chapters 70.47 and 74.09 RCW with access to a twenty-four hour, seven day a week nurse hotline. [2011 1st sp.s. c 15 s 58; 2007 c 259 s 15.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

RCW 41.05.039 Health information—Secure access—Lead organization—Director's duties. (1) By August 1, 2009, the 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 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 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 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 director on the progress implementing the requirements of this section and RCW 41.05.042; and

(g) With the 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 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. [2023 c 51 s 9; 2009 c 300 s 3.]

Findings—2009 c 300: See note following RCW 41.05.036.

RCW 41.05.042 Health information—Processes, guidelines, and standards. By December 1, 2011, the lead organization shall, consistent with the federal health insurance portability and accountability act, develop processes, guidelines, and standards that address:

(1) Identification and prioritization of high value health data from health data providers. High value health data include:

(a) Prescriptions;

(b) Immunization records;

(c) Laboratory results;

(d) Allergies; and

(e) Diagnostic imaging;

(2) Processes to request, submit, and receive data;

(3) Data security, including:

(a) Storage, access, encryption, and password protection;

(b) Secure methods for accepting and responding to requests for data;

(c) Handling unauthorized access to or disclosure of individually identifiable patient health information, including penalties for unauthorized disclosure; and

(d) Authentication of individuals, including patients and providers, when requesting access to health information, and maintenance of a permanent audit trail of such requests, including:

(i) Identification of the party making the request;

(ii) The data elements reported; and
(iii) Transaction dates;
(4) Materials written in plain language that explain the exchange of health information and how patients can effectively manage such information, including the use of online tools for that purpose;
(5) Materials for health care providers that explain the exchange of health information and the secure management of such information. [2009 c 300 s 4.]

Findings—2009 c 300: See note following RCW 41.05.036.

RCW 41.05.046 Health information—Conflict with federal requirements. If any provision in RCW 41.05.036, 41.05.039, and 41.05.042 conflicts with existing or new federal requirements, the director shall recommend modifications, as needed, to assure compliance with the aims of RCW 41.05.036, 41.05.039, and 41.05.042 and federal requirements. [2023 c 51 s 10; 2009 c 300 s 5.]

Findings—2009 c 300: See note following RCW 41.05.036.

RCW 41.05.050 Contributions for employees and dependents. (1)(a) Every employer and employer group as defined in RCW 41.05.011 shall provide contributions to insurance and health care plans for its employees and their dependents, the content of such plans to be determined by the authority.
(b) Contributions paid by employer groups for their employees, shall include an amount determined by the authority to pay such administrative expenses of the authority as are necessary to administer the plans for employees of those groups.
(2) To account for any increased cost of benefit plans developed by the board, the authority may develop a rate surcharge applicable to participating employer groups as defined in RCW 41.05.011.
(3) The contributions of any: (a) Department, division, or separate agency of the state government; (b) county, municipal, or other political subdivisions; (c) any tribal government as are covered by this chapter; and (d) school districts, educational service districts, and charter schools, shall be set by the authority, subject to the approval of the governor for availability of funds as specifically appropriated by the legislature for that purpose. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.
(4)(a) For all groups of educational service district employees enrolling in plans developed by the public employees' benefits board after January 1, 2020, and until January 1, 2024, the authority shall collect from each participating educational service district an amount equal to the composite rate charged to state agencies, plus an amount equal to the employee premiums by plan and by family size as would be charged to employees, only if the authority determines that this method of billing the educational service districts will not result in a material difference between revenues from educational service districts and expenditures made by the authority on behalf of educational service districts and their employees. The authority may collect these amounts in accordance with the educational service district fiscal year, as described in RCW 28A.505.030.

(b)(i) Beginning January 1, 2020, all school districts, represented employees of educational service districts, and charter schools shall commence participation in the school employees' benefits board program established under RCW 41.05.740. All school districts, represented employees of educational service districts, charter schools, and all school district employee groups participating in the public employees' benefits board plans before January 1, 2020, shall thereafter participate in the school employees' benefits board program administered by the authority. All school districts, represented employees of educational service districts, and charter schools shall provide contributions to the authority for insurance and health care plans for school employees and their dependents. These contributions must be provided to the authority for all eligible school employees eligible for benefits under RCW 41.05.740(6)(d), including school employees who have waived their coverage; contributions to the authority are not required for individuals eligible for benefits under RCW 41.05.740(6)(e) who waive their coverage.

(ii) Beginning January 1, 2024, all educational service districts shall participate in the school employees' benefits board program.

(5) The authority shall transmit a recommendation for the amount of the employer contributions to the governor and the director of financial management for inclusion in the proposed budgets submitted to the legislature. [2023 c 13 s 4; 2019 c 411 s 5; 2018 c 260 s 10; 2017 3rd sp.s. c 13 s 806; 2016 c 67 s 3; 2009 c 537 s 5; 2007 c 114 s 4; 2005 c 518 s 919; 2003 c 158 s 1. Prior: 2002 c 319 s 4; 2002 c 142 s 2; prior: 1995 1st sp.s. c 6 s 22; 1994 c 309 s 2; 1994 c 153 s 4; prior: 1993 c 492 s 216; 1993 c 386 s 7; 1988 c 107 s 18; 1987 c 122 s 4; 1984 c 107 s 1; 1983 c 15 s 20; 1983 c 2 s 9; prior: 1982 1st ex.s. c 34 s 2; 1981 c 344 s 6; 1979 c 151 s 55; 1977 ex.s. c 136 s 4; 1975-'76 2nd ex.s. c 106 s 4; 1975 1st ex.s. c 38 s 2; 1973 1st ex.s. c 147 s 3; 1970 ex.s. c 39 s 5.]

Finding—Intent—2023 c 13: See note following RCW 41.05.011.

Intent—2017 3rd sp.s. c 13: See note following RCW 28A.150.410.

Effective date—2009 c 537: See note following RCW 41.05.008.

Intent—Effective date—2007 c 114: See notes following RCW 41.05.011.

Effective date—2005 c 518: See note following RCW 28A.600.110.

Intent—2002 c 319: See note following RCW 41.04.208.

Effective date—1995 1st sp.s. c 6: See note following RCW 28A.400.410.

Intent—Effective dates—1994 c 153: See notes following RCW 41.05.011.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

Effective date—1993 c 386 ss 3, 7, and 11: See note following RCW 41.04.205.

Intent—1993 c 386: See note following RCW 28A.400.391.

Severability—1983 c 2: See note following RCW 18.71.030.

Severability—1981 c 344: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1981 c 344 s 8.]

Effective date—Conditions prerequisite to implementing sections—1977 ex.s. c 136: "This 1977 amendatory act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect on July 1, 1977: PROVIDED, That if the state operating budget appropriations act does not contain the funds necessary for the implementation of this 1977 amendatory act in an appropriated amount sufficient to fully fund the employer's contribution to the state employee insurance benefits program which is established by the board in accordance with RCW 41.05.050 (2) and (3) as now or hereafter amended, sections 1, 5, and 6 of this 1977 amendatory act shall be null and void." [1977 ex.s. c 136 s 8.]

Effective date—Effect of veto—1973 1st ex.s. c 147: "This bill shall not take effect until the funds necessary for its implementation have been specifically appropriated by the legislature and such appropriation itself has become law. It is the intention of the legislature that if the governor shall veto this section or any item thereof, none of the provisions of this bill shall take effect." [1973 1st ex.s. c 147 s 10.]

Savings—1973 1st ex.s. c 147: "Nothing contained in this 1973 amendatory act shall be deemed to amend, alter or affect the provisions of Chapter 23, Laws of 1972, Extraordinary Session, and RCW 28B.10.840 through 28B.10.844 as now or hereafter amended." [1973 1st ex.s. c 147 s 13.]

Severability—1973 1st ex.s. c 147: "If any provision of this 1973 amendatory act, or its application to any person or circumstances is held invalid, the remainder of the act, or the application of the provision to other persons or circumstances is not affected." [1973 1st ex.s. c 147 s 9.]

Severability—1970 ex.s. c 39: "If any provision of this act, or its application to any person or circumstance is held invalid, the remainder of the act, or the application of the provision to other persons or circumstances is not affected." [1970 ex.s. c 39 s 14.]

RCW 41.05.055 Public employees' benefits board—Members. (1) The public employees' benefits board is created within the authority. The function of the public employees' benefits board is to design and approve insurance benefit plans for employees and to establish eligibility criteria for participation in insurance benefit plans.

(2) The public employees' benefits board shall be composed of nine members through December 31, 2019, and of eight members thereafter, 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 public employees' benefits board, and represents an organized group of retired public employees;

(b) Through December 31, 2019, two representatives of school district employees, one of whom shall represent an association of school employees as a nonvoting member, and one of whom is retired, and represents an organized group of retired school employees. Thereafter, and only while retired school employees are served by the public employees' benefits board, only the retired representative shall serve on the public employees' benefits board;

(c) Four members with experience in health benefit management and cost containment, one of whom shall be a nonvoting member; and

(d) The director.

(3) The governor shall appoint the initial members of the public employees' benefits board to staggered terms not to exceed four years. Members appointed thereafter shall serve two-year terms. Members of the public employees' benefits 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 public employees' benefits board shall prescribe rules for the conduct of its business. The director shall serve as chair of the public employees' benefits board. Meetings of the public employees' benefits board shall be at the call of the chair. [2018 c 260 s 11; 2017 3rd sp.s. c 13 s 807; 2009 c 537 s 6; 1995 1st sp.s. c 6 s 4; 1994 c 36 s 1; 1993 c 492 s 217; 1989 c 324 s 1; 1988 c 107 s 7.]

Intent—2017 3rd sp.s. c 13: See note following RCW 28A.150.410.

Effective date—2009 c 537: See note following RCW 41.05.008.

Effective date—1995 1st sp.s. c 6: See note following RCW 28A.400.410.

Effective date—1994 c 36: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect immediately [March 21, 1994]." [1994 c 36 s 2.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 41.05.065 Public employees' benefits board—Duties—Eligibility—Definitions—Penalties. (1) The public employees' benefits 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 public employees' benefits board shall develop employee benefit plans that include comprehensive health care benefits for employees. In developing these plans, the public employees' benefits 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 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 public employees' benefits 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 public employees' benefits board shall design benefits and determine the terms and conditions of employee and retired or disabled school 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) (i) through (vi) may contractually agree with the authority to benefits eligibility criteria which differs from that determined by the public employees' benefits board. The eligibility criteria established by the public employees' benefits 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 public employees' benefits board shall define "benefits-eligible position."

(5) The public employees' benefits 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 public employees' benefits 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 public employees' benefits 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 public employees' benefits 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 public employees' benefits board and may be permitted to waive coverage under terms and conditions established by the public employees' benefits board.

(9) The public employees' benefits 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 public employees' benefits 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 public employees' benefits board determines to be in the best interests of employees and the state. The public employees' benefits 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 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 public employees' benefits 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 public employees' benefits 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 public employees' benefits board.

(11) The public employees' benefits 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. [2018 c 260 s 12; 2015 c 116 s 3; 2011 1st sp.s. c 8 s 1;

2009 c 537 s 7. Prior: 2007 c 156 s 10; 2007 c 114 s 5; 2006 c 299 s 2; prior: 2005 c 518 s 920; 2005 c 195 s 1; 2003 c 158 s 2; 2002 c 142 s 3; 1996 c 140 s 1; 1995 1st sp.s. c 6 s 5; 1994 c 153 s 5; prior: 1993 c 492 s 218; 1993 c 386 s 9; 1988 c 107 s 8.]

Effective date—2009 c 537: See note following RCW 41.05.008.

Intent—Effective date—2007 c 114: See notes following RCW 41.05.011.

Effective date—2005 c 518: See note following RCW 28A.600.110.

Effective date—2005 c 195: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2005." [2005 c 195 s 4.]

Effective date—1995 1st sp.s. c 6: See note following RCW 28A.400.410.

Intent—Effective dates—1994 c 153: See notes following RCW 41.05.011.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

Intent—1993 c 386: See note following RCW 28A.400.391.

Effective date—1993 c 386 ss 1, 2, 4-6, 8-10, and 12-16: See note following RCW 28A.400.391.

RCW 41.05.066 Domestic partner benefits. A certificate of domestic partnership qualified under the provisions of RCW 26.60.030 shall be recognized as evidence of a state registered domestic partnership fulfilling all necessary eligibility criteria for the partner of the public employee to receive benefits. Nothing in this section affects the requirements of domestic partners to complete documentation related to federal tax status that may currently be required by the board for public employees choosing to make premium payments on a pretax basis. [2023 c 51 s 11; 2018 c 260 s 13; 2015 c 116 s 4; 2007 c 156 s 9.]

RCW 41.05.068 Federal employer incentive program—Authority to participate. The authority may participate as an employer-sponsored program established in section 1860D-22 of the medicare prescription drug, improvement, and modernization act of 2003, P.L. 108-173 et seq., to receive federal employer subsidy funds for continuing to provide retired employee health coverage, including a pharmacy benefit. The director, in consultation with the office of financial management, shall evaluate participation in the employer incentive program, including but not limited to any necessary program changes to meet the eligibility requirements that employer-sponsored retiree

health coverage provide prescription drug coverage at least equal to the actuarial value of standard prescription drug coverage under medicare part D. Any employer subsidy moneys received from participation in the federal employer incentive program shall be deposited in the state general fund. [2023 c 51 s 12; 2009 c 479 s 25; 2005 c 195 s 2.]

Effective date—2009 c 479: See note following RCW 2.56.030.

Effective date—2005 c 195: See note following RCW 41.05.065.

RCW 41.05.074 Public employees—Prior authorization standards and criteria—Health plan requirements—Definitions. (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 website 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, acupuncture and Eastern 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 website 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. [2019 c 308 s 20; 2015 c 251 s 1.]

Findings—2019 c 308: See note following RCW 18.06.010.

Effective date—2015 c 251: "This act takes effect January 1, 2017." [2015 c 251 s 3.]

RCW 41.05.075 Employee benefit plans—Contracts with insuring entities—Performance measures—Financial incentives—Health information technology. (1) The 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. The process of contracting for plans offered by the school employees' benefits board is subject to insight and direction by the school employees' benefits board.

(2) The 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 entities described in RCW 28A.400.275(2) shall provide the school employees' benefits board and authority specified data by April 1, 2018, in a format to be determined by the authority, to support an initial benefits plans procurement. At a minimum, the data must cover the period January 1, 2014, through December 31, 2017, and include:

(a) A summary of the benefit packages offered to each group of school employees, including covered benefits, point-of-service cost-sharing, member count, and the group policy number;

(b) Aggregated subscriber and member demographic information, including age band and gender, by insurance tier by month and by benefit packages;

(c) Monthly total by benefit package, including premiums paid, inpatient facility claims paid, outpatient facility claims paid, physician claims paid, pharmacy claims paid, capitation amounts paid, and other claims paid;

(d) A listing for calendar years 2014 through 2017 of large claims defined as annual amounts paid in excess of one hundred thousand dollars including the amount paid, the member enrollment status, and the primary diagnosis;

(e) A listing of calendar year 2017 allowed claims by provider entity; and

(f) All data needed for design, procurement, rate setting, and administration of all school employees' benefits board benefits.

Any data that may be confidential and contain personal health information may be protected in accordance with a data-sharing agreement.

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

(5) The director shall centralize the enrollment files for all employee, school employee, and retired or disabled school employee

health plans offered under chapter 41.05 RCW and develop enrollment demographics on a plan-specific basis.

(6) All claims data shall be the property of the state. The 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 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 (8) of this section.

(7) 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 director from establishing appropriate utilization controls approved pursuant to RCW 41.05.065(2) (a), (b), and (d).

(8) The 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, 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.

(9) The 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. [2018 c 260 s 14; 2017 3rd sp.s. c 13 s 808; 2007 c 259 s 34; 2006 c 103 s 3; 2005 c 446 s 2; 2002 c 142 s 4. Prior: 1994 sp.s. c 9 s 724; 1994 c 309 s 3; 1994 c 153 s 6; 1993 c 386 s 10; 1988 c 107 s 9.]

***Reviser's note:** The term "advanced registered nurse practitioner" was changed to "advanced practice registered nurse" by 2024 c 239 s 1, effective June 30, 2027.

Effective date—2018 c 260 ss 14, 22, 23, 31, and 32: "Sections 14, 22, 23, 31, and 32 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect immediately [March 23, 2018]." [2018 c 260 s 35.]

Intent—2017 3rd sp.s. c 13: See note following RCW 28A.150.410.

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

Intent—2006 c 103: See note following RCW 41.05.021.

Severability—Headings and captions not law—Effective date—1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

Intent—Effective dates—1994 c 153: See notes following RCW 41.05.011.

Intent—1993 c 386: See note following RCW 28A.400.391.

Effective date—1993 c 386 ss 1, 2, 4-6, 8-10, and 12-16: See note following RCW 28A.400.391.

RCW 41.05.080 Participation in insurance plans and contracts—Retired, disabled, or separated employees—Certain surviving spouses, state registered domestic partners, and dependent children. (1) Under the qualifications, terms, conditions, and benefits set by the public employees' benefits board:

(a)(i) Retired or disabled state employees, retired or disabled school employees, or retired or disabled employees of employer groups covered by this chapter may continue their participation in insurance plans and contracts after retirement or disablement.

(ii) The retired or disabled employees of employer groups whose contractual agreement with the authority terminates may continue their participation in insurance plans and contracts after the contractual agreement is terminated. The retired or disabled employees of employer groups whose contractual agreement with the authority terminates are not eligible for any subsidy provided under RCW 41.05.085;

(b) Separated employees may continue their participation in insurance plans and contracts if participation is selected immediately upon separation from employment;

(c) Surviving spouses, surviving state registered domestic partners, and dependent children of emergency service personnel killed in the line of duty may participate in insurance plans and contracts.

(2) Rates charged surviving spouses and surviving state registered domestic partners of emergency service personnel killed in the line of duty, retired or disabled employees, separated employees, spouses, or dependent children who are not eligible for parts A and B of medicare shall be based on the experience of the community-rated risk pool established under RCW 41.05.022.

(3) Rates charged to surviving spouses and surviving state registered domestic partners of emergency service personnel killed in the line of duty, retired or disabled employees, separated employees, spouses, or children who are eligible for parts A and B of medicare shall be calculated from a separate experience risk pool comprised only of individuals eligible for parts A and B of medicare; however, the premiums charged to medicare-eligible retirees and disabled employees shall be reduced by the amount of the subsidy provided under RCW 41.05.085, except as provided in subsection (1)(a)(ii) of this section.

(4) Surviving spouses, surviving state registered domestic partners, and dependent children of emergency service personnel killed in the line of duty and retired or disabled and separated employees shall be responsible for payment of premium rates developed by the authority which shall include the cost to the authority of providing insurance coverage including any amounts necessary for reserves and administration in accordance with this chapter. These self pay rates will be established based on a separate rate for the employee, the spouse, state registered domestic partners, and the children.

(5) When a person described in subsection (1)(a)(i), (b), or (c) of this section dies, the authority shall waive the payment of the decedent's premiums and any applicable premium surcharges for the medical, dental, or vision plan for the month in which the death occurred. The authority shall enroll any eligible surviving dependents in the same medical, dental, or vision plan that they had been enrolled in, which shall be made effective on the first day of the month in which the death occurred, and the eligible surviving dependent shall be responsible for the payment of premiums and any applicable premium surcharges for themselves and any other eligible dependents.

(6) The term "retired state employees" for the purpose of this section shall include but not be limited to members of the legislature whether voluntarily or involuntarily leaving state office. [2024 c 185 s 1. Prior: 2023 c 312 s 1; 2023 c 13 s 5; 2018 c 260 s 15; 2015 c 116 s 5; prior: 2009 c 523 s 1; 2009 c 522 s 9; 2007 c 114 s 6; 2001 c 165 s 3; 1996 c 39 s 22; 1994 c 153 s 7; 1993 c 386 s 11; 1977 ex.s. c 136 s 6; 1975-'76 2nd ex.s. c 106 s 6; 1973 1st ex.s. c 147 s 7; 1970 ex.s. c 39 s 8.]

Effective date—2023 c 312: See note following RCW 41.05.083.

Finding—Intent—2023 c 13: See note following RCW 41.05.011.

Intent—Effective date—2007 c 114: See notes following RCW 41.05.011.

Effective date—Application—2001 c 165: See note following RCW 41.05.011.

Effective dates—1996 c 39: See note following RCW 41.32.010.

Intent—Effective dates—1994 c 153: See notes following RCW 41.05.011.

Effective date—1993 c 386 ss 3, 7, and 11: See note following RCW 41.04.205.

Intent—1993 c 386: See note following RCW 28A.400.391.

Effective date—Conditions prerequisite to implementing sections—1977 ex.s. c 136: See note following RCW 41.05.050.

Effective date—Effect of veto—Savings—Severability—1973 1st ex.s. c 147: See notes following RCW 41.05.050.

Severability—1970 ex.s. c 39: See note following RCW 41.05.050.

RCW 41.05.083 Employer groups—Participation in insurance plans and contracts—Termination of agreement—Payment for retired or disabled employees. (1) Employer groups that enter into a contractual agreement with the authority after May 4, 2023, and whose contractual agreement with the authority is subsequently terminated, shall make a one-time payment as calculated in subsection (2) of this section to the authority for each of the employer group's retired or disabled employees who continue their participation in insurance plans and contracts under RCW 41.05.080(1)(a)(ii).

(2) For each of the employer group's retired or disabled employees who will be continuing their participation, the authority shall determine the one-time payment amount by calculating the difference in cost between the rate charged to retired or disabled employees under RCW 41.05.080(2) and the actuarially determined value of the medical benefits for retired and disabled employees who are not eligible for parts A and B of medicare, and then multiplying that difference by the number of months until the retired or disabled employee would become eligible for medicare.

(3) Employer groups shall not be entitled to any refund of the amount paid to the authority under this section. [2023 c 312 s 2.]

Effective date—2023 c 312: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 4, 2023]." [2023 c 312 s 4.]

RCW 41.05.085 Retired state employee and retired or disabled school employee health insurance subsidy. (1) 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 subsidy to reduce the medical and prescription drug insurance premium 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.

(2) The amount of any premium reduction shall be established by the public employees' benefits 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 public employees' benefits 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 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. [2024 c 197 s 1; 2018 c 260 s 16; 2005 c 195 s 3; 1994 c 153 s 8.]

Effective date—2005 c 195: See note following RCW 41.05.065.

Intent—Effective dates—1994 c 153: See notes following RCW 41.05.011.

RCW 41.05.095 Coverage for dependents under the age of twenty-six. (1) Any plan offered to employees under this chapter must offer each employee the option of covering any dependent of the employee under the age of twenty-six.

(2) Coverage must terminate upon attainment of age twenty-six except in the case of a child who is and continues to be both (a) incapable of self-sustaining employment by reason of a developmental or physical disability and (b) chiefly dependent upon the employee for support and maintenance, provided proof of such incapacity and dependency is furnished by the employee within sixty days of the child's attainment of age twenty-six and subsequently as may be required by the authority, but not more frequently than annually after the two-year period following the child's attainment of age twenty-six. [2020 c 274 s 20; 2015 c 116 s 6; 2010 c 94 s 11; 2007 c 259 s 18.]

Purpose—2010 c 94: See note following RCW 44.04.280.

Effective date—2007 c 259 ss 18-22: "Sections 18 through 22 of this act take effect January 1, 2009." [2007 c 259 s 72.]

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

RCW 41.05.100 Chapter not applicable to certain employees of Cooperative Extension Service. The provisions of this chapter shall not be applicable to any employee of the Washington State University Cooperative Extension Service who holds a federal civil service appointment and is thereby eligible for insurance coverage under the regulations of the United States Department of Agriculture and the United States Civil Service Commission, and which employee elects participation in the federal programs in lieu of the programs established pursuant to this chapter. Such election may be made only once. [1979 ex.s. c 9 s 1.]

RCW 41.05.120 Public employees' and retirees' insurance account—School employees' insurance account. (1) The public employees' and retirees' insurance account is hereby established in the custody of the state treasurer, to be used by the 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 and claims for employee and retiree insurance benefit contracts and subsidy amounts provided under RCW 41.05.085, and transfers from the 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 director. Moneys from the account may be transferred to the flexible spending administrative account to provide reserves and start-up costs for the operation of the 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 director shall determine whether the state treasurer or the state investment board or both shall invest moneys in the public employees' and retirees' insurance account.

(3) The school employees' insurance account is hereby established in the custody of the state treasurer, to be used by the director for the deposit of contributions, reserves, dividends, and refunds, for payment of premiums and claims for school employee insurance benefit contracts, and for transfers from the school employees' benefits board flexible spending and dependent care administrative account as authorized in this subsection. Moneys from the account shall be disbursed by the state treasurer by warrants on vouchers duly authorized by the director. Moneys from the account may be transferred to the school employees' benefits board flexible spending and dependent care administrative account to provide reserves and start-up costs for the operation of the school employees' benefits board flexible spending arrangement and dependent care assistance program.

(4) The state treasurer and the state investment board may invest moneys in the school employees' insurance account. These investments must be in accordance with RCW 43.84.080 or 43.84.150, whichever is applicable. The director shall determine whether the state treasurer or the state investment board or both shall invest moneys in the school employees' insurance account.

(5) Moneys may be transferred between the public employees' and retirees' insurance account and the school employees' insurance account for short-term cash management and cash balance purposes. [2023 c 435 s 10; 2018 c 260 s 25; 2017 3rd sp.s. c 13 s 809. Prior: 2005 c 518 s 921; 2005 c 143 s 3; 1994 c 153 s 9; 1993 c 492 s 219; 1991 sp.s. c 13 s 100; 1988 c 107 s 10.]

Effective date—2023 c 435: See note following RCW 43.79.570.

Intent—2017 3rd sp.s. c 13: See note following RCW 28A.150.410.

Effective date—2005 c 518: See note following RCW 28A.600.110.

Intent—Effective dates—1994 c 153: See notes following RCW 41.05.011.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

Effective dates—Severability—1991 sp.s. c 13: See notes following RCW 18.08.240.

RCW 41.05.123 Flexible spending administrative account—Salary reduction account—School employees' benefits board flexible spending and dependent care administrative account—School employees' benefits board salary reduction account. (1) For the public employees' benefits board program, the flexible spending administrative account is created in the custody of the state treasurer.

(a) All receipts from the following must be deposited in the account:

(i) 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; and

(ii) 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 director or the 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.

(b) The salary reduction account is created in the custody of the state treasurer. 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 director or the 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.

(c) 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.

(d) 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.

(2) For the school employees' benefits board program, the school employees' benefits board flexible spending and dependent care administrative account is created in the custody of the state treasurer.

(a) All receipts from the following must be deposited in the account:

(i) Revenues from school employees' benefits board organizations for costs associated with operating the school employees' benefits board *medical flexible spending arrangement program and the school employees' benefits board dependent care assistance program provided through the salary reduction plan authorized under this chapter; and

(ii) 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 school employees' benefits board *medical flexible spending arrangement program and the school employees' benefits board dependent care assistance program provided through the salary reduction plan authorized under this chapter. Only the director or the 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.

(b) The school employees' benefits board salary reduction account is created in the custody of the state treasurer. School employee salary reductions paid to reimburse participants or service providers for benefits provided by the school employees' benefits board *medical flexible spending arrangement program and the school employees' benefits board dependent care assistance program provided through the salary reduction plan authorized under this chapter shall be paid from the school employees' benefits board salary reduction account. The funds held by the state to pay for benefits provided by the school employees' benefits board *medical flexible spending arrangement program and the school employees' benefits board dependent care assistance program provided through the salary reduction plan authorized under this chapter shall be deposited in the school employees' benefits board salary reduction account. Unclaimed moneys remaining in the school employees' benefits board 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 school employees' benefits board flexible spending and dependent care administrative account. Only the director or the 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.

(c) Program claims reserves and money necessary for start-up costs transferred from the school employees' insurance account established in RCW 41.05.120 may be deposited in the school employees' benefits board flexible spending and dependent care administrative account. Moneys in excess of the amount necessary for administrative and operating expenses of the school employees' benefits board *medical flexible spending arrangement and the school employees' benefits board dependent care assistance program may be transferred to the school employees' insurance account.

(d) The authority may periodically bill school employees' benefits board organizations for costs associated with operating the school employees' benefits board *medical flexible spending arrangement program and the school employees' benefits board dependent care assistance program provided through the salary reduction plan authorized under this chapter. [2018 c 260 s 26; 2008 c 229 s 6; 2005 c 143 s 2.]

***Reviser's note:** The term "medical flexible spending arrangement" was changed to "flexible spending arrangement" by 2023 c 51 s 3.

Effective date—2008 c 229: See note following RCW 41.05.295.

RCW 41.05.130 State health care authority administrative account—School employees' insurance administrative account. (1) 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.

(2) The school employees' insurance administrative account is hereby created in the state treasury. Moneys in the account may be used for operating, contracting, and other administrative expenses of the authority in administration of the school employees insurance program, including reimbursement of the state health care authority administrative account for initial operating expenses of the authority associated with chapter 13, Laws of 2017 3rd sp. sess. [2023 c 51 s 13; 2017 3rd sp.s. c 13 s 810; 2014 c 221 s 914; 1988 c 107 s 11.]

Intent—2017 3rd sp.s. c 13: See note following RCW 28A.150.410.

Effective date—2014 c 221: See note following RCW 28A.710.260.

RCW 41.05.140 Payment of claims—Self-insurance—Insurance reserve fund created. (1) Except for property and casualty insurance, the authority may self-fund, self-insure, or enter into other methods of providing insurance coverage for insurance programs under its jurisdiction, including the basic health plan as provided in chapter 70.47 RCW. The authority shall contract for payment of claims or other administrative services for programs under its jurisdiction. If a program does not require the prepayment of reserves, the authority shall establish such reserves within a reasonable period of time for the payment of claims as are normally required for that type of insurance under an insured program. The authority shall endeavor to reimburse basic health plan health care providers under this section at rates similar to the average reimbursement rates offered by the statewide benchmark plan determined through the request for proposal process.

(2) Reserves established by the authority for employee and retiree benefit programs shall be held in a separate account in the custody of the state treasurer and shall be known as the public employees' and retirees' insurance reserve fund. The state treasurer may invest the moneys in the reserve fund pursuant to RCW 43.79A.040.

(3) Reserves established by the authority for school employee benefit programs shall be held in a separate account in the custody of the state treasurer and shall be known as the school employees' benefits board insurance reserve fund. The state treasurer may invest the moneys in the reserve fund pursuant to RCW 43.79A.040.

(4) Any savings realized as a result of a program created for employees or school employees and retirees under this section shall not be used to increase benefits unless such use is authorized by statute.

(5) Any program created under this section shall be subject to the examination requirements of chapter 48.03 RCW as if the program were a domestic insurer. In conducting an examination, the

commissioner shall determine the adequacy of the reserves established for the program.

(6) The authority shall keep full and adequate accounts and records of the assets, obligations, transactions, and affairs of any program created under this section.

(7) The authority shall file a quarterly statement of the financial condition, transactions, and affairs of any program created under this section in a form and manner prescribed by the insurance commissioner. The statement shall contain information as required by the commissioner for the type of insurance being offered under the program. A copy of the annual statement shall be filed with the speaker of the house of representatives and the president of the senate.

(8) The provisions of this section do not apply to the administration of chapter 74.09 RCW. [2018 c 260 s 17; 2013 c 251 s 10; 2012 c 187 s 10; 2011 1st sp.s. c 15 s 59; 2000 c 80 s 5; 2000 c 79 s 44; 1994 c 153 s 10. Prior: 1993 c 492 s 220; 1993 c 386 s 12; 1988 c 107 s 12.]

Residual balance of funds—Effective date—2013 c 251: See notes following RCW 41.06.280.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

Intent—Effective dates—1994 c 153: See notes following RCW 41.05.011.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

Intent—1993 c 386: See note following RCW 28A.400.391.

Effective date—1993 c 386 ss 1, 2, 4-6, 8-10, and 12-16: See note following RCW 28A.400.391.

RCW 41.05.143 Uniform medical plan benefits administration account—Uniform dental plan benefits administration account—School employees' benefits board medical benefits administrative account—School employees' benefits board dental benefits administration account. (1) The uniform medical plan benefits administration account is created in the custody of the state treasurer. Only the director or the 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 director or the 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 school employees' benefits board medical benefits administrative account is created in the custody of the state treasurer. Only the director or the director's designee may authorize expenditures from the account. Moneys in the account shall be used exclusively for school employees' benefits board 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. Receipts from amounts due from or on behalf of enrollees for expenditures related to benefits administration, including moneys disbursed from the school employees' 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.

(5) The school employees' benefits board dental benefits administration account is created in the custody of the state treasurer. Only the director or the director's designee may authorize expenditures from the account. Moneys in the account shall be used exclusively for school employees' benefits board contracted expenditures related to benefits administration for the self-insured dental plan as established under RCW 41.05.140. Receipts from amounts due from or on behalf of the self-insured dental plan enrollees for expenditures related to benefits administration, including moneys disbursed from the school employees' 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. [2022 c 157 s 11; 2018 c 260 s 27; 2017 3rd sp.s. c 13 s 811; 2007 c 507 s 1; 2000 2nd sp.s. c 1 s 901.]

Intent—2017 3rd sp.s. c 13: See note following RCW 28A.150.410.

Severability—2000 2nd sp.s. c 1: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [2000 2nd sp.s. c 1 s 1047.]

Effective date—2000 2nd sp.s. c 1: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 2, 2000]." [2000 2nd sp.s. c 1 s 1048.]

RCW 41.05.155 Fern Lodge maintenance account. The Fern Lodge maintenance account is created in the custody of the state treasurer. All receipts from the collection of rents for the Snohomish county long-term civil commitment facility known as Fern Lodge must be deposited into the account. Expenditures from the account may only be used for the ongoing maintenance and operational costs of Fern Lodge. Only the director or the director's designee may authorize expenses from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures. [2024 c 168 s 4.]

Effective dates—2024 c 168 ss 4-13: "(1) Sections 4 through 10 and 12 of this act take effect July 1, 2024.

(2) Section 11 of this act takes effect July 1, 2030.

(3) Section 13 of this act takes effect July 1, 2028." [2024 c 168 s 17.]

RCW 41.05.160 Rules. The 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. [2023 c 51 s 14; 1988 c 107 s 15.]

RCW 41.05.165 Rules—Insurance benefit reimbursement. The authority shall adopt rules that provide for members of the legislature who choose reimbursement under RCW 44.04.230 in lieu of insurance benefits under this chapter. [1998 c 62 s 2.]

Effective date—1998 c 62: See note following RCW 44.04.230.

RCW 41.05.170 Neurodevelopmental therapies—Employer-sponsored group contracts. (1) Each health plan offered to public employees and their covered dependents under this chapter which is not subject to the provisions of Title 48 RCW and is established or renewed on or after twelve months after July 23, 1989, shall include coverage for neurodevelopmental therapies for covered individuals age six and under.

(2) Benefits provided under this section shall cover the services of those authorized to deliver occupational therapy, speech therapy,

and physical therapy. Benefits shall be payable only where the services have been delivered pursuant to the referral and periodic review of a holder of a license issued pursuant to chapter 18.71 or 18.57 RCW or where covered services have been rendered by such licensee. Nothing in this section shall preclude a self-funded plan authorized under this chapter from negotiating rates with qualified providers.

(3) Benefits provided under this section shall be for medically necessary services as determined by the self-funded plan authorized under this chapter. Benefits shall be payable for services for the maintenance of a covered individual in cases where significant deterioration in the patient's condition would result without the service. Benefits shall be payable to restore and improve function.

(4) It is the intent of this section that the state, as an employer providing comprehensive health coverage including the benefits required by this section, retains the authority to design and employ utilization and cost controls. Therefore, benefits delivered under this section may be subject to contractual provisions regarding deductible amounts and/or copayments established by the self-funded plan authorized under this chapter. Benefits provided under this section may be subject to standard waiting periods for preexisting conditions, and may be subject to the submission of written treatment plans.

(5) In recognition of the intent expressed in subsection (4) of this section, benefits provided under this section may be subject to contractual provisions establishing annual and/or lifetime benefit limits. Such limits may define the total dollar benefits available, or may limit the number of services delivered as established by the self-funded plan authorized under this chapter. [1989 c 345 s 4.]

RCW 41.05.175 Prescribed, self-administered anticancer medication. (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 (25) and (26).

(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. [2020 c 18 s 13; 2011 c 159 s 2.]

***Reviser's note:** RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsections (25) and (26) to subsections (27) and (28). RCW 48.43.005 was amended by 2024 c 218 s 1, changing subsections (27) and (28) to subsections (29) and (30).

Explanatory statement—2020 c 18: See note following RCW 43.79A.040.

Findings—2011 c 159: "The Washington state legislature finds that for cancer patients, there is an inequity in how much they have

to pay toward the cost of a self-administered oral medication and how much they have to pay for an intravenous product that is administered in a physician's office or clinic. The legislature further finds that when these inequities exist, patients' access to medically necessary, appropriate treatment is often unfairly restricted. The legislature also acknowledges that self-administered chemotherapy is the only treatment for some types of cancer where there is no intravenous alternative. The legislature declares that in order to reduce the out-of-pocket costs for cancer patients whose diagnosis requires treatment through self-administered anticancer medication, the cost-sharing responsibilities for these patients must be on a basis at least comparable to those of patients receiving intravenously administered anticancer medication." [2011 c 159 s 1.]

RCW 41.05.177 Prostate cancer screening—Required coverage. (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. [2006 c 367 s 1.]

***Reviser's note:** The term "advanced registered nurse practitioner" was changed to "advanced practice registered nurse" by 2024 c 239 s 1, effective June 30, 2027.

RCW 41.05.180 Mammograms—Insurance coverage. 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. [1994 sp.s. c 9 s 725; 1989 c 338 s 5.]

Reviser's note: *(1) The term "advanced registered nurse practitioner" was changed to "advanced practice registered nurse" by 2024 c 239 s 1, effective June 30, 2027.

**(2) The reference to "nursing care quality assurance commission" was changed to "board of nursing" by 2023 c 123.

Severability—Headings and captions not law—Effective date—1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

RCW 41.05.183 General anesthesia services for dental procedures—Public employee benefit plans. (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 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 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. [2001 c 321 s 1.]

RCW 41.05.185 Diabetes benefits—State purchased health care. The legislature finds that diabetes imposes a significant health risk and tremendous financial burden on the citizens and government of the state of Washington, and that access to the medically accepted standards of care for diabetes, its treatment and supplies, and self-

management training and education is crucial to prevent or delay the short and long-term complications of diabetes and its attendant costs.

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

(a) "Person with diabetes" means a person diagnosed by a health care provider as having insulin using diabetes, noninsulin using diabetes, or elevated blood glucose levels induced by pregnancy; and

(b) "Health care provider" means a health care provider as defined in RCW 48.43.005.

(2) All state purchased health care purchased or renewed after January 1, 1998, except the basic health plan described in chapter 70.47 RCW, shall provide benefits for at least the following services and supplies for persons with diabetes:

(a) For state purchased health care that includes coverage for pharmacy services, appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and

(b) For all state purchased health care, outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by health care providers with expertise in diabetes. Nothing in this section prevents any state agency purchasing health care according to this section from restricting patients to seeing only health care providers who have signed participating provider agreements with that state agency or an insuring entity under contract with that state agency.

(3) Coverage required under this section may be subject to customary cost-sharing provisions established for all other similar services or supplies within a policy.

(4) Health care coverage may not be reduced or eliminated due to this section.

(5) Services required under this section shall be covered when deemed medically necessary by the medical director, or his or her designee, subject to any referral and formulary requirements. [1997 c 276 s 1.]

Effective date—1997 c 276: "This act takes effect January 1, 1998." [1997 c 276 s 6.]

RCW 41.05.188 Eosinophilic gastrointestinal associated disorder—Elemental formula. (1) Each health benefit plan offered to public employees and their covered dependents under this chapter that is not subject to chapter 48.43 RCW and that is issued or renewed after December 31, 2015, must offer benefits or coverage for medically necessary elemental formula, regardless of delivery method, when a licensed physician or other health care provider with prescriptive authority:

(a) Diagnoses a patient with an eosinophilic gastrointestinal associated disorder; and

(b) Orders and supervises the use of the elemental formula.

(2) Nothing in this section prohibits a health benefit plan from requiring prior authorization or imposing other appropriate utilization controls in approving coverage for medically necessary elemental formula. [2014 c 115 s 1.]

RCW 41.05.195 Medicare supplemental insurance policies. Notwithstanding any other provisions of this chapter or rules or procedures adopted by the authority, the authority shall make available to retired or disabled employees who are enrolled in parts A and B of medicare one or more medicare supplemental insurance policies that conform to the requirements of chapter 48.66 RCW. The policies shall be chosen in consultation with the public employees' benefits board. These policies shall be made available to retired or disabled state employees; retired or disabled school district employees; retired employees of employer groups eligible for coverage available under the authority; or surviving spouses or surviving state registered domestic partners of emergency service personnel killed in the line of duty. [2023 c 13 s 6; 2015 c 116 s 7; 2009 c 523 s 2; 2007 c 114 s 7; 2005 c 47 s 1; 1993 c 492 s 222.]

Finding—Intent—2023 c 13: See note following RCW 41.05.011.

Intent—Effective date—2007 c 114: See notes following RCW 41.05.011.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 41.05.197 Medicare supplemental insurance policies. The medicare supplemental insurance policies authorized under RCW 41.05.195 shall be made available to any resident of the state who:

(1) Is enrolled in parts A and B of medicare; and

(2) Is not eligible to purchase coverage as a retired or disabled employee under RCW 41.05.195. State residents purchasing a medicare supplemental insurance policy under this section shall be required to pay the full cost of any such policy. [2005 c 47 s 2; 1993 c 492 s 223.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 41.05.220 Community and migrant health centers—Maternity health care centers—People of color—Underserved populations. (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 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 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. [2023 c 51 s 15; 1998 c 245 s 38; 1993 c 492 s 232.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 41.05.225 Blind licensees in the business enterprises program—Plan of health insurance. (1) The public employees' benefits board shall offer a plan of health insurance to blind licensees who are actively operating facilities and participating in the business enterprises program established in RCW 74.18.200 through 74.18.230, and maintained by the department of services for the blind. The plan of health insurance benefits must be the same or substantially similar to the plan of health insurance benefits offered to state employees under this chapter. Enrollment will be at the option of each individual licensee or vendor, under rules established by the public employees' benefits board.

(2) All costs incurred by the state or the public employees' benefits board for providing health insurance coverage to active blind vendors, excluding family participation, under subsection (1) of this section may be paid for from net proceeds from vending machine operations in public buildings under RCW 74.18.230.

(3) Money from the business enterprises program under the federal Randolph-Sheppard Act may not be used for family participation in the health insurance benefits provided under this section. Family insurance benefits are the sole responsibility of the individual blind vendors. [2018 c 260 s 18; 2002 c 71 s 1.]

RCW 41.05.295 Dependent care assistance program—Health care authority—Powers, duties, and functions. (1) All powers, duties, and functions of the department of retirement systems pertaining to the dependent care assistance program are transferred to the health care authority.

(2)(a) All reports, documents, surveys, books, records, files, papers, or written material in the possession of the department of retirement systems pertaining to the powers, functions, and duties transferred shall be delivered to the custody of the health care

authority. All funds, credits, or other assets held in connection with the powers, functions, and duties transferred shall be assigned to the health care authority.

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

(4) The transfer of the powers, duties, and functions of the department of retirement systems shall not affect the validity of any act performed before January 1, 2009.

(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. [2008 c 229 s 1.]

Effective date—2008 c 229: "This act takes effect January 1, 2009." [2008 c 229 s 15.]

RCW 41.05.300 Salary reduction agreements—Authorized. (1) The state of Washington may enter into salary reduction agreements with employees and school employees pursuant to the internal revenue code, for the purpose of making it possible for employees and school employees to select on a "before-tax basis" certain taxable and nontaxable benefits. The purpose of the salary reduction plan established in this chapter is to attract and retain individuals in governmental service by permitting them to enter into agreements with the state to provide for benefits pursuant to 26 U.S.C. Sec. 125, 26 U.S.C. Sec. 129, and other applicable sections of the internal revenue code.

(2) Nothing in the salary reduction plan constitutes an employment agreement between the participant and the state, and nothing contained in the participant's salary reduction agreement, the plan, this section, or RCW 41.05.123, 41.05.310 through 41.05.360, and 41.05.295 gives a participant any right to be retained in state employment. [2018 c 260 s 19; 2008 c 229 s 3; 1995 1st sp.s. c 6 s 11.]

Effective date—2008 c 229: See note following RCW 41.05.295.

Effective date—1995 1st sp.s. c 6: See note following RCW 28A.400.410.

RCW 41.05.310 Salary reduction plan—Policies and procedures—Plan document. 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 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, 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, 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. [2023 c 51 s 16; 2008 c 229 s 4; 1995 1st sp.s. c 6 s 12.]

Effective date—2008 c 229: See note following RCW 41.05.295.

Effective date—1995 1st sp.s. c 6: See note following RCW 28A.400.410.

RCW 41.05.320 Salary reduction plan—Eligibility—Participation, withdrawal. (1) Elected officials and permanent employees and school employees are eligible to participate in the salary reduction plan and reduce their salary by agreement with the authority. The authority may adopt rules to: (a) Limit the participation of employing agencies and their employees in the plan; and (b) permit participation in the plan by temporary employees and school employees.

(2) Persons eligible under subsection (1) of this section may enter into salary reduction agreements with the state.

(3)(a) An eligible person may become a participant of the salary reduction plan for a full plan year with annual benefit plan selection for each new plan year made before the beginning of the plan year, as determined by the authority, or upon becoming eligible.

(b) Once an eligible person elects to participate in the salary reduction plan and determines the amount his or her gross salary shall be reduced and the benefit plan for which the funds are to be used during the plan year, the agreement shall be irrevocable and may not be amended during the plan year except as provided in (c) of this subsection. Prior to making an election to participate in the salary reduction plan, the eligible person shall be informed in writing of all the benefits and reductions that will occur as a result of such election.

(c) The authority shall provide in the salary reduction plan that a participant may enroll, terminate, or change his or her election after the plan year has begun if there is a significant change in a participant's status, as provided by 26 U.S.C. Sec. 125 and the regulations adopted under that section and defined by the authority.

(4) The authority shall establish as part of the salary reduction plan the procedures for and effect of withdrawal from the plan by reason of retirement, death, leave of absence, or termination of employment. To the extent possible under federal law, the authority shall protect participants from forfeiture of rights under the plan.

(5) Any reduction of salary under the salary reduction plan shall not reduce the reportable compensation for the purpose of computing the state retirement and pension benefits earned by the public employee pursuant to chapters 41.26, 41.32, 41.35, 41.37, 41.40, and 43.43 RCW. [2023 c 51 s 17; 2018 c 260 s 20; 2008 c 229 s 5; 2007 c 492 s 6; 1995 1st sp.s. c 6 s 13.]

Effective date—2008 c 229: See note following RCW 41.05.295.

Effective date—1995 1st sp.s. c 6: See note following RCW 28A.400.410.

RCW 41.05.330 Salary reduction plan—Accounts and records. The authority shall keep or cause to be kept full and adequate accounts and records of the assets, obligations, transactions, and affairs of a salary reduction plan created under RCW 41.05.300. [2008 c 229 s 7; 1995 1st sp.s. c 6 s 14.]

Effective date—2008 c 229: See note following RCW 41.05.295.

Effective date—1995 1st sp.s. c 6: See note following RCW 28A.400.410.

RCW 41.05.340 Salary reduction plan—Termination—Amendment. (1) The state may terminate the salary reduction plan at the end of the plan year or upon notification of federal action affecting the status of the plan.

(2) The authority may amend the salary reduction plan at any time if the amendment does not affect the rights of the participants to receive eligible reimbursement from the participants' accounts. [2008 c 229 s 8; 1995 1st sp.s. c 6 s 15.]

Effective date—2008 c 229: See note following RCW 41.05.295.

Effective date—1995 1st sp.s. c 6: See note following RCW 28A.400.410.

RCW 41.05.350 Salary reduction plan—Rules. The authority shall adopt rules necessary to implement RCW 41.05.123, 41.05.300 through 41.05.340, and 41.05.295. [2008 c 229 s 9; 1995 1st sp.s. c 6 s 16.]

Effective date—2008 c 229: See note following RCW 41.05.295.

Effective date—1995 1st sp.s. c 6: See note following RCW 28A.400.410.

RCW 41.05.360 Salary reduction plan—Construction. RCW 41.05.123, 41.05.300 through 41.05.350, and 41.05.295 shall be construed to effectuate the purposes of 26 U.S.C. Sec. 125 and other applicable sections of the internal revenue code as required. [2008 c 229 s 10; 1995 1st sp.s. c 6 s 17.]

Effective date—2008 c 229: See note following RCW 41.05.295.

Effective date—1995 1st sp.s. c 6: See note following RCW 28A.400.410.

RCW 41.05.400 Plan of health care coverage—Available funds—Components—Eligibility—Director's duties. (1) The 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 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 director. Such eligibility may terminate pursuant to subsection (8) of this section.

(4) The 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 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 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 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 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 director shall provide written notice to any person who is no longer eligible for coverage under the plan within thirty days of the 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. [2023 c 51 s 18; 2000 c 80 s 7; 2000 c 79 s 46.]

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

RCW 41.05.405 Public option plans—Availability—Hospital contracts—Recommendations. (1) If a public option plan is not available in each county in the state during plan year 2022 or later, the following requirements apply for all subsequent plan years:

(a) Upon an offer from a public option plan, a hospital licensed under chapter 70.41 RCW that receives payment for services provided to enrollees in the public employees' benefits program or school employees' benefits program, or through a medical assistance program

under chapter 74.09 RCW, must contract with at least one public option plan to provide in-network services to enrollees of that plan. This subsection (1)(a) does not apply to a hospital owned and operated by a health maintenance organization licensed under chapter 48.46 RCW; and

(b) The authority shall contract, under RCW 41.05.410, with one or more health carriers to offer at least one standardized bronze, one standardized silver, and one standardized gold qualified health plan in every county in the state or in each county within a region of the state.

(2) Health carriers and hospitals may not condition negotiations or participation of a hospital licensed under chapter 70.41 RCW in any health plan offered by the health carrier on the hospital's negotiations or participation in a public option plan.

(3) By December 1st of the plan year during which enrollment in public option plans statewide is greater than 10,000 covered lives:

(a) The health benefit exchange, in consultation with the insurance commissioner and the authority, shall analyze public option plan rates paid to hospitals for in-network services and whether they have impacted hospital financial sustainability. The analysis must include any impact on hospitals' operating margins during the years public option health plans have been offered in the state and the estimated impact on operating margins in future years if enrollment in public option plans increases. It must also examine the income levels of public option plan enrollees over time. The analysis may examine a sample of hospitals of various sizes and located in various counties. In conducting its analysis, the exchange must give substantial weight to any available reporting of health care provider and health system costs under RCW 70.390.050;

(b) The health care cost transparency board established under chapter 70.390 RCW shall analyze the effect that enrollment in public option plans has had on consumers, including an analysis of the benefits provided to, and premiums and cost-sharing amounts paid by, consumers enrolled in public option plans compared to other standardized and nonstandardized qualified health plans; and

(c) The health benefit exchange, in consultation with the insurance commissioner, the authority, and interested stakeholders, including, but not limited to, statewide associations representing hospitals, health insurers, and physicians, shall review the analyses completed under (a) and (b) of this subsection and develop recommendations to the legislature to address financial or other issues identified in the analyses.

(4) The authority may adopt program rules, in consultation with the office of the insurance commissioner, to ensure compliance with this section, including levying fines and taking other contract actions it deems necessary to enforce compliance with this section.

(5) For the purposes of this section, "public option plan" means a qualified health plan contracted by the authority under RCW 41.05.410. [2021 c 246 s 5.]

RCW 41.05.410 Qualified health plans—Contract for—Requirements—Cost and quality data. (1) The authority, in consultation with the health benefit exchange, must contract with one or more health carriers to offer qualified health plans on the Washington health benefit exchange for plan years beginning in 2021. A health carrier contracting with the authority under this section must offer at least

one bronze, one silver, and one gold qualified health plan in a single county or in multiple counties. The goal of the procurement conducted under this section is to have a choice of qualified health plans under this section offered in every county in the state. The authority may not execute a contract with an apparently successful bidder under this section until after the insurance commissioner has given final approval of the health carrier's rates and forms pertaining to the health plan to be offered under this section and certification of the health plan under RCW 43.71.065.

(2) A qualified health plan offered under this section must meet the following criteria:

(a) The qualified health plan must be a standardized health plan established under RCW 43.71.095;

(b) The qualified health plan must meet all requirements for qualified health plan certification under RCW 43.71.065 including, but not limited to, requirements relating to rate review and network adequacy;

(c) The qualified health plan must incorporate recommendations of the Robert Bree collaborative and the health technology assessment program;

(d) The qualified health plan may use an integrated delivery system or a managed care model that includes care coordination or care management to enrollees as appropriate;

(e) The qualified health plan must meet additional participation requirements to reduce barriers to maintaining and improving health and align to state agency value-based purchasing. These requirements may include, but are not limited to, standards for population health management; high-value, proven care; health equity; primary care; care coordination and chronic disease management; wellness and prevention; prevention of wasteful and harmful care; and patient engagement;

(f) To reduce administrative burden and increase transparency, the qualified health plan's utilization review processes must:

(i) Be focused on care that has high variation, high cost, or low evidence of clinical effectiveness; and

(ii) Meet national accreditation standards;

(g) The total amount the qualified health plan reimburses providers and facilities for all covered benefits in the statewide aggregate, excluding pharmacy benefits, may not exceed one hundred sixty percent of the total amount medicare would have reimbursed providers and facilities for the same or similar services in the statewide aggregate;

(h) For services provided by rural hospitals certified by the centers for medicare and medicaid services as critical access hospitals or sole community hospitals, the rates may not be less than one hundred one percent of allowable costs as defined by the United States centers for medicare and medicaid services for purposes of medicare cost reporting;

(i) Reimbursement for primary care services, as defined by the authority, provided by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine, may not be less than one hundred thirty-five percent of the amount that would have been reimbursed under the medicare program for the same or similar services; and

(j) The qualified health plan must comply with any requirements established by the authority to address amounts expended on pharmacy benefits including, but not limited to, increasing generic utilization and use of evidence-based formularies.

(3)(a) At the request of the authority for monitoring, enforcement, or program and quality improvement activities, a qualified health plan offered under this section must provide cost and quality of care information and data to the authority, and may not enter into an agreement with a provider or third party that would restrict the qualified health plan from providing this information or data.

(b) Pursuant to RCW 42.56.650, any cost or quality information or data submitted to the authority is exempt from public disclosure.

(4) Nothing in this section prohibits a health carrier offering qualified health plans under this section from offering other health plans in the individual market. [2021 c 246 s 6; 2019 c 364 s 3.]

RCW 41.05.413 Qualified health plans—Reimbursement limit—Waiver. The director may, in his or her sole discretion, waive the requirements of RCW 41.05.410(2)(g) if he or she finds that:

(1) A health carrier offering a qualified health plan under RCW 41.05.410 is unable to form a provider network that meets the network access standards adopted by the insurance commissioner due to the requirements of RCW 41.05.410(2)(g); and

(2) The health carrier is able to achieve actuarially sound premiums that are ten percent lower than the previous plan year through other means. [2023 c 51 s 19; 2019 c 364 s 4.]

RCW 41.05.430 Plan of health care coverage—Immediate postpartum contraception devices. (1) For births taking place in a licensed hospital or birthing center, a health plan offered to employees and their covered dependents must allow a provider to separately bill for devices, implants, professional services, or a combination thereof, associated with immediate postpartum contraception and may not consider such devices, implants, services, or combinations thereof to be part of any payments for general obstetric procedures.

(2) For purposes of this section, "immediate postpartum contraception" means the postpartum insertion of intrauterine devices or contraceptive implants performed before the patient is discharged from the hospital or birthing center and includes the devices or implants themselves.

(3) This section does not apply to facility services associated with immediate postpartum contraception.

(4) Nothing in this section affects an enrollee's right to directly access women's health care services, including contraceptive services.

(5) This section applies to health plans issued or renewed on or after January 1, 2023. [2022 c 122 s 2.]

Findings—Intent—2022 c 122: "The legislature finds that healthy birth spacing helps reduce adverse health outcomes for both parents and babies. The legislature further finds that increasing immediate postpartum access to contraception, before a patient is discharged from the hospital or birthing center, is critical to maternal and newborn health and that immediate postpartum contraception is associated with longer contraceptive coverage, fewer unintended pregnancies, and cost savings for payers and health care systems. To help achieve these outcomes, it is the intent of the legislature to

increase access to immediate postpartum contraception by requiring commercial health insurers to pay for immediate postpartum contraception separately from the maternity bundle in a manner that mirrors the payment process for immediate postpartum contraception used by the state's medicaid program." [2022 c 122 s 1.]

RCW 41.05.520 Pharmacy connection program—Notice. (1) The 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 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 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 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 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. [2023 c 51 s 20; 2003 1st sp.s. c 29 s 7.]

Finding—Intent—Severability—Conflict with federal requirements—Effective date—2003 1st sp.s. c 29: See notes following RCW 74.09.650.

RCW 41.05.525 Treatment of opioid use disorder—Prior authorization. A health plan offered to employees, school employees, and their covered dependents under this chapter issued or renewed on or after January 1, 2020, shall provide coverage without prior authorization of at least one federal food and drug administration approved product for the treatment of opioid use disorder in the drug classes opioid agonists, opioid antagonists, and opioid partial agonists. [2019 c 314 s 36.]

Declaration—2019 c 314: See note following RCW 18.22.810.

RCW 41.05.526 Withdrawal management services—Substance use disorder treatment services—Prior authorization—Utilization review—Medical necessity review. (1) Except as provided in subsection (2) of this section, a health plan offered to employees and their covered dependents under this chapter issued or renewed on or after January 1, 2021, may not require an enrollee to obtain prior authorization for withdrawal management services or inpatient or residential substance use disorder treatment services in a behavioral health agency licensed or certified under RCW 71.24.037.

(2)(a) A health plan offered to employees and their covered dependents under this chapter issued or renewed on or after January 1, 2021, must:

(i) Provide coverage for no less than two business days, excluding weekends and holidays, in a behavioral health agency that provides inpatient or residential substance use disorder treatment prior to conducting a utilization review; and

(ii) Provide coverage for no less than three days in a behavioral health agency that provides withdrawal management services prior to conducting a utilization review.

(b)(i) The health plan may not require an enrollee to obtain prior authorization for the services specified in (a) of this subsection as a condition for payment of services prior to the times specified in (a) of this subsection.

(ii) Once the times specified in (a) of this subsection have passed, the health plan may initiate utilization management review procedures if the behavioral health agency continues to provide services or is in the process of arranging for a seamless transfer to an appropriate facility or lower level of care under subsection (6) of this section. For a health plan issued or renewed on or after January 1, 2025, if a health plan authorizes inpatient or residential substance use disorder treatment services pursuant to (a)(i) of this subsection following the initial medical necessity review process under (c)(iii) of this subsection, the length of the initial authorization may not be less than 14 days from the date that the patient was admitted to the behavioral health agency. Any subsequent reauthorization that the health plan approves after the first 14 days must continue for no less than seven days prior to requiring further reauthorization. Nothing prohibits a health plan from requesting information to assist with a seamless transfer under this subsection.

(c)(i) The behavioral health agency under (a) of this subsection must notify an enrollee's health plan as soon as practicable after admitting the enrollee, but not later than twenty-four hours after admitting the enrollee. The time of notification does not reduce the requirements established in (a) of this subsection.

(ii) The behavioral health agency under (a) of this subsection must provide the health plan with its initial assessment and initial treatment plan for the enrollee within two business days of admission, excluding weekends and holidays, or within three days in the case of a behavioral health agency that provides withdrawal management services.

(iii) After the time period in (a) of this subsection and receipt of the material provided under (c)(ii) of this subsection, the plan may initiate a medical necessity review process. Medical necessity review must be based on the standard set of criteria established under RCW 41.05.528. In a review for inpatient or residential substance use disorder treatment services, a health plan may not make a determination that a patient does not meet medical necessity criteria based primarily on the patient's length of abstinence. If the patient's abstinence from substance use was due to incarceration, hospitalization, or inpatient treatment, a health plan may not consider the patient's length of abstinence in determining medical necessity. If the health plan determines within one business day from the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the health plan's medical necessity review is completed more than one business day after the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection, the health plan must pay for the services delivered from the time of admission until the time at which the medical necessity review is completed and the agency is advised of the decision in writing.

(3)(a) The behavioral health agency shall document to the health plan the patient's need for continuing care and justification for level of care placement following the current treatment period, based on the standard set of criteria established under RCW 41.05.528, with documentation recorded in the patient's medical record.

(b) For a health plan issued or renewed on or after January 1, 2025, for inpatient or residential substance use disorder treatment services, the health plan may not consider the patient's length of stay at the behavioral health agency when making decisions regarding the authorization to continue care at the behavioral health agency.

(4) Nothing in this section prevents a health carrier from denying coverage based on insurance fraud.

(5) If the behavioral health agency under subsection (2)(a) of this section is not in the enrollee's network:

(a) The health plan is not responsible for reimbursing the behavioral health agency at a greater rate than would be paid had the agency been in the enrollee's network; and

(b) The behavioral health agency may not balance bill, as defined in RCW 48.43.005.

(6) When the treatment plan approved by the health plan involves transfer of the enrollee to a different facility or to a lower level of care, the care coordination unit of the health plan shall work with the current agency to make arrangements for a seamless transfer as soon as possible to an appropriate and available facility or level of care. The health plan shall pay the agency for the cost of care at the current facility until the seamless transfer to the different facility or lower level of care is complete. A seamless transfer to a lower

level of care may include same day or next day appointments for outpatient care, and does not include payment for nontreatment services, such as housing services. If placement with an agency in the health plan's network is not available, the health plan shall pay the current agency until a seamless transfer arrangement is made.

(7) The requirements of this section do not apply to treatment provided in out-of-state facilities.

(8) For the purposes of this section "withdrawal management services" means twenty-four hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery. [2024 c 366 s 6; 2020 c 345 s 2.]

Findings—Intent—2024 c 366: See note following RCW 71.24.847.

Findings—Intent—2020 c 345: "(1) The legislature finds that:

(a) Substance use disorder is a treatable brain disease from which people recover;

(b) Electing to go to addiction treatment is an act of great courage; and

(c) When people with substance use disorder are provided rapid access to quality treatment within their window of willingness, recovery happens.

(2) The legislature therefore intends to ensure that there is no wrong door for individuals accessing substance use disorder treatment services by requiring coverage, and prohibiting barriers created by prior authorization and premature utilization management review when persons with substance use disorders are ready or urgently in need of treatment services." [2020 c 345 s 1.]

RCW 41.05.527 Opioid overdose reversal medication bulk purchasing and distribution program. (1) A health plan offered to public employees and their covered dependents under this chapter that is issued or renewed on or after January 1, 2023, must participate in the bulk purchasing and distribution program for opioid overdose reversal medication established in RCW 70.14.170 once the program is operational.

(2) For health plans issued or renewed on or after January 1, 2025, a health carrier must reimburse a hospital or psychiatric hospital that bills for the following outpatient services:

(a) For opioid overdose reversal medication dispensed or distributed to a patient under RCW 70.41.485 as a separate reimbursable expense; and

(b) For the administration of long-acting injectable buprenorphine as a separate reimbursable expense.

(3) Reimbursements provided under subsection (2) of this section must be separate from any bundled payment for outpatient hospital or emergency department services. [2024 c 366 s 16; 2021 c 273 s 10.]

Findings—Intent—2024 c 366: See note following RCW 71.24.847.

Rules—2021 c 273 ss 7-12: See note following RCW 70.14.170.

Findings—Intent—2021 c 273: See note following RCW 70.41.480.

RCW 41.05.528 Standard set of criteria—Medical necessity for substance use disorder treatment—Substance use disorder levels of care—Rules. For the purposes of promoting standardized training for behavioral health professionals and facilitating communications between behavioral health agencies, executive agencies, managed care organizations, private health plans, and plans offered through the public employees' benefits board, it is the policy of the state to adopt a single standard set of criteria to define medical necessity for substance use disorder treatment and to define substance use disorder levels of care in Washington. The criteria selected must be comprehensive, widely understood and accepted in the field, and based on continuously updated research and evidence. The health care authority and the office of the insurance commissioner must independently review their regulations and practices by January 1, 2021. The health care authority may make rules if necessary to promulgate the selected standard set of criteria. [2020 c 345 s 6.]

Findings—Intent—2020 c 345: See note following RCW 41.05.526.

RCW 41.05.530 Prescription drug assistance, education—Rules. The authority may adopt rules to implement chapter 29, Laws of 2003 1st sp. sess. [2003 1st sp.s. c 29 s 10.]

Finding—Intent—Severability—Conflict with federal requirements—Effective date—2003 1st sp.s. c 29: See notes following RCW 74.09.650.

RCW 41.05.531 Standard set of criteria—Updated versions—Review and use. When updated versions of the ASAM Criteria, treatment criteria for addictive, substance related, and co-occurring conditions, inclusive of adolescent and transition age youth versions, are published by the American society of addiction medicine, the health care authority and the office of the insurance commissioner shall jointly determine whether to use the updated version, and, if so, the date upon which the updated version must begin to be used by medicaid managed care organizations, carriers, and other relevant entities. Both agencies shall post notice of their decision on their websites. For purposes of the ASAM Criteria, 4th edition, medicaid managed care organizations and carriers shall begin to use the updated criteria no later than January 1, 2026, unless the health care authority and the office of the insurance commissioner jointly determine that it should not be used. [2024 c 366 s 10.]

Findings—Intent—2024 c 366: See note following RCW 71.24.847.

RCW 41.05.533 Medication synchronization policy required for health benefit plans covering prescription drugs—Requirements—Definitions. (1) A health benefit plan offered to public employees and their covered dependents under this chapter that is not subject to chapter 48.43 RCW, that is issued or renewed after December 31, 2015, and that provides coverage for prescription drugs must implement a medication synchronization policy for the dispensing of prescription drugs to the plan's enrollees.

(a) If an enrollee requests medication synchronization for a new prescription, the health [benefit] plan must permit filling the drug: (i) For less than a one-month supply of the drug if synchronization will require more than a fifteen-day supply of the drug; or (ii) for more than a one-month supply of the drug if synchronization will require a fifteen-day supply of the drug or less.

(b) The health benefit plan shall adjust the enrollee cost-sharing for a prescription drug subject to coinsurance that is dispensed for less than the standard refill amount for the purpose of synchronizing the medications.

(c) The health benefit plan shall adjust the enrollee cost-sharing for a prescription drug with a copayment that is dispensed for less than the standard refill amount for the purpose of synchronizing the medications by:

(i) Discounting the copayment rate by fifty percent;

(ii) Discounting the copayment rate based on fifteen-day increments; or

(iii) Any other method that meets the intent of this section and is approved by the office of the insurance commissioner.

(2) Upon request of an enrollee, the prescribing provider or pharmacist shall:

(a) Determine that filling or refilling the prescription is in the best interest of the enrollee, taking into account the appropriateness of synchronization for the drug being dispensed;

(b) Inform the enrollee that the prescription will be filled to less than the standard refill amount for the purpose of synchronizing his or her medications; and

(c) Deny synchronization on the grounds of threat to patient safety or suspected fraud or abuse.

(3) For purposes of this section, the following terms have the following meanings unless the context clearly requires otherwise:

(a) "Medication synchronization" means the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period.

(b) "Prescription" has the same meaning as in RCW 18.64.011. [2015 c 213 s 2.]

RCW 41.05.540 State employee health program—Requirements. (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. [2023 c 51 s 21; 2007 c 259 s 40; 2005 c 360 s 8.]

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

Findings—Intent—2005 c 360: See note following RCW 36.70A.070.

RCW 41.05.550 Prescription drug assistance foundation—Nonprofit and tax-exempt corporation—Definitions—Liability. (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 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. [2023 c 51 s 22; 2015 c 161 s 1; 2008 c 87 s 1; 2005 c 267 s 1.]

RCW 41.05.600 Mental health services—Definition—Coverage required, when. (1) For the purposes of this section, "mental health services" means:

(a) For health benefit plans issued or renewed before January 1, 2021, 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 June 11, 2020, or such subsequent date as may be provided by the director by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (i) Substance related disorders; (ii) 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; (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and (iv) court ordered treatment unless the authority's or contracted insuring entity's medical director determines the treatment to be medically necessary; and

(b) For health benefit plans issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use 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 June 11, 2020, or such subsequent date as may be provided by the director by rule, consistent with the purposes of chapter 6, Laws of 2005.

(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 coverage for:

(a) 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

(b) 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) This section does not prohibit a requirement that mental health services be medically necessary, if a comparable requirement is applicable to medical and surgical services.

(4) Nothing in this section shall be construed to prevent the management of mental health.

(5) The director will consider care management techniques for mental health services if a comparable benefit management requirement is applicable to medical and surgical 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. [2020 c 228 s 1; 2005 c 6 s 2.]

Findings—Intent—2005 c 6: "The legislature finds that the costs of leaving mental disorders untreated or undertreated are significant, and often include: Decreased job productivity, loss of employment, increased disability costs, deteriorating school performance, increased use of other health services, treatment delays leading to more costly treatments, suicide, family breakdown and impoverishment, and institutionalization, whether in hospitals, juvenile detention, jails, or prisons.

Treatable mental disorders are prevalent and often have a high impact on health and productive life. The legislature finds that the potential benefits of improved access to mental health services are

significant. Additionally, the legislature declares that it is not cost-effective to treat persons with mental disorders differently than persons with medical and surgical disorders.

Therefore, the legislature intends to require that insurance coverage be at parity for mental health services, which means this coverage be delivered under the same terms and conditions as medical and surgical services." [2005 c 6 s 1.]

Severability—2005 c 6: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [2005 c 6 s 13.]

RCW 41.05.601 Mental health services—Rules. The director may adopt rules to implement RCW 41.05.600. [2023 c 51 s 23; 2005 c 6 s 12.]

Findings—Intent—Severability—2005 c 6: See notes following RCW 41.05.600.

RCW 41.05.630 Annual report of customer service complaints and appeals. 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. [2010 c 293 s 1.]

RCW 41.05.650 Community health care collaborative grant program—Grants—Administrative support—Eligibility. (1) The community health care collaborative grant program is established to further the efforts of community-based coalitions to increase access to appropriate, affordable health care for Washington residents, particularly employed low-income persons and children in school who are uninsured and underinsured, through local programs addressing one or more of the following: (a) Access to medical treatment; (b) the efficient use of health care resources; and (c) quality of care.

(2) Consistent with funds appropriated for community health care collaborative grants specifically for this purpose, two-year grants may be awarded pursuant to RCW 41.05.660 by the director of the health care authority.

(3) The health care authority shall provide administrative support for the program. Administrative support activities may include health care authority facilitation of statewide discussions regarding best practices and standardized performance measures among grantees, or subcontracting for such discussions.

(4) Eligibility for community health care collaborative grants shall be limited to nonprofit organizations established to serve a defined geographic region or organizations with public agency status under the jurisdiction of a local, county, or tribal government. To be eligible, such entities must have a formal collaborative governance structure and decision-making process that includes representation by the following health care providers: Hospitals, public health, behavioral health, community health centers, rural health clinics, and private practitioners that serve low-income persons in the region, unless there are no such providers within the region, or providers decline or refuse to participate or place unreasonable conditions on their participation. The nature and format of the application, and the application procedure, shall be determined by the director of the health care authority. At a minimum, each application shall: (a) Identify the geographic region served by the organization; (b) show how the structure and operation of the organization reflects the interests of, and is accountable to, this region and members providing care within this region; (c) indicate the size of the grant being requested, and how the money will be spent; and (d) include sufficient information for an evaluation of the application based on the criteria established in RCW 41.05.660. [2023 c 51 s 24; 2009 c 299 s 1.]

RCW 41.05.651 Rules—2009 c 299. The health care authority may adopt rules to implement chapter 299, Laws of 2009. [2009 c 299 s 4.]

RCW 41.05.660 Community health care collaborative grant program—Award and disbursement of grants. (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. 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;

(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 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 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. [2023 c 51 s 25; 2009 c 299 s 2.]

RCW 41.05.670 Chronic care management incentives—Provider reimbursement methods. (1) Effective January 1, 2013, the authority must contract with all of the public employees' benefits board managed care plans and the self-insured plan or plans to include provider reimbursement methods that incentivize chronic care management within health homes resulting in reduced emergency department and inpatient use.

(2) Health home services contracted for under this section may be prioritized to enrollees with complex, high cost, or multiple chronic conditions.

(3) For the purposes of this section, "chronic care management" and "health home" have the same meaning as in RCW 74.09.010.

(4) Contracts with fully insured plans and with any third-party administrator for the self-funded plan that include the items in subsection (1) of this section must be funded within the resources provided by employer funding rates provided for employee health benefits in the omnibus appropriations act.

(5) Nothing in this section shall require contracted third-party health plans administering the self-insured contract to expend resources to implement items in subsection (1) of this section beyond the resources provided by employer funding rates provided for employee health benefits in the omnibus appropriations act or from other sources in the absence of these provisions.

(6) The school employees' benefits board, under RCW 41.05.740, shall implement the provisions of this section, effective January 1, 2020. [2017 3rd sp.s. c 13 s 812; 2011 c 316 s 6.]

Intent—2017 3rd sp.s. c 13: See note following RCW 28A.150.410.

RCW 41.05.690 Performance measures committee—Membership—Selection of performance measures—Benchmarks for purchasing decisions—Public process for evaluation of measures. (1) There is created a performance measures committee, the purpose of which is to identify and recommend standard statewide measures of health performance to inform public and private health care purchasers and to propose benchmarks to track costs and improvements in health outcomes.

(2) Members of the committee must include representation from state agencies, small and large employers, health plans, patient groups, federally recognized tribes, consumers, academic experts on health care measurement, hospitals, physicians, and other providers. The governor shall appoint the members of the committee, except that a statewide association representing hospitals may appoint a member representing hospitals, and a statewide association representing physicians may appoint a member representing physicians. The governor shall ensure that members represent diverse geographic locations and both rural and urban communities. The chief executive officer of the lead organization must also serve on the committee. The committee must be chaired by the director of the authority.

(3) The committee shall develop a transparent process for selecting performance measures, and the process must include opportunities for public comment.

(4) By January 1, 2015, the committee shall submit the performance measures to the authority. The measures must include dimensions of:

(a) Prevention and screening;

(b) Effective management of chronic conditions;

(c) Key health outcomes;

(d) Care coordination and patient safety; and

(e) Use of the lowest cost, highest quality care for preventive care and acute and chronic conditions.

(5) The committee shall develop a measure set that:

(a) Is of manageable size;

(b) Is based on readily available claims and clinical data;

(c) Gives preference to nationally reported measures and, where nationally reported measures may not be appropriate, measures used by state agencies that purchase health care or commercial health plans;

(d) Focuses on the overall performance of the system, including outcomes and total cost;

(e) Is aligned with the governor's performance management system measures and common measure requirements specific to medicaid delivery systems under RCW 70.320.020 and 71.24.435;

(f) Considers the needs of different stakeholders and the populations served; and

(g) Is usable by multiple payers, providers, hospitals, purchasers, public health, and communities as part of health improvement, care improvement, provider payment systems, benefit design, and administrative simplification for providers and hospitals.

(6) State agencies shall use the measure set developed under this section to inform and set benchmarks for purchasing decisions.

(7) The committee shall establish a public process to periodically evaluate the measure set and make additions or changes to the measure set as needed. [2019 c 325 s 5009; 2014 c 223 s 6.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Finding—2014 c 223: "(1) The legislature finds that the state of Washington has an opportunity to transform its health care delivery system.

(2) The state health care innovation plan establishes the following primary drivers of health transformation, each with individual key actions that are necessary to achieve the objective:

(a) Improve health overall by stressing prevention and early detection of disease and integration of behavioral health;

(b) Developing linkages between the health care delivery system and community; and

(c) Supporting regional collaboratives for communities and populations, improve health care quality, and lower costs." [2014 c 223 s 1.]

RCW 41.05.700 Reimbursement of health care services provided through telemedicine or store and forward technology—Audio-only telemedicine. (1)(a) A health plan offered to employees, school employees, and their covered dependents under this chapter issued or renewed on or after January 1, 2017, shall reimburse a provider for a health care service provided to a covered person through telemedicine or store and forward technology if:

(i) The plan provides coverage of the health care service when provided in person by the provider;

(ii) The health care service is medically necessary;

(iii) The health care service is a service recognized as an essential health benefit under section 1302(b) of the federal patient protection and affordable care act in effect on January 1, 2015;

(iv) The health care service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the health care service meets the standards required by state and federal laws governing the privacy and security of protected health information; and

(v) Beginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider.

(b)(i) Except as provided in (b)(ii) of this subsection, a health plan offered to employees, school employees, and their covered dependents under this chapter issued or renewed on or after January 1, 2021, shall reimburse a provider for a health care service provided to a covered person through telemedicine the same amount of compensation the carrier would pay the provider if the health care service was provided in person by the provider.

(ii) Hospitals, hospital systems, telemedicine companies, and provider groups consisting of eleven or more providers may elect to negotiate an amount of compensation for telemedicine services that differs from the amount of compensation for in-person services.

(iii) For purposes of this subsection (1)(b), the number of providers in a provider group refers to all providers within the group, regardless of a provider's location.

(2) For purposes of this section, reimbursement of store and forward technology is available only for those covered services specified in the negotiated agreement between the health plan and health care provider.

(3) An originating site for a telemedicine health care service subject to subsection (1) of this section includes a:

(a) Hospital;
(b) Rural health clinic;
(c) Federally qualified health center;
(d) Physician's or other health care provider's office;
(e) Licensed or certified behavioral health agency;
(f) Skilled nursing facility;
(g) Home or any location determined by the individual receiving the service; or
(h) Renal dialysis center, except an independent renal dialysis center.

(4) Except for subsection (3)(g) of this section, any originating site under subsection (3) of this section may charge a facility fee for infrastructure and preparation of the patient. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the health plan. A distant site, a hospital that is an originating site for audio-only telemedicine, or any other site not identified in subsection (3) of this section may not charge a facility fee.

(5) The plan may not distinguish between originating sites that are rural and urban in providing the coverage required in subsection (1) of this section.

(6) The plan may subject coverage of a telemedicine or store and forward technology health service under subsection (1) of this section to all terms and conditions of the plan including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable health care service provided in person.

(7) This section does not require the plan to reimburse:
(a) An originating site for professional fees;
(b) A provider for a health care service that is not a covered benefit under the plan; or
(c) An originating site or health care provider when the site or provider is not a contracted provider under the plan.

(8)(a) If a provider intends to bill a patient or the patient's health plan for an audio-only telemedicine service, the provider must obtain patient consent for the billing in advance of the service being delivered.

(b) If the health care authority has cause to believe that a provider has engaged in a pattern of unresolved violations of this subsection (8), the health care authority may submit information to the appropriate disciplining authority, as defined in RCW 18.130.020, for action. Prior to submitting information to the appropriate disciplining authority, the health care authority may provide the provider with an opportunity to cure the alleged violations or explain why the actions in question did not violate this subsection (8).

(c) If the provider has engaged in a pattern of unresolved violations of this subsection (8), the appropriate disciplining authority may levy a fine or cost recovery upon the provider in an amount not to exceed the applicable statutory amount per violation and take other action as permitted under the authority of the disciplining authority. Upon completion of its review of any potential violation submitted by the health care authority or initiated directly by an enrollee, the disciplining authority shall notify the health care authority of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation.

(9) For purposes of this section:

(a)(i) "Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.

(ii) For purposes of this section only, "audio-only telemedicine" does not include:

(A) The use of facsimile or email; or

(B) The delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results;

(b) "Disciplining authority" has the same meaning as in RCW 18.130.020;

(c) "Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine;

(d) "Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and:

(i) The covered person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(ii) The covered person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine;

(e) "Health care service" has the same meaning as in RCW 48.43.005;

(f) "Hospital" means a facility licensed under chapter 70.41, 71.12, or 72.23 RCW;

(g) "Originating site" means the physical location of a patient receiving health care services through telemedicine;

(h) "Provider" has the same meaning as in RCW 48.43.005;

(i) "Store and forward technology" means use of an asynchronous transmission of a covered person's medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email; and

(j) "Telemedicine" means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" includes audio-only telemedicine, but does not include facsimile or email. [2024 c 215 s 1; 2023 c 8 s 1; 2022 c 213 s 1; 2021 c 157 s 1; 2020 c 92 s 2; 2018 c 260 s 30; 2017 c 219 s 2; 2016 c 68 s 4; 2015 c 23 s 2.]

Conflict with federal requirements—2022 c 213: "If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. Rules adopted under this act must meet federal requirements that are a necessary condition to the receipt of federal funds by the state." [2022 c 213 s 6.]

Conflict with federal requirements—2021 c 157: See note following RCW 74.09.327.

Effective date—2020 c 92: See note following RCW 48.43.735.

Effective date—2017 c 219: See note following RCW 48.43.735.

Effective date—Intent—2016 c 68: See notes following RCW 48.43.735.

Effective date—2015 c 23 ss 2-4: "Sections 2 through 4 of this act take effect January 1, 2017." [2015 c 23 s 7.]

Adoption of sections—2015 c 23 ss 2-4: "The legislature encourages health plans to adopt the requirements of sections 2 through 4 of this act prior to January 1, 2017. Therefore, nothing in this act prohibits a plan from adopting the requirements of sections 2 through 4 of this act prior to January 1, 2017." [2015 c 23 s 8.]

Intent—2015 c 23: "It is the intent of the legislature to recognize the application of telemedicine as a reimbursable service by which an individual receives medical services from a health care provider without in-person contact with the provider. It is also the intent of the legislature to reduce the compliance requirements on hospitals when granting privileges or associations to telemedicine physicians." [2015 c 23 s 1.]

RCW 41.05.730 Ground emergency medical transportation services—Medicaid reimbursement—Calculation—Federal approval—Department's duties. (1) An eligible provider, as described in subsection (2) of this section, must, in addition to the rate of payment that the provider would otherwise receive for medicaid ground emergency medical transportation services, receive supplemental medicaid reimbursement to the extent provided by law.

(2) A provider is eligible for supplemental reimbursement only if the provider has all of the following characteristics continuously during a state fiscal year:

(a) Provides ground emergency medical transportation services to medicaid beneficiaries:

(b) Is a provider that is enrolled as a medicaid provider for the period being claimed;

(c) Is owned or operated by the state, a city, county, fire protection district, community services district, health care

district, federally recognized Indian tribe or any unit of government as defined in 42 C.F.R. Sec. 433.50;

(3) An eligible provider's supplemental reimbursement pursuant to this section must be calculated and paid as follows:

(a) The supplemental reimbursement to an eligible provider, as described in subsection (2) of this section, must be equal to the amount of federal financial participation received as a result of the claims submitted pursuant to subsection (6)(b) of this section;

(b) In no instance may the amount certified pursuant to subsection (5)(a) of this section, when combined with the amount received from all other sources of reimbursement from the medicaid program, exceed one hundred percent of actual costs, as determined pursuant to the medicaid state plan, for ground emergency medical transportation services;

(c) The supplemental medicaid reimbursement provided by this section must be distributed exclusively to eligible providers under a payment methodology based on ground emergency medical transportation services provided to medicaid beneficiaries by eligible providers on a per-transport basis or other federally permissible basis. The authority shall obtain approval from the federal centers for medicare and medicaid services for the payment methodology to be utilized, and may not make any payment pursuant to this section prior to obtaining that approval.

(4)(a) It is the legislature's intent in enacting this section to provide the supplemental reimbursement described in this section without any expenditure from the general fund. An eligible provider, as a condition of receiving supplemental reimbursement pursuant to this section, shall enter into, and maintain, an agreement with the authority for the purposes of implementing this section and reimbursing the department for the costs of administering this section.

(b) The nonfederal share of the supplemental reimbursement submitted to the federal centers for medicare and medicaid services for purposes of claiming federal financial participation shall be paid only with funds from the governmental entities described in subsection (2)(c) of this section and certified to the state as provided in subsection (5) of this section.

(5) Participation in the program by an eligible provider described in this section is voluntary. If an applicable governmental entity elects to seek supplemental reimbursement pursuant to this section on behalf of an eligible provider owned or operated by the entity, as described in subsection (2)(c) of this section, the governmental entity shall do all of the following:

(a) Certify, in conformity with the requirements of 42 C.F.R. Sec. 433.51, that the claimed expenditures for the ground emergency medical transportation services are eligible for federal financial participation;

(b) Provide evidence supporting the certification as specified by the department;

(c) Submit data as specified by the department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation;

(d) Keep, maintain, and have readily retrievable, any records specified by the department to fully disclose reimbursement amounts to which the eligible provider is entitled, and any other records required by the federal centers for medicare and medicaid services.

(6) The department shall promptly seek any necessary federal approvals for the implementation of this section. The department may limit the program to those costs that are allowable expenditures under Title XIX of the federal social security act (42 U.S.C. Sec. 1396 et seq.). If federal approval is not obtained for implementation of this section, this section may not be implemented.

(a) The department shall submit claims for federal financial participation for the expenditures for the services described in subsection (5) of this section that are allowable expenditures under federal law.

(b) The department shall, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

(7) If either a final judicial determination is made by any court of appellate jurisdiction or a final determination is made by the administrator of the federal centers for medicare and medicaid services that the supplemental reimbursement provided for in this section must be made to any provider not described in this section, the director shall execute a declaration stating that the determination has been made and on that date this section becomes inoperative. [2015 c 147 s 1.]

RCW 41.05.735 Ground emergency medical transportation services—Medicaid reimbursement—Intergovernmental transfer program—Federal approval—Authority's duties. (1) The authority shall design and implement, in consultation with eligible providers as described in subsection (2) of this section, an intergovernmental transfer program relating to medicaid managed care, ground emergency medical transport services including those services provided by emergency medical technicians at the basic, advanced, and paramedic levels in the prestabilization and preparation for transport in order to increase capitation payments for the purpose of increasing reimbursement to eligible providers.

(2) A provider is eligible for increased reimbursement pursuant to this section only if the provider meets both of the following conditions in an applicable state fiscal year:

(a) Provides ground emergency medical transport services to medicaid managed care enrollees pursuant to a contract or other arrangement with a medicaid managed care plan.

(b) Is owned or operated by the state, a city, county, fire protection district, special district, community services district, health care district, federally recognized Indian tribe or unit of government as defined in 42 C.F.R. Sec. 433.50.

(3) To the extent intergovernmental transfers are voluntarily made by, and accepted from, an eligible provider described in subsection (2) of this section, or a governmental entity affiliated with an eligible provider, the department shall make increased capitation payments to applicable medicaid managed care plans for covered ground emergency medical transportation services.

(a) The increased capitation payments made pursuant to this section must be in amounts at least actuarially equivalent to the supplemental fee-for-service payments available for eligible providers to the extent permissible under federal law.

(b) Except as provided in subsection (6) of this section, all funds associated with intergovernmental transfers made and accepted pursuant to this section must be used to fund additional payments to eligible providers.

(c) Medicaid managed care plans shall pay one hundred percent of any amount of increased capitation payments made pursuant to this section to eligible providers for providing and making available ground emergency medical transportation and paramedical services pursuant to a contract or other arrangement with a medicaid managed care plan.

(4) The intergovernmental transfer program developed pursuant to this section must be implemented on the date federal approval was obtained, and only to the extent intergovernmental transfers from the eligible provider, or the governmental entity with which it is affiliated, are provided for this purpose. To the extent permitted by federal law, the department may implement the intergovernmental transfer program and increased capitation payments pursuant to this section on a retroactive basis as needed.

(5) Participation in the intergovernmental transfers under this section is voluntary on the part of the transferring entities for purposes of all applicable federal laws.

(6) This section must be implemented without any additional expenditure from the state general fund. As a condition of participation under this section, each eligible provider as described in subsection (2) of this section, or the governmental entity affiliated with an eligible provider, shall agree to reimburse the department for any costs associated with implementing this section. Intergovernmental transfers described in this section are subject to a twenty percent administration fee of the nonfederal share paid to the department and is allowed to count as a cost of providing the services.

(7) As a condition of participation under this section, medicaid managed care plans, eligible providers as described in subsection (2) of this section, and governmental entities affiliated with eligible providers shall agree to comply with any requests for information or similar data requirements imposed by the department for purposes of obtaining supporting documentation necessary to claim federal funds or to obtain federal approvals.

(8) This section must be implemented only if and to the extent federal financial participation is available and is not otherwise jeopardized, and any necessary federal approvals have been obtained.

(9) To the extent that the director determines that the payments made pursuant to this section do not comply with federal medicaid requirements, the director retains the discretion to return or not accept an intergovernmental transfer, and may adjust payments pursuant to this section as necessary to comply with federal medicaid requirements.

(10) To the extent federal approval is obtained, the increased capitation payments under this section may commence for dates of service on or after January 1, 2015. [2015 c 147 s 2.]

RCW 41.05.740 School employees' benefits board. (1) The school employees' benefits board is created within the authority. The function of the school employees' benefits board is to design and approve insurance benefit plans for school employees and to establish eligibility criteria for participation in insurance benefit plans.

(2) By September 30, 2017, the governor shall appoint the following voting members to the school employees' benefits board as follows:

(a) Two members from associations representing certificated employees;

(b) Two members from associations representing classified employees;

(c) Four members with expertise in employee health benefits policy and administration, one of which is nominated by an association representing school business officials; and

(d) The director of the authority or his or her designee.

(3) Initial members of the school employees' benefits board shall serve staggered terms not to exceed four years. Members appointed thereafter shall serve two-year terms.

(4) Compensation and reimbursement related to school employees' benefits board member service are as follows:

(a) Members of the school employees' benefits board must be compensated in accordance with RCW 43.03.250 and must be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

(b) While school employees' benefits board members are carrying out their powers and duties under this chapter, if the service of any certificated or classified employee results in a need for a school employees' benefits board organization to employ a substitute for such certificated or classified employee during such service, payment for such a substitute may be made by the authority from funds appropriated by the legislature for the school employees' benefits board program. If such substitute is paid by the authority, no deduction shall be made from the salary of the certificated or classified employee. In no event shall a school employees' benefits board organization deduct from the salary of a certificated or classified employee serving on the school employees' benefits board more than the amount paid the substitute employed by the school employees' benefits board organization.

(5) The director of the authority or his or her designee shall be the chair and another member shall be selected by the school employees' benefits board as vice chair. The chair shall conduct meetings of the school employees' benefits board. The vice chair shall preside over meetings in the absence of the chair. The school employees' benefits board shall develop bylaws for the conduct of its business.

(6) The school employees' benefits board shall:

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

(b) Develop school employee benefit plans that include comprehensive, evidence-based health care benefits for school employees. In developing these plans, the school employees' benefits board shall consider the following elements:

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

(ii) 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;

(iii) Wellness, preventive care, chronic disease management, and other incentives that focus on proven strategies;

(iv) Utilization review procedures to support cost-effective benefits delivery;

(v) Ways to leverage efficient purchasing by coordinating with the public employees' benefits board;

(vi) Effective coordination of benefits; and

(vii) Minimum standards for insuring entities;

(c) Authorize premium contributions for a school employee and the employee's dependents in a manner that encourages the use of cost-efficient health care systems. For participating school employees, the required school employee share of the cost for family coverage premiums may not exceed three times the premiums for a school employee purchasing single coverage for the same coverage plan;

(d) Determine the terms and conditions of school employee and dependent eligibility criteria, enrollment policies, and scope of coverage. Employer groups obtaining benefits through contractual agreement with the authority for school employees defined in RCW 41.05.011(6)(b)(iv) may contractually agree with the authority to benefits eligibility criteria which differs from that determined by the school employees' benefits board. At a minimum, the eligibility criteria established by the school employees' benefits board shall address the following:

(i) The effective date of coverage following hire;

(ii) The benefits eligibility criteria, but the school employees' benefits board's criteria shall be no more restrictive than requiring that a school employee be anticipated to work at least six hundred thirty hours per school year to be benefits eligible; and

(iii) Coverage for dependents, including criteria for legal spouses; children up to age twenty-six; children of any age with disabilities, mental illness, or intellectual or other developmental disabilities; and state registered domestic partners, as defined in RCW 26.60.020, and others authorized by the legislature;

(e) Establish terms and conditions for a school employees' benefits board organization to have the ability to locally negotiate eligibility criteria for a school employee who is anticipated to work less than six hundred thirty hours in a school year. A school employees' benefits board organization that elects to use a lower threshold of hours for benefits eligibility must use benefits authorized by the school employees' benefits board and shall do so as an enrichment to the state's definition of basic education;

(f) Establish penalties to be imposed when a school employees' benefits board organization fails to comply with established participation criteria; and

(g) Participate with the authority in the preparation of specifications and selection of carriers contracted for school employee benefit plan coverage of eligible school employees in accordance with the criteria set forth in rules. To the extent possible, the school employees' benefits board shall leverage efficient purchasing by coordinating with the public employees' benefits board.

(7) School employees shall choose participation in one of the health care benefit plans developed by the school employees' benefits board. Individual school employees eligible for benefits under

subsection (6)(d) of this section may be permitted to waive coverage under terms and conditions established by the school employees' benefits board.

(8) By November 30, 2021, the authority shall review the benefit plans provided through the school employees' benefits board, complete an analysis of the benefits provided and the administration of the benefits plans, and determine whether provisions in chapter 13, Laws of 2017 3rd sp. sess. have resulted in cost savings to the state. The authority shall submit a report to the relevant legislative policy and fiscal committees summarizing the results of the review and analysis. [2023 c 13 s 7; 2018 c 260 s 1; 2017 3rd sp.s. c 13 s 801.]

Finding—Intent—2023 c 13: See note following RCW 41.05.011.

Effective date—2017 3rd sp.s. c 13 ss 102, 505, and 801: See note following RCW 28A.400.205.

Intent—2017 3rd sp.s. c 13: See note following RCW 28A.150.410.

RCW 41.05.742 Single enrollment requirement. Beginning with the 2022 plan year, individuals are limited to a single enrollment in medical, dental, and vision plans in either the school employees' benefits board or the public employees' benefits board. The school employees' benefits board and the public employees' benefits board shall adopt policies to reflect this single enrollment requirement. [2021 c 18 s 1; 2020 c 8 s 4.]

Effective date—2020 c 8: See note following RCW 41.05.744.

RCW 41.05.743 School board members—Eligibility for health benefits. (1) For purposes of this section, "school board member" means the board of directors of a school district as governed by chapter 28A.343 RCW or the board of directors of an educational service district as governed by chapter 28A.310 RCW.

(2) As of January 1, 2024, a school board member may participate in the benefit plans offered by and subject to the terms and conditions determined by the school employees' benefits board. A school board member may enroll in medical, dental, and vision benefits and shall be responsible for premium rates developed by the authority. A school board member shall be responsible for submitting the full self-pay premium amount for the benefits the member elects to enroll in for each month the member is covered.

(3) A school board member may participate in the school employees' benefits board program for the duration of the member's elected term as a school board member and may renew the member's participation at the start of each subsequent term as a school board member.

(4) If a school board member voluntarily ends the member's enrollment in the school employees' benefits board program prior to the end of their elected term, the member is no longer eligible under this section to participate in the school employees' benefits board program for the remainder of the member's elected term.

(5) This section does not create any eligibility for school board members to participate in retiree benefits provided by the public employees' benefits board program. [2023 c 13 s 8.]

Finding—Intent—2023 c 13: See note following RCW 41.05.011.

RCW 41.05.744 School employee eligibility during COVID-19 state of emergency. (1) A school employee eligible as of February 29, 2020, for the employer contribution towards benefits offered by the school employees' benefits board shall maintain their eligibility for the employer contribution under the following circumstances directly related or in response to the governor's February 29, 2020, proclamation of a state of emergency existing in all counties in the state of Washington related to the novel coronavirus (COVID-19):

(a) During any school closures or changes in school operations for the school employee;

(b) While the school employee is quarantined or required to care for a family member, as defined by RCW 49.46.210(2), who is quarantined; and

(c) In order to take care of a child as defined by RCW 49.46.210(2), when the child's:

(i) School is closed;

(ii) Regular day care facility is closed; or

(iii) Regular child care provider is unable to provide services.

(2) Requirements in subsection (1) of this section expires when the governor's state of emergency related to the novel coronavirus (COVID-19) ends.

(3) When regular school operations resume, school employees shall continue to maintain their eligibility for the employer contribution for the remainder of the school year so long as their work schedule returns to the schedule in place before February 29, 2020, or, if there is a change in schedule, so long as the new schedule, had it been in effect at the start of the school year, would have resulted in the employee being anticipated to work the minimum hours to meet benefits eligibility.

(4) Quarantine, as used in subsection (1)(b) [of this section] includes only periods of isolation required by the federal government, a foreign national government, a state or local public health official, a health care provider, or an employer. [2020 c 8 s 5.]

Effective date—2020 c 8: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [March 17, 2020]." [2020 c 8 s 6.]

RCW 41.05.745 School employees' benefits board—Employee-paid, voluntary benefits—Optional benefits. (1) In addition to the benefits offering authority under this chapter, the school employees' benefits board may study and, subject to the availability of funding, offer the following employee-paid, voluntary benefits:

(a) Emergency transportation;

(b) Identity protection;

(c) Legal aid;

(d) Long-term care insurance;

(e) Noncommercial personal automobile insurance;

(f) Personal homeowner's or renter's insurance;

(g) Pet insurance;

(h) Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit regulated by the office of the insurance commissioner;

(i) Travel insurance; and

(j) Voluntary employees' beneficiary association accounts.

(2) The health care authority, in consultation with the school employees' benefits board, shall review the optional benefits reported by school districts as required in RCW 28A.400.280 and determine if the optional benefits are in competition with benefits currently offered under either the authority's or the board's authorities. If a school district benefit offering is determined to be in competition with the benefits offered under either the authority's or the board's authorities, the health care authority must inform the school district of the benefits conflict and work with the school district, and the applicable carrier, to either modify and remove competing components of the district-based benefit or end the district-based offering. If a carrier is in the process of modifying benefits, including seeking any required regulatory approval, a school district may continue to offer the original benefit.

(3) Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered pursuant to this section as an independent, noncoordinated benefit is not a health plan as defined in RCW 48.43.005. [2020 c 231 s 3.]

RCW 41.05.750 Problem gambling and gambling disorder treatment program. (1) A program for (a) year-round integrated problem gambling prevention efforts that include community engagement and the treatment of problem gambling and gambling disorder; and (b) the support, certification, and training of professionals in the identification and treatment of problem gambling and gambling disorder is established within the authority. The department of health may license or certify behavioral health agencies for problem gambling treatment. The authority may contract for any services provided under the program. The authority shall conduct a program evaluation, including tracking program participation and evaluating outcomes.

(2) To receive treatment under subsection (1) of this section, a person must:

(a) Need treatment for problem gambling or gambling disorder, or be impacted by a loved one experiencing problem gambling or gambling disorder;

(b) Be identified by the authority as being most amenable to and likely to benefit from treatment; and

(c) Be unable to afford treatment.

(3) Treatment under this section is available only to the extent of the funds appropriated or otherwise made available to the authority for this purpose. The authority may solicit and accept for use any gift of money or property made by will or otherwise, and any grant of money, services, or property from the federal government, any tribal government, the state, or any political subdivision thereof or any private source, and do all things necessary to cooperate with the

federal government or any of its agencies or any tribal government in making an application for any grant.

(4)(a) The authority shall establish and facilitate an ongoing advisory committee that will hold quarterly meetings to:

(i) Track progress of recommendations from the 2022 legislative problem gambling task force final report;

(ii) Provide advice and feedback on the state problem gambling program upon request by the authority; and

(iii) Discuss emerging issues related to problem gambling and identify possible strategies for improvement.

(b) The advisory committee membership must include, at a minimum, at least one representative from each of the following:

(i) The Washington state gambling commission;

(ii) The Washington state lottery commission;

(iii) The Washington state horse racing commission;

(iv) The Washington state health care authority;

(v) The tribal gaming industry;

(vi) An established business primarily engaged in the selling of food or drink for consumption on the premises and that offers punchboards, pull-tabs, and social card games as a commercial stimulant;

(vii) The gambling counselor certification committee;

(viii) A nonprofit problem gambling organization; and

(ix) The recovery community including at least one member with lived experience of problem gambling. [2023 c 284 s 2; 2018 c 201 s 2004; 2010 c 171 s 1; 2005 c 369 s 2; 2002 c 349 s 4. Formerly RCW 43.20A.890, 67.70.350.]

Findings—Intent—2023 c 284: "(1) The legislature finds that:

(a) The costs to society of problem gambling and gambling disorder include family disintegration, criminal activity, and financial insolvencies;

(b) Individuals experiencing problem gambling and gambling disorder are at significantly increased risks for other co-occurring disorders, including substance use disorder and mental health issues such as depression, anxiety, or other behavioral health concerns;

(c) Residents of Washington may participate in a variety of legal gaming activities such as the state-run lottery, tribal gaming by federally recognized Indian tribes, certain fund-raisers offered by bona fide charitable and nonprofit organizations, and punchboards, pull-tabs, and social card games approved as a commercial stimulant at established businesses primarily engaged in the selling of food or drink for consumption on the premises;

(d) A 2021 prevalence study found that among all adults, 1.5 percent are at a moderate-to-severe risk for developing a gambling disorder, and among adults who gamble, 3.5 percent are at a moderate-to-severe risk of a gambling disorder; and

(e) The 2022 problem gambling task force final report, delivered to the legislature in December 2022, determined there are critical gaps in providing state-funded comprehensive problem gambling services to Washington residents, including:

(i) Prevention efforts not coordinated with other behavioral health and substance abuse prevention initiatives;

(ii) Problem gambling treatment coverage is not available across the state; and

(iii) No state-supported residential treatment services are available in Washington state.

(2) The legislature intends to provide long-term, dedicated funding for prevention, public awareness efforts, and education regarding problem gambling disorder, clinical training, workforce development, and accessible treatment services for individuals impacted by problem gambling or gambling disorders as well as after-care support." [2023 c 284 s 1.]

Effective date—2023 c 284: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2023." [2023 c 284 s 8.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Findings—Intent—2005 c 369: "(1) The legislature finds that:

(a) The costs to society of problem and pathological gambling include family disintegration, criminal activity, and financial insolvencies;

(b) Problem and pathological gamblers suffer a higher incidence of addictive disorders such as alcohol and substance abuse;

(c) Residents of Washington have the opportunity to participate in a variety of legal gambling activities operated by the state, by federally recognized tribes, and by private businesses and nonprofit organizations; and

(d) A 1999 study found that five percent of adult Washington residents and eight percent of adolescents could be classified as problem gamblers during their lifetimes, and that more than one percent of adults have been afflicted with pathological gambling.

(2) The legislature intends to provide long-term, dedicated funding for public awareness and education regarding problem and pathological gambling, training in its identification and treatment, and treatment services for problem and pathological gamblers and, as clinically appropriate, members of their families." [2005 c 369 s 1.]

Severability—2005 c 369: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [2005 c 369 s 10.]

Effective date—2005 c 369: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2005." [2005 c 369 s 11.]

RCW 41.05.751 Problem gambling account. The problem gambling account is created in the state treasury. Money in the account may be spent only after appropriation. Expenditures from the account may be used only for the purposes of the program established under RCW 41.05.750. [2018 c 201 s 2005; 2005 c 369 s 3. Formerly RCW 43.20A.892.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Findings—Intent—Severability—Effective date—2005 c 369: See notes following RCW 41.05.750.

RCW 41.05.760 Recovery residences—Registry. (1) The authority shall establish and maintain a registry of approved recovery residences. The authority may contract with a nationally recognized recovery residence certification organization based in Washington to establish and maintain the registry.

(2) The authority or the contracted entity described in subsection (1) of this section shall determine that a recovery residence is approved for inclusion in the registry if the recovery residence has been certified by a nationally recognized recovery residence certification organization based in Washington that is approved by the authority or if the recovery residence is a chapter of a national recovery residence organization with peer-run homes that is approved by the authority as meeting the following standards in its certification process:

(a) Peers are required to be involved in the governance of the recovery residence;

(b) Recovery support is integrated into the daily activities;

(c) The recovery residence must be maintained as a home-like environment that promotes healthy recovery;

(d) Resident activities are promoted within the recovery residence and in the community through work, education, community engagement, or other activities; and

(e) The recovery residence maintains an environment free from alcohol and illicit drugs.

(3) Nothing in this section requires that a recovery residence become certified by the certifying organization approved by the authority in subsection (2) of this section or be included in the registry, unless the recovery residence decides to participate in the recovery residence program activities established in this chapter.

(4) For the purposes of this section, "recovery residence" means a home-like environment that promotes healthy recovery from a substance use disorder and supports persons recovering from a substance use disorder through the use of peer recovery support. [2019 c 264 s 2.]

Findings—2019 c 264: "(1) The legislature finds that substance use disorder is a disease impacting the whole family and the whole society and requires a system of care that includes prevention, treatment, and recovery services that support and strengthen impacted individuals, families, and the community at large.

(2) The legislature further finds that access to quality recovery housing is crucial for helping individuals remain in recovery from substance use disorder beyond treatment. Furthermore, recovery housing serves to preserve the state's financial investment in a person's treatment. Without access to quality recovery housing, individuals are much less likely to recover from substance use disorder and more likely to face continued issues that impact their well-being, their families, and their communities. These issues include death by overdose or other substance use disorder-related medical

complications; higher health care costs; high use of emergency departments and public health care systems; higher risk for involvement with law enforcement and incarceration; and an inability to obtain and maintain employment. These challenges are compounded by an overall lack of affordable housing nationwide.

(3) The legislature recognizes that recovery is a long-term process and requires a comprehensive approach. Recognizing the potential for fraudulent and unethical recovery housing operators, this act is designed to address the quality of recovery housing in the state of Washington." [2019 c 264 s 1.]

RCW 41.05.761 Recovery residences—Technical assistance for residences seeking certification. ***(Expires July 1, 2025.)*** (1) Subject to the availability of amounts appropriated for this specific purpose, the authority shall contract with the nationally recognized recovery residence organization based in Washington that is approved by the authority in RCW 41.05.760 to provide technical assistance to recovery residences actively seeking certification. The technical assistance shall include, but not be limited to:

(a) New manager training;

(b) Assistance preparing facility operations documents and policies; and

(c) Support for working with residents on medication-assisted treatment.

(2) This section expires July 1, 2025. [2019 c 264 s 3.]

Findings—2019 c 264: See note following RCW 41.05.760.

RCW 41.05.762 Recovery residences—Revolving fund. ***(Expires July 1, 2025.)*** (1) The authority shall establish a revolving fund for loans to operators of new recovery residences or existing recovery residences actively seeking certification and registration under RCW 41.05.760. Approved uses of the funds include, but are not limited to:

(a) Facility modifications necessary to achieve certification; and

(b) Operating start-up costs, including rent or mortgage payments, security deposits, salaries for on-site staff, and minimal maintenance costs.

(2) This section expires July 1, 2025. [2019 c 264 s 4.]

Findings—2019 c 264: See note following RCW 41.05.760.

RCW 41.05.810 Prenatal substance exposure treatment—Contracting. (1) By January 1, 2024, the authority, on behalf of clients or potential clients of the department of children, youth, and families as described in this subsection, shall contract with a provider with expertise in comprehensive prenatal substance exposure treatment and family supports to offer services to children over the age of three and families who are or have been involved in the child welfare system or who are at risk of becoming involved in the child welfare system. This contract shall maximize the number of families that can be served through referrals by authority employees and other community partners in order to keep families together, reduce the

number of placements, and prevent adverse outcomes for impacted children.

(2) By January 1, 2025, the authority, on behalf of clients or potential clients of the department of children, youth, and families as described in this subsection, shall contract with up to three providers across the state, in addition to the contracted provider in subsection (1) of this section, to offer comprehensive treatment services for prenatal substance exposure and family supports for children who were prenatally exposed to substances and who are, or have been, involved in the child welfare system.

(3) Comprehensive treatment and family supports must be trauma-informed and may include:

(a) Occupational, speech, and language therapy;

(b) Behavioral health counseling and caregiver counseling;

(c) Sensory processing support;

(d) Educational advocacy, psychoeducation, social skills support, and groups;

(e) Linkages to community resources; and

(f) Family supports and education, including the programs for parents, caregivers, and families recommended by the federal centers for disease control and prevention.

(4) The authority shall contract with the provider referenced in subsection (1) of this section to support the providers under contract in subsection (2) of this section by:

(a) Creating education and training programs for providers working with children who had prenatal substance exposure; and

(b) Offering ongoing coaching and support in creating a safe and healing environment, free from judgment, where families are supported through the challenges of care for children with prenatal substance exposure.

(5) The authority, in collaboration with the department of children, youth, and families, shall work with the contracted providers and families to collect relevant outcome data and provide a report on the expansion of services under the contracts and the outcomes experienced by persons receiving services under this section. The authority shall submit the report to the legislature with any recommendations related to improving availability of and access to services and ways to improve outcomes by June 1, 2028. [2023 c 288 s 2.]

Findings—2023 c 288: "The legislature finds that:

(1) Fetal alcohol spectrum disorders are lifelong physical, developmental, behavioral, and intellectual disabilities caused by prenatal alcohol exposure;

(2) According to the federal centers for disease control and prevention, fetal alcohol spectrum disorders affect as many as one in 20 people in the United States;

(3) The health care authority estimates that one percent of births, or approximately 870 children each year, are born with fetal alcohol spectrum disorders;

(4) In addition to alcohol use, other substances consumed during pregnancy may result in prenatal substance exposure affecting the physical, developmental, behavioral, and intellectual abilities of the exposed child;

(5) Washington has limited diagnostic capacity and currently lacks the capacity to diagnose and treat every child who needs support and treatment due to prenatal substance exposure;

(6) Without appropriate treatment and supports, children born with fetal alcohol spectrum disorders and other prenatal substance disorders are likely to experience adverse outcomes. According to current statistics, these children face adverse outcomes such as:

(a) 61 percent of children with fetal alcohol spectrum disorders are suspended or expelled from school by age 12;

(b) 90 percent of persons with fetal alcohol spectrum disorders develop comorbid mental health conditions; and

(c) 60 percent of youth with fetal alcohol spectrum disorders are involved in the justice system;

(7) Untreated and unsupported prenatal substance exposure results in higher costs for the state and worse outcomes for children and their families;

(8) Investing in prevention and earlier intervention, including diagnostic capacity, treatment, and services for children and supports for families and caregivers will improve school outcomes; and

(9) Effective prenatal substance exposure response requires effective and ongoing cross-agency strategic planning and coordination." [2023 c 288 s 1.]

RCW 41.05.812 Prenatal substance exposure—Expanded treatment and services. (1) Subject to the availability of amounts appropriated for this specific purpose, the authority shall expand specific treatment and services to children and youth with prenatal substance exposure who would benefit from evidence-based services impacting their behavioral and physical health.

(2) The authority shall contract for the services authorized in this section with behavioral health entities in a manner that allows leveraging of federal medicaid funds to pay for a portion of the costs.

(3) The authority shall consult with the department of children, youth, and families in the implementation of the program and services authorized under this section. [2024 c 328 s 203.]

Findings—Intent—2024 c 328: See note following RCW 13.34.050.

RCW 41.05.820 Qualified requirement for health carrier in insurance holding company to offer silver and gold health plans. (1) For plan years beginning January 1, 2020, at least one health carrier in an insurance holding company system must offer in the exchange at least one silver and one gold qualified health plan in any county in which any health carrier in that insurance holding company system offers a fully insured health plan that was approved, on or after June 7, 2018, by the school employees' benefits board or the public employees' benefits board to be offered to employees and their covered dependents under this chapter.

(2) The rates for a health plan approved by the school employees' benefits board or the public employees' benefits board may not include the administrative costs or actuarial risks associated with a qualified health plan offered under subsection (1) of this section.

(3) The authority shall perform an actuarial review during the annual rate setting process for plans approved by the school employees' benefits board or the public employees' benefits board to ensure compliance with subsection (2) of this section.

(4) For purposes of this section, "exchange" and "health carrier" have the same meaning as in RCW 48.43.005.

(5) For purposes of this section, "insurance holding company system" has the same meaning as in RCW 48.31B.005. [2018 c 219 s 2.]

Findings—Intent—2018 c 219: "(1) The legislature finds that:

(a) Access to health care is fundamental to the health and safety of the citizens of Washington state;

(b) Health insurance coverage is necessary for most people to access health care;

(c) Due to uncertainty in the health insurance marketplace, volatility in the current federal regulatory environment, and rising health care costs, ensuring access to the private health insurance market in every county in Washington state is becoming more difficult;

(d) The consequences of losing private health insurance coverage in a county would be catastrophic, leading to deteriorating health outcomes, lost productivity, and lower quality of life; and

(e) If the private market fails to provide coverage in a county, the state must intervene.

(2) The legislature therefore intends to:

(a) Leverage the provider networks used by private insurers offering coverage to state and school employees to ensure private insurance coverage is available in all counties where those insurers offer coverage to state and school employees; and

(b) Until such coverage is available, make coverage in the Washington state health insurance pool more affordable to persons residing in counties where no private insurance is available." [2018 c 219 s 1.]

RCW 41.05.831 Coverage for hearing instruments. A health plan offered to public employees and their covered dependents under this chapter issued or renewed on or after January 1, 2024, is subject to RCW 48.43.135. [2023 c 245 s 3.]

RCW 41.05.840 Universal health care commission. (1) The universal health care commission is established to create immediate and impactful changes in the health care access and delivery system in Washington and to prepare the state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system once the necessary federal authority has become available. The authority must begin any necessary federal application process within 60 days of its availability.

(2) The commission includes the following voting members:

(a) One member from each of the two largest caucuses of the house of representatives, appointed by the speaker of the house of representatives;

(b) One member from each of the two largest caucuses of the senate, appointed by the president of the senate;

(c) The secretary of the department of health, or the secretary's designee;

(d) The director of the health care authority, or the director's designee;

(e) The chief executive officer of the Washington health benefit exchange, or the chief executive officer's designee;

(f) The insurance commissioner, or the commissioner's designee;

(g) The director of the office of equity, or the director's designee; and

(h) Six members appointed by the governor, using an equity lens, with knowledge and experience regarding health care coverage, access, and financing, or other relevant expertise, including at least one consumer representative and at least one invitation to an individual representing tribal governments with knowledge of the Indian health care delivery in the state.

(3)(a) The governor must appoint the chair of the commission from any of the members identified in subsection (2) of this section for a term of no more than three years. A majority of the voting members of the commission shall constitute a quorum for any votes of the commission.

(b) The commission's meetings shall be open to the public pursuant to chapter 42.30 RCW. The authority must publish on its website the dates and locations of commission meetings, agendas of prior and upcoming commission meetings, and meeting materials for prior and upcoming commission meetings.

(4) The health care authority shall staff the commission.

(5) Members of the commission shall serve without compensation but must be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

(6) The commission may establish advisory committees that include members of the public with knowledge and experience in health care, in order to support stakeholder engagement and an analytical process by which key design options are developed. A member of an advisory committee need not be a member of the commission.

(7) By November 1, 2022, the commission shall submit a baseline report to the legislature and the governor, and post it on the authority's website. The report must include:

(a) A complete synthesis of analyses done on Washington's existing health care finance and delivery system, including cost, quality, workforce, and provider consolidation trends and how they impact the state's ability to provide all Washingtonians with timely access to high quality, affordable health care;

(b) A strategy for developing implementable changes to the state's health care financing and delivery system to increase access to health care services and health coverage, reduce health care costs, reduce health disparities, improve quality, and prepare for the transition to a unified health care financing system by actively examining data and reports from sources that are monitoring the health care system. Such sources shall include data or reports from the health care cost transparency board under RCW 70.390.070, the public health advisory board, the governor's interagency coordinating council on health disparities under RCW 43.20.275, the all-payer health care claims database established under chapter 43.371 RCW, prescription drug price data, performance measure data under chapter 70.320 RCW, and other health care cost containment programs;

(c) An inventory of the key design elements of a universal health care system including:

(i) A unified financing system including, but not limited to, a single-payer financing system;

(ii) Eligibility and enrollment processes and requirements;

(iii) Covered benefits and services;

(iv) Provider participation;

(v) Effective and efficient provider payments, including consideration of global budgets and health plan payments;

(vi) Cost containment and savings strategies that are designed to assure that total health care expenditures do not exceed the health care cost growth benchmark established under chapter 70.390 RCW;

(vii) Quality improvement strategies;

(viii) Participant cost sharing, if appropriate;

(ix) Quality monitoring and disparities reduction;

(x) Initiatives for improving culturally appropriate health services within public and private health-related agencies;

(xi) Strategies to reduce health disparities including, but not limited to, mitigating structural racism and other determinants of health as set forth by the office of equity;

(xii) Information technology systems and financial management systems;

(xiii) Data sharing and transparency; and

(xiv) Governance and administration structure, including integration of federal funding sources;

(d) An assessment of the state's current level of preparedness to meet the elements of (c) of this subsection and steps Washington should take to prepare for a just transition to a unified health care financing system, including a single-payer financing system. Recommendations must include, but are not limited to, administrative changes, reorganization of state programs, retraining programs for displaced workers, federal waivers, and statutory and constitutional changes;

(e) Recommendations for implementing reimbursement rates for health care providers serving medical assistance clients who are enrolled in programs under chapter 74.09 RCW at a rate that is no less than 80 percent of the rate paid by medicare for similar services;

(f) Recommendations for coverage expansions to be implemented prior to and consistent with a universal health care system, including potential funding sources; and

(g) Recommendations for the creation of a finance committee to develop a financially feasible model to implement universal health care coverage using state and federal funds.

(8) Following the submission of the baseline report on November 1, 2022, the commission must structure its work to continue to further identify opportunities to implement reforms consistent with subsection (7)(b) of this section and to implement structural changes to prepare the state for a transition to a unified health care financing system. The commission must submit annual reports to the governor and the legislature each November 1st, beginning in 2023. The reports must detail the work of the commission, the opportunities identified to advance the goals under subsection (7) of this section, which, if any, of the opportunities a state agency is implementing, which, if any, opportunities should be pursued with legislative policy or fiscal authority, and which opportunities have been identified as beneficial, but lack federal authority to implement.

(9) Subject to sufficient existing agency authority, state agencies may implement specific elements of any report issued under this section. This section shall not be construed to authorize the commission to implement a universal health care system through a

unified financing system until there is further action by the legislature and the governor.

(10) The commission must hold its first meeting within 90 days of July 25, 2021. [2021 c 309 s 2.]

Findings—Intent—2021 c 309: "(1) The legislature finds that:

(a) Healthy Washingtonians contribute to the economic well-being of their families and communities, and access to appropriate health services and improved health outcomes allow all Washingtonian families to enjoy productive and satisfying lives;

(b) Washington and the United States are experiencing the deepest economic crisis since the Great Depression, caused by a public health crisis;

(c) Skyrocketing unemployment rates due to COVID-19 have exposed the frailties and inequalities of the current health care system while causing unsustainable strain to the state's medicaid system;

(d) Thousands of union and nonunion workers are unemployed and without health insurance;

(e) Approximately 125,000 undocumented people live in the state with no access to health care during a global pandemic;

(f) Multiple economic analyses show that a universal system is less expensive, more equitable, and will produce billions in savings per year; and

(g) While a unified health care financing system can provide universal coverage, increase access to care, decrease costs, and improve quality, implementing such a system in the state is dependent on foundational legal, financial, and programmatic changes from the federal government.

(2) The legislature intends to create a permanent universal health care commission to:

(a) Implement immediate and impactful changes in the state's current health care system to increase access to quality, affordable health care by streamlining access to coverage, reducing fragmentation of health care financing across multiple public and private health insurance entities, reducing unnecessary administrative costs, reducing health disparities, and establishing mechanisms to expeditiously link residents with their chosen providers; and

(b) Establish the preliminary infrastructure to create a universal health system, including a unified financing system, that controls health care spending so that the system is affordable to the state, employers, and individuals, once the necessary federal authorities have been realized.

(3) The legislature further intends that the state, in collaboration with all communities, health plans, and providers, should take steps to improve health outcomes for all residents of the state." [2021 c 309 s 1.]

RCW 41.05.845 Prior authorization. (1) A health plan offered to public employees, retirees, and their covered dependents under this chapter issued or renewed on or after January 1, 2024, shall comply with the following standards related to prior authorization for health care services and prescription drugs:

(a) The health plan shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior

authorization request through an electronic prior authorization process:

(i) For electronic standard prior authorization requests, the health plan shall make a decision and notify the provider or facility of the results of the decision within three calendar days, excluding holidays, of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the health plan to make a decision, the health plan shall request any additional information from the provider or facility within one calendar day of submission of the electronic prior authorization request.

(ii) For electronic expedited prior authorization requests, the health plan shall make a decision and notify the provider or facility of the results of the decision within one calendar day of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the health plan to make a decision, the health plan shall request any additional information from the provider or facility within one calendar day of submission of the electronic prior authorization request.

(b) The health plan shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior authorization request through a process other than an electronic prior authorization process described in subsection (2) of this section:

(i) For nonelectronic standard prior authorization requests, the health plan shall make a decision and notify the provider or facility of the results of the decision within five calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the health plan to make a decision, the health plan shall request any additional information from the provider or facility within five calendar days of submission of the nonelectronic prior authorization request.

(ii) For nonelectronic expedited prior authorization requests, the health plan shall make a decision and notify the provider or facility of the results of the decision within two calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the health plan to make a decision, the health plan shall request any additional information from the provider or facility within one calendar day of submission of the nonelectronic prior authorization request.

(c) In any instance in which the health plan has determined that a provider or facility has not provided sufficient information for making a determination under (a) and (b) of this subsection, the health plan may establish a specific reasonable time frame for submission of the additional information. This time frame must be communicated to the provider and enrollee with the health plan's request for additional information.

(d) The prior authorization requirements of the health plan must be described in detail and written in easily understandable language. The health plan shall make its most current prior authorization

requirements and restrictions, including the written clinical review criteria, available to providers and facilities in an electronic format upon request. The prior authorization requirements must be based on peer-reviewed clinical review criteria. The clinical review criteria must be evidence-based criteria and must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous people, other people of color, gender, and underserved populations. The clinical review criteria must be evaluated and updated, if necessary, at least annually.

(2)(a) Each health plan offered to public employees, retirees, and their covered dependents under this chapter shall build and maintain a prior authorization application programming interface that automates the process for in-network providers to determine whether a prior authorization is required for health care services, identify prior authorization information and documentation requirements, and facilitate the exchange of prior authorization requests and determinations from its electronic health records or practice management system. The application programming interface must support the exchange of prior authorization requests and determinations for health care services beginning January 1, 2025, and must:

(i) Use health level 7 fast health care interoperability resources in accordance with standards and provisions defined in 45 C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);

(ii) Automate the process to determine whether a prior authorization is required for durable medical equipment or a health care service;

(iii) Allow providers to query the health plan's prior authorization documentation requirements;

(iv) Support an automated approach using nonproprietary open workflows to compile and exchange the necessary data elements to populate the prior authorization requirements that are compliant with the federal health insurance portability and accountability act of 1996 or have an exception from the federal centers for medicare and medicaid services; and

(v) Indicate that a prior authorization denial or authorization of a service less intensive than that included in the original request is an adverse benefit determination and is subject to the health plan's grievance and appeal process under RCW 48.43.535.

(b) Each health plan offered to public employees, retirees, and their covered dependents under this chapter shall establish and maintain an interoperable electronic process or application programming interface that automates the process for in-network providers to determine whether a prior authorization is required for a covered prescription drug. The application programming interface must support the exchange of prior authorization requests and determinations for prescription drugs, including information on covered alternative prescription drugs, beginning January 1, 2027, and must:

(i) Allow providers to identify prior authorization information and documentation requirements;

(ii) Facilitate the exchange of prior authorization requests and determinations from its electronic health records or practice management system, and may include the necessary data elements to populate the prior authorization requirements that are compliant with the federal health insurance portability and accountability act of

1996 or have an exception from the federal centers for medicare and medicaid services; and

(iii) Indicate that a prior authorization denial or authorization of a drug other than the one included in the original prior authorization request is an adverse benefit determination and is subject to the health plan's grievance and appeal process under RCW 48.43.535.

(c) If federal rules related to standards for using an application programming interface to communicate prior authorization status to providers are not finalized by the federal centers for medicare and medicaid services by September 13, 2023, the requirements of (a) of this subsection may not be enforced until January 1, 2026.

(d)(i) If the health plan determines that it will not be able to satisfy the requirements of (a) of this subsection by January 1, 2025, the health plan shall submit a narrative justification to the authority on or before September 1, 2024, describing:

(A) The reasons that the health plan cannot reasonably satisfy the requirements;

(B) The impact of noncompliance upon providers and enrollees;

(C) The current or proposed means of providing health information to the providers; and

(D) A timeline and implementation plan to achieve compliance with the requirements.

(ii) The authority may grant a one-year delay in enforcement of the requirements of (a) of this subsection (2) if the authority determines that the health plan has made a good faith effort to comply with the requirements.

(iii) This subsection (2)(d) shall not apply if the delay in enforcement in (c) of this subsection takes effect because the federal centers for medicare and medicaid services did not finalize the applicable regulations by September 13, 2023.

(3) Nothing in this section applies to prior authorization determinations made pursuant to RCW 41.05.526.

(4) For the purposes of this section:

(a) "Expedited prior authorization request" means a request by a provider or facility for approval of a health care service or prescription drug where:

(i) The passage of time:

(A) Could seriously jeopardize the life or health of the enrollee;

(B) Could seriously jeopardize the enrollee's ability to regain maximum function; or

(C) In the opinion of a provider or facility with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the health care service or prescription drug that is the subject of the request; or

(ii) The enrollee is undergoing a current course of treatment using a nonformulary drug.

(b) "Standard prior authorization request" means a request by a provider or facility for approval of a health care service or prescription drug where the request is made in advance of the enrollee obtaining a health care service that is not required to be expedited.

(5) This section shall not apply to coverage provided under the medicare part C or part D programs set forth in Title XVIII of the social security act of 1965, as amended. [2023 c 382 s 2.]

RCW 41.05.850 Abortion coverage—Cost sharing. (1) Except as provided in subsection (2) of this section, a health plan offered to public employees and their covered dependents under this chapter issued or renewed on or after January 1, 2024, that provides coverage for abortion may not impose cost sharing for the abortion of a pregnancy.

(2) For a health plan that provides coverage for abortion of a pregnancy and is offered as a qualifying health plan for a health savings account, the health plan shall establish the plan's cost sharing for the coverage required by this section at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under internal revenue service laws and regulations. [2023 c 194 s 2.]

RCW 41.05.890 Certain health care and financial related data provided to authority—Exempt from disclosure. (1) All health care and financial related data as required by section 4, chapter 3, Laws of 2012 2nd sp. sess. that was sent by school districts and their benefits providers to the office of the insurance commissioner for plan years ending in 2012 through 2016 for the purposes of studying health benefits provided to school employees must be provided to the authority by March 15, 2018.

(2) All claims data, including health care and financial related data received by the authority under subsection (1) of this section, is the property of the state and is exempt from disclosure and not subject to chapter 42.56 RCW. [2018 c 260 s 31.]

Effective date—2018 c 260 ss 14, 22, 23, 31, and 32: See note following RCW 41.05.075.

RCW 41.05.900 Short title. This chapter shall be known as the Washington state health care reform act of 1988. [1988 c 107 s 1.]

RCW 41.05.901 Implementation—Effective dates—1988 c 107. (1) The state health care authority shall be established and shall take such steps as are necessary to ensure that this act is fully implemented on October 1, 1988.

There is hereby appropriated for the biennium ending June 30, 1989, the sum of one million three hundred thousand dollars, or as much thereof as is necessary, to the office of the governor from the state employees' insurance administrative account, for the purposes of implementing this subsection.

(2) Subsection (1) of this section, RCW 48.14.027 and 82.04.4331, and sections 13 and 31, chapter 107, Laws of 1988 are necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect March 16, 1988.

(3) The remainder of this act shall take effect on October 1, 1988. [1988 c 107 s 36.]

RCW 41.05.950 Retired or disabled public employees—Special health coverage enrollment opportunity. (1) A retired or disabled employee who: (a) Is receiving a retirement allowance under chapters [chapter] 41.32, 41.35, 41.37, or 41.40 RCW; (b) was previously denied coverage solely for failure to timely notify the authority of their plan to defer coverage; and (c) appealed the denial of benefits to the authority on or before December 31, 2022, may enroll in medical and dental plans under the authority, provided they apply no later than the end of the open enrollment period for the plan year beginning January 1, 2024.

(2) A retired or disabled employee enrolling in benefits under this section may only enroll in a fully insured medicare advantage or medicare supplement plan.

(3) Retired or disabled employees and their dependents are responsible for payment of rates developed by the authority, and must include any amounts necessary for administration in accordance with this chapter. Premium rates charged to retired or disabled employees and their dependents shall be based on the experience of the community-rated risk pools established under RCW 41.05.022 and 41.05.080 and must be reduced by the amount of the subsidy provided under RCW 41.05.085.

(4) The authority may establish rules to implement the enrollment opportunity under this section. [2023 c 15 s 1.]

Effective date—2023 c 15: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [March 30, 2023]." [2023 c 15 s 2.]

RCW 41.05.951 Retired or disabled employees of employer groups—Return following termination of employer's agreement—2023 c 312. Any retired or disabled employee whose participation in insurance plans or contracts under RCW 41.05.080(1)(a)(i) ended due to the termination of the contractual agreement between the authority and an employer group on or before January 1, 2023, must be allowed to return and participate in insurance plans and contracts as described in RCW 41.05.080(1)(a)(ii) so long as the retired or disabled employee notifies the health care authority in writing by December 31, 2023, after which participation will begin on the first day of the month following the date the authority receives the retired or disabled employee's written notice. [2023 c 312 s 3.]

Effective date—2023 c 312: See note following RCW 41.05.083.