

# 2025 HCA budget & legislation proposals

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The Health Care Authority (HCA) serves as the state's single- Medicaid state agency and is the largest purchaser of health care in the state. We lead the effort on transforming health care through programs and initiatives that range from the administration of Apple Health (Medicaid) and behavioral health activities to developing models for value-based purchasing and health technology assessments. We use data to inform our decisions and work in collaboration with local communities to ensure that Washington residents have access to better health and better care at a lower cost.

HCA leads state efforts to transform health care, including reimbursement of mental health and substance use disorders (SUD). HCA focuses on expanding access, investing in the workforce, controlling costs, prevention efforts, and using HCA's purchasing power to enhance value and quality for those we serve.

Our 2025 Agency Request Legislation and Decision Packages build on the significant investments our state has made in health care delivery system over the past decade. HCA will keep the state well-positioned to drive better health outcomes and control costs.

This summary reflects the agency's highest priority requests but is not a comprehensive list of items HCA will request for the Governor's budget. **Please note all funding amounts included in this document are for fiscal year (FY) 25-27.**

## AGENCY REQUEST LEGISLATION

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**PEBB/SEBB access & affordability:** Strives to maintain health plan networks and stabilize long-term affordability by requiring hospitals to contract with PEBB and SEBB plans that offer in good faith to contract; caps reimbursement for hospital services while requiring sustained and increased reimbursement for services provided by primary care, behavioral health, and certain small and rural hospitals; and requires certain reporting.

**Updating the Washington State All Payer Claims Database (WA-APCD):** Updates WA-APCD statutes, including aligning with federal price transparency rules and state transparency efforts; adjusts duplicate reporting requirements; and establishes the option for HCA to contract for a Lead Organization or act in that capacity/role.

**Care coordination & information sharing for counselors and social workers:** Improves communication and care coordination by allowing marriage and family therapists and social workers to share patient information with other providers when operating in their professional capacity, in line with existing state health care privacy protections.

**Aligning PEB/SEB Board authorities:** Aligns board authorities around permissible types of alternative coverage offerings (e.g., pet insurance).

## DECISION PACKAGES

### Maintaining coverage and ensuring access

**Apple Health Expansion (AHE):** Seeking \$84,281,000 in General State Funds (GF-S) to expand the AHE program budget cap, increasing available slots by 14,000 in the program for eligible individuals.

**MAGI post eligibility review:** Seeking \$11,539,000 (GF-S) to reduce barriers and churn for Apple Health clients. In July 2025, increases the compatibility threshold up to 25% when individuals apply for or renew coverage. Also includes funds for staff support, process automation, and text messaging to support outreach.

**Federal and state interoperability and prior authorization requirements:** Seeking \$12,258,000 (GF-S) to implement and maintain Provider Access, Payer-to-Payer, and Prior Authorization application programming interfaces (APIs) required by recently adopted federal rules.

**Managed care rules & accountability:** Seeking \$4,067,000 (GF-S) to support necessary contractor resources for updates to the managed care delivery system to comply with new federal Medicaid rules.

**Federal rule alignment on streamlined eligibility:** Seeking \$3,858,000 (GF-S) to align with updated Centers for Medicare & Medicaid Services (CMS) eligibility rules. Removes premiums for Apple Health for Kids, simplifies application requirements, and updates processes to reduce churn.

### Strengthening behavioral health, SUD, and housing supports

**Non-Native SUD encounters at Tribal facilities:** Seeking \$70,907,000 (GF-S) to cover the state-share of SUD services provided to non-American Indian (AI)/Alaska Native (AN) Apple Health clients. Tribal facilities currently cover the costs to draw down federal match.

**Trueblood Phase 4:** HCA, in partnership with the Department of Social and Health Services (DSHS), is committed to prioritizing the successful implementation of any agreements finalized as part

of Trueblood Phase 4 negotiations and anticipates the need for associated state appropriations.

**ASAM 4<sup>th</sup> edition statewide implementation and program support:** Seeking \$10,590,000 (GF-S) to ensure the agency is adequately resourced for implementation of the American Society of Addiction Medicine (ASAM) criteria to ensure Medicaid managed care organizations (MCOs) and insurance carriers transition to the updated ASAM criteria and begin preparation for the adolescent and transition age adults (ATAY) version in 2026.

**CCBHC development:** Seeking \$2,156,000 (GF-S) for ongoing work to establish certified community behavioral health centers (CCBHCs) as a statewide model in Washington by FY 2027.

**Blake projects-programs:** Seeking \$19,573,000 (GF-S) to continue and expand funding for programs established by the Blake Bill (Senate Bill 5536), including: collegiate recovery supports; health engagement hub (HEH) implementation and evaluation support; MOUD in Jail Program Support while transitioning to Medicaid waiver; WSIPP study of the recovery navigator program (RNP), outcomes & effectiveness reporting for trainings; implementation of diversion data integration platform; and development of a statewide behavioral health treatment and recovery support services mapping tool.

**Naloxone and LAI buprenorphine:** Seeking \$5,000,000 (GF-S) in FY26 for behavioral health agencies (BHAs) to buy supplies of naloxone and for small clinics to buy long-acting injectable (LAI) buprenorphine to support expanded access statewide to opioid overdose reversal medications and treatments for opioid use disorder.

**New Journeys:** Seeking \$520,000 (GF-S) to continue and expand support for evidence-based treatment for the New Journeys program, providing outreach and intervention for youth and young adults when first diagnosed with psychosis.

**Reentry Community Services Program:** Seeking \$6,408,000 (GF-S) in appropriation authority to continue providing wraparound supports, reducing recidivism, and increasing community safety to accommodate an expanded eligible population.

**Reentry pre-release services:** With CMS program approval under the MTP renewal (called MTP 2.0),

HCA now requests \$14,928,000 (GF-S) to provide targeted reentry pre-release services for incarcerated individuals up to 90 days before their release, effective July 1, 2025.

**Foundational Community Supports (FCS)**

**program:** Seeking an increase in expenditure authority to account for significant growth in FCS enrollments and demand for services. Also seeking authority to align FCS service reimbursement rates according to Mercer's rate study recommendations.

**Complex Discharge Program expansion:** Seeking \$27,222,000 (GF-S) for increased staff support, analytics, and extension of pilot program through 2027 to create parity for children and individuals in long term civil commitment (LTCC) settings.

## Improving health outcomes through enhanced rates & benefits

**Primary care infrastructure grants:** Seeking \$10,300,000 (GF-S) to offer grant funds to primary care providers (PCPs) to invest in the infrastructure required to deliver whole-person, high-quality care. Grants would be administered by Accountable Communities of Health (ACHs).

**Medicaid primary care rate increase:** Seeking \$68,395,000 (GF-S) to increase the enhanced pediatric and adult primary care fee schedules to Medicare rates, as part of a broader strategy to improve the access to and quality of primary care services for Medicaid clients.

**Family therapy rates for young children:** Seeking \$645,000 (GF-S) to increase family therapy rates for young children (ages birth through 5 years) to align evidence-based practices for infant-early childhood mental health.

**Ambulatory surgery center payment**

**methodology:** Seeking \$6,569,000 (GF-S) to update the Ambulatory Service Center (ASC) payment methodology to be in line with current Medicare methodology and align with Medicare payment methodology and rates.

**Health Technology Clinical Committee (HTCC)**

**implementation:** Seeking \$21,950,000 (GF-S) to implement new HTCC decisions, including expanded and improved coverage for evidence-based treatment of bariatric surgery and spinal cord stimulators for people with low back pain. Broader access will improve the health and well-

being of Medicaid beneficiaries and will contribute to prevention of expensive obesity-related complications and intensive medical interventions.

## PEBB/SEBB

**PEBB and SEBB benefit enhancements:** Seeking \$20,463,000 (School Employees' Insurance Account) to add coverage for doula services in the Uniform Medical Plan (UMP), provide coverage for behavioral health and SUD peer support services, and enhance and align the Uniform Dental Plan (UDP) PEBB dental benefit with benefits currently offered under SEBB.

**PEBB and SEBB IT resources/benefit accounts:** Seeking \$7,322,000 (St Health Care Authority Admin Acct) to improve Benefits 24/7, including additional positions to address current and future system changes, and increase ability to address access to care issues, faster resolution, and analysis.

## Critical staffing support

**Provider enrollment support:** Seeking \$465,000 (GF-S) to increase staffing and reduce the increasing backlog of work to support provider enrollment in Medicaid. Provider enrollment is a necessary step for providers to ensure they can bill Medicaid (fee-for-service (FFS) and managed care) for services provided.

**Critical behavior health supports:** Seeking \$1,978,000 (GF-S) for 7 new and 3 existing project FTEs. Funding allows HCA to achieve successful implementation of the state's behavioral health priorities and key projects related to statewide administration of behavioral health services.

**MAGI post eligibility reviews:** Seeking \$11,539,000 (GF-S) for continued funding, additional permanent staffing to maintain current productivity and avoid future backlogs, outreach and education efforts, and enhance our Medicaid customer experience.

**Staff supports for maternal access:** Seeking \$1,586,000 (GF-S) for sustainable funding for staff to continue and expand high-priority maternal access and services designed to reduce health inequities. Includes funding to:

- Implement Senate Bill 5580 "Improving maternal health outcomes"
- Prevent loss of staff currently driving clinical policy advancements for maternal services and early childhood supports

## Health and Human Services (HHS) Enterprise Coalition projects and IT investments

**WaCares Program implementation and maintenance:** Seeking \$9,514,000 through the Long-Term Services and Supports (LTSS) Trust account to ensure call center systems are programmed for WaCares use and necessary staff are trained and onboarded prior to the 2026 start date, as well as for ongoing program maintenance and operations.

**HHS Enterprise Coalition Master Person Index (MPI):** Seeking \$1,153,000 (GF-S) for staff support

necessary to continue the MPI project. This is a coalition-wide project supporting the development of unique identification across coalition programs and systems.

**Health Care Management and Coordination System (HCMACS):** Seeking \$50,958,000 (GF-S) to continue support for a statewide enterprise solution for care coordination and case management that supports clients as they move through shared services between state agencies and hospitals/private care settings. The Legislature appropriated funds to initiate this work in previous biennia, but certain amounts for FY25 need to be rolled into FY26, and ongoing funding was not included in previous four-year modeling.

# State & school employee health care access and affordability

- Ensures hospitals will participate in Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) plan networks to ensure continued access to critical services for state and school employees.
- Establishes price ceilings for health plan reimbursement of high-cost hospital services. Also establishes reimbursement floors for primary care and behavioral health services to rationalize reimbursement and sustain access to preventive services while containing health plan cost growth.

## Summary

- Applies to all fully insured and self-funded PEBB and SEBB program health plans.
- Requires hospitals to participate in health plan networks when a carrier or third-party administrator (TPA) makes a good faith offer to contract.
- Establishes pricing thresholds for hospital, primary care, and behavioral health services beginning in January 2027:
  - Hospital prices, except for children's hospitals, for all inpatient and outpatient hospital services, cannot exceed 200% of Medicare.
    - Children's hospital prices cannot exceed 350% of Medicare.
  - Sole community hospitals (SCHs) and critical access hospitals (CAHs) must be paid at rates that are at least 101% of allowable cost.
  - Primary care and non-facility based behavioral health services must be reimbursed at levels no less than 150% of Medicare.
- Beginning January 2029, inpatient and outpatient hospital prices cannot exceed 190% of Medicare, and children's hospital prices cannot exceed 300% of Medicare.
- Requires premiums to consider reimbursement changes driven by the legislation.
- Directs HCA to report on impacts to the Legislature by 2030.

## Background

The frequency of payer-hospital contract termination notices has increased in recent years. These notices confuse enrollees, create concern about providers or facilities going out of network, and risk disrupting routine and essential care for patients. Hospitals' threat of leaving a plan's network also creates a barrier to controlling prices for hospital services amidst increased consolidation in the market.

In addition, reimbursement of primary care and behavioral health lags significantly behind reimbursement for specialty and hospital-based services. This impacts provider recruitment and retention, and patient access to care.

Washington implemented reference pricing strategies in 2019 through our individual market public option (Cascade Select). Our state has seen these plans control premiums more effectively than alternatives that lack price controls. Oregon, among other states, has also seen success with similar

# State & school employee health care access and affordability

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policies. [A recent audit by the Oregon Health Authority](#) found that they saved \$112.7 million in 2021 because of their reference pricing laws.

## **Fiscal impact**

HCA anticipates total health plan expenditures to reduce, based on expected rate trends. The total amount of reduced spending is unknown, but it's expected to offset increases or potentially lower employee premiums and state expenditures by \$47 million in 2027 and potentially increasing to over \$160 million per year by 2029.

Additional state expenditures are anticipated to cover agency administrative expenses for oversight and compliance activities. HCA also expects the potential for additional health plan expenses in the first year to adapt provider contracts.

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**BILL REQUEST - CODE REVISER'S OFFICE**

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BILL REQ. #: Z-0050.3/25 3rd draft

ATTY/TYPIST: KS:lel

BRIEF DESCRIPTION: Ensuring access to primary care, behavioral health, and affordable hospital services.

1 AN ACT Relating to ensuring access to primary care, behavioral  
2 health, and affordable hospital services; and adding a new section to  
3 chapter 41.05 RCW.

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

5 NEW SECTION. **Sec. 1.** A new section is added to chapter 41.05  
6 RCW to read as follows:

7 (1) For purposes of this section, "contractor" means a health  
8 carrier that provides medical insurance offered to public employees  
9 and their covered dependents under this chapter, or a third-party  
10 administrator contracted by the authority to provide medical coverage  
11 to public employees under this chapter.

12 (2) Upon a good faith offer from a contractor, a hospital  
13 licensed under chapter 70.41 RCW that receives payment for services  
14 through any program administered by the authority under chapter 74.09  
15 RCW must contract with that contractor. This subsection does not  
16 apply to a hospital owned and operated by a health maintenance  
17 organization licensed under chapter 48.46 RCW.

18 (3) Each contractor, for its health plans that provide medical  
19 coverage offered to public employees and their covered dependents,  
20 must meet the following requirements:

21 (a) Beginning January 1, 2027:



1 (i) Except as provided in (a)(ii) of this subsection,  
2 reimbursement to any provider or facility for inpatient and  
3 outpatient hospital services may not exceed the lesser of billed  
4 charges, the contractor's contracted rate for the provider, or 200  
5 percent of the total amount medicare would have reimbursed for the  
6 same or similar services;

7 (ii) Reimbursement to any provider or facility for inpatient and  
8 outpatient hospital services provided at a specialty hospital  
9 primarily engaged in the care and treatment of children may not  
10 exceed the lesser of billed charges, the contractor's contracted rate  
11 for the provider, or 350 percent of the total amount medicare would  
12 have reimbursed providers and facilities for the same or similar  
13 services;

14 (iii) Reimbursement for services provided by rural hospitals  
15 certified by the centers for medicare and medicaid services as  
16 critical access hospitals or sole community hospitals may not be less  
17 than 101 percent of allowable costs as defined by the United States  
18 centers for medicare and medicaid services for purposes of medicare  
19 cost reporting;

20 (iv) Reimbursement for primary care services, as defined by the  
21 authority, may not be less than 150 percent of the amount that would  
22 have been reimbursed under the medicare program for the same or  
23 similar services; and

24 (v) Reimbursement for nonfacility-based behavioral health  
25 services, as defined by the authority, may not be less than 150  
26 percent of the amount that would have been reimbursed under the  
27 medicare program for the same or similar services.

28 (b) Beginning January 1, 2029:

29 (i) Except as provided in (b)(ii) of this subsection,  
30 reimbursement to any provider or facility for inpatient and  
31 outpatient hospital services may not exceed the lesser of billed  
32 charges, the contractor's contracted rate for the provider, or 190  
33 percent of the total amount medicare would have reimbursed providers  
34 and facilities for the same or similar services; and

35 (ii) Reimbursement to any provider or facility for inpatient and  
36 outpatient hospital services provided at a specialty hospital  
37 primarily engaged in the care and treatment of children may not  
38 exceed the lesser of billed charges, the contractor's contracted rate  
39 for the provider, or 300 percent of the total amount medicare would

1 have reimbursed the providers and facilities for the same or similar  
2 services.

3 (4) Nothing in this section prohibits a contractor from  
4 reimbursing a hospital through a nonfee-for-service payment  
5 methodology, so long as the payments incentivize higher quality or  
6 improved health outcomes and the contractor continues to comply with  
7 the reimbursement requirements in this section.

8 (5) Premiums must take into account changes in reimbursement for  
9 hospital, primary care, and behavioral health services anticipated to  
10 result from the application of this section.

11 (6) At the request of the authority for monitoring, enforcement,  
12 or program and quality improvement activities, a contractor must  
13 provide cost and quality of care information and data to the  
14 authority and may not enter into an agreement with a provider or  
15 third party that would restrict the contractor from providing this  
16 information or data.

17 (7) By December 31, 2030, the authority, in consultation with the  
18 office of the insurance commissioner, shall provide a report to the  
19 governor's office and relevant committees of the legislature  
20 analyzing the initial impacts of this section on network access,  
21 enrollee premiums, and state expenditures for medical coverage  
22 offered to public employees under this chapter. The report may  
23 include recommendations for legislative changes to the policy  
24 established in this section.

25 (8) The authority may adopt rules to implement this section,  
26 including rules for levying fines and taking other contract actions  
27 it deems necessary to enforce compliance with this section.

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# Washington State All Payer Claims Database (WA-APCD)

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- Removes the definition and references of “proprietary financial information” in the WA-APCD statute ([RCW 43.371](#)) to align with federal transparency requirements.
- Permits HCA to either contract for a Lead Organization (LO) through a competitive procurement process or act as the LO.
- Adjusts reporting timelines for OFM from biennially to every five years.

## Summary

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WA-APCD is a tool used to collect health care claims data for reporting and to develop analytics that help the public make informed health care decisions. The WA-APCD remains an integral component of Washington’s health care improvement efforts, serving as a reliable source of claims data proven essential to promoting transparency and implementing initiatives around cost and quality.

State law requires most health plans in Washington State to submit claims data to the WA-APCD. **The proposed changes will not change the scope of information that the WA-APCD already receives, nor the existing protections around the distribution and use of protected health information (PHI).**

HCA’s proposal aligns the statutory treatment of claims paid amounts with federal price transparency requirements published in 2020. Under this proposal, claims data that contains specific reimbursement arrangements and negotiated rates between providers/facilities and insurers would not constitute proprietary financial information. This change would allow policymakers and the public broader access to claims data already required to be publicly disclosed.

## Background

WA-APCD acts as a critical resource for the state’s Health Care Cost Transparency Board (Cost Board) efforts. Some of the work WA-APCD supports includes:

- Health care cost driver analysis for Cost Board.
- Analytic support initiative by the Institute for Health Metrics and Evaluation (IHME) to support the Cost Board.
- RAND hospital repricing study to support Washington Health Benefit Exchange (HBE) and Cost Board.
- Balance Billing Protection Act-related analyses and reporting to support the Office of the Insurance Commissioner (OIC) and state law.
- Facility level price and quality transparency reporting on [WA-APCD website](#).

Under current state law, “proprietary financial information” in the WA-APCD can be disclosed only to researchers with institutional review board (IRB) approval; federal, state, Tribal, and local governments; any entity when functioning as the LO; and the HBE, despite recent federal rules requiring that contracted rates between payers and providers be made publicly available.

Federal requirements bring health care service pricing into the public domain; however, the data publicly disclosed by Transparency in Coverage (TiC) regulations does not provide insight into how services are utilized, at what frequency, and by which populations. In addition, TiC regulations do not indicate how rates are changing over time and contributing to cost growth – work supported by the WA-APCD.

As part of the procurement process for the WA-APCD lead organization (LO), HCA contracted with Manatt to perform a national landscape analysis. In Manatt's report "[Strengths, Weaknesses, Opportunities, and Threats](#)" analysis, one of the identified weaknesses is the state law prohibition on the public release of proprietary financial information.

### **Fiscal impact**

HCA's proposal does not have a fiscal impact. However, we are also requesting a Decision Package to address the anticipated budget shortfall for HCA to have enough funds to procure an LO or continue to act as the LO for the WA-APCD.

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**BILL REQUEST - CODE REVISER'S OFFICE**

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BILL REQ. #: Z-0047.3/25 3rd draft

ATTY/TYPIST: MW:akl

BRIEF DESCRIPTION: Modernizing the all payers claim database.

1       AN ACT Relating to modernizing the all payers claims database by  
2       updating reporting requirements, data disclosure standards, and lead  
3       organization requirements; and amending RCW 43.371.010, 43.371.020,  
4       43.371.050, 43.371.060, 43.371.070, and 43.371.090.

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

6       **Sec. 1.** RCW 43.371.010 and 2019 c 319 s 2 are each amended to  
7       read as follows:

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

10       (1) "Authority" means the health care authority.

11       (2) "Carrier" and "health carrier" have the same meaning as in  
12       RCW 48.43.005.

13       (3) "Claims data" means the data required by RCW 43.371.030 to be  
14       submitted to the database, including billed, allowed and paid  
15       amounts, and such additional information as defined by the director  
16       in rule.

17       (4) "Data supplier" means: (a) A carrier, third-party  
18       administrator, or a public program identified in RCW 43.371.030 that  
19       provides claims data; and (b) a carrier or any other entity that  
20       provides claims data to the database at the request of an employer-

sponsored self-funded health plan or Taft-Hartley trust health plan pursuant to RCW 43.371.030(1).

(5) "Data vendor" means an entity contracted to perform data collection, processing, aggregation, extracts, analytics, and reporting.

(6) "Database" means the statewide all-payer health care claims database established in RCW 43.371.020.

(7) "Direct patient identifier" means a data variable that directly identifies an individual, including: Names; telephone numbers; fax numbers; social security number; medical record numbers; health plan beneficiary numbers; account numbers; certificate or license numbers; vehicle identifiers and serial numbers, including license plate numbers; device identifiers and serial numbers; web universal resource locators; internet protocol address numbers; biometric identifiers, including finger and voice prints; and full face photographic images and any comparable images.

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

(9) "Indirect patient identifier" means a data variable that may identify an individual when combined with other information.

(10) "Lead organization" means the organization selected under RCW 43.371.020.

(11) "Office" means the office of financial management.

~~(12) ("Proprietary financial information" means claims data or reports that disclose or would allow the determination of specific terms of contracts, discounts, or fixed reimbursement arrangements or other specific reimbursement arrangements between an individual health care facility or health care provider, as those terms are defined in RCW 48.43.005, and a specific payer, or internal fee schedule or other internal pricing mechanism of integrated delivery systems owned by a carrier.~~

~~(13))~~ "Unique identifier" means an obfuscated identifier assigned to an individual represented in the database to establish a basis for following the individual longitudinally throughout different payers and encounters in the data without revealing the individual's identity.

**Sec. 2.** RCW 43.371.020 and 2024 c 54 s 54 are each amended to read as follows:

(1) The office shall establish a statewide all-payer health care claims database. On January 1, 2020, the office must transfer

1 authority and oversight for the database to the authority. The office  
2 and authority must develop a transition plan that sustains operations  
3 by July 1, 2019. The database shall support transparent public  
4 reporting of health care information. The database must improve  
5 transparency to: Assist patients, providers, and hospitals to make  
6 informed choices about care; enable providers, hospitals, and  
7 communities to improve by benchmarking their performance against that  
8 of others by focusing on best practices; enable purchasers to  
9 identify value, build expectations into their purchasing strategy,  
10 and reward improvements over time; and promote competition based on  
11 quality and cost. The database must systematically collect all  
12 medical claims and pharmacy claims from private and public payers,  
13 with data from all settings of care that permit the systematic  
14 analysis of health care delivery.

15 (2) The authority (~~((shall use))~~) may act as the lead organization,  
16 or select a lead organization from among the best potential bidders  
17 using a competitive procurement process, in accordance with chapter  
18 39.26 RCW, (~~((to select a lead organization from among the best~~  
19 ~~potential bidders))~~) to coordinate and manage the database.

20 (a)(i) In conducting the competitive procurement, the authority  
21 must ensure that no state officer or state employee participating in  
22 the procurement process:

23 (A) Has a current relationship or had a relationship within the  
24 last three years with any organization that bids on the procurement  
25 that would constitute a conflict with the proper discharge of  
26 official duties under chapter 42.52 RCW; or

27 (B) Is a compensated or uncompensated member of a bidding  
28 organization's board of directors, advisory committee, or has held  
29 such a position in the past three years.

30 (ii) If any relationship or interest described in (a)(i) of this  
31 subsection is discovered during the procurement process, the officer  
32 or employee with the prohibited relationship must withdraw from  
33 involvement in the procurement process.

34 (b) Due to the complexities of the all-payer claims database and  
35 the unique privacy, quality, and financial objectives, the authority  
36 must give strong consideration to the following elements in  
37 determining the appropriate lead organization contractor: (i) The  
38 organization's degree of experience in health care data collection,  
39 analysis, analytics, and security; (ii) whether the organization has  
40 a long-term self-sustainable financial model; (iii) the



1 organization's experience in convening and effectively engaging  
2 stakeholders to develop reports, especially among groups of health  
3 providers, carriers, and self-insured purchasers; (iv) the  
4 organization's experience in meeting budget and timelines for report  
5 generations; and (v) the organization's ability to combine cost and  
6 quality data to assess total cost of care.

7 (c) The successful lead organization must apply to be certified  
8 as a qualified entity pursuant to 42 C.F.R. Sec. 401.703(a) by the  
9 centers for medicare and medicaid services.

10 (d) The authority may not select a lead organization that:

11 (i) Is a health plan as defined by and consistent with the  
12 definitions in RCW 48.43.005;

13 (ii) Is a hospital as defined in RCW 70.41.020;

14 (iii) Is a provider regulated under Title 18 RCW;

15 (iv) Is a third-party administrator as defined in RCW 70.290.010;  
16 or

17 (v) Is an entity with a controlling interest in any entity  
18 covered in (d)(i) through (iv) of this subsection.

19 (3) As part of the competitive procurement process referenced in  
20 subsection (2) of this section, the lead organization shall enter  
21 into a contract with a data vendor or multiple data vendors to  
22 perform data collection, processing, aggregation, extracts, and  
23 analytics. A data vendor must:

24 (a) Establish a secure data submission process with data  
25 suppliers;

26 (b) Review data submitters' files according to standards  
27 established by the authority;

28 (c) Assess each record's alignment with established format,  
29 frequency, and consistency criteria;

30 (d) Maintain responsibility for quality assurance, including, but  
31 not limited to: (i) The accuracy and validity of data suppliers'  
32 data; (ii) accuracy of dates of service spans; (iii) maintaining  
33 consistency of record layout and counts; and (iv) identifying  
34 duplicate records;

35 (e) Assign unique identifiers, as defined in RCW 43.371.010, to  
36 individuals represented in the database;

37 (f) Ensure that direct patient identifiers(~~(7)~~) and indirect  
38 patient identifiers(~~(, and proprietary financial information)~~) are  
39 released only in compliance with the terms of this chapter;

1 (g) Demonstrate internal controls and affiliations with separate  
2 organizations as appropriate to ensure safe data collection, security  
3 of the data with state of the art encryption methods, actuarial  
4 support, and data review for accuracy and quality assurance;

5 (h) Store data on secure servers that are compliant with the  
6 federal health insurance portability and accountability act and  
7 regulations, with access to the data strictly controlled and limited  
8 to staff with appropriate training, clearance, and background checks;  
9 and

10 (i) Maintain state of the art security standards for transferring  
11 data to approved data requestors.

12 (4) The lead organization and data vendor must submit detailed  
13 descriptions to Washington technology solutions to ensure robust  
14 security methods are in place. Washington technology solutions must  
15 report its findings to the authority and the appropriate committees  
16 of the legislature.

17 (5) The lead organization is responsible for internal governance,  
18 management, funding, and operations of the database. At the direction  
19 of the authority, the lead organization shall work with the data  
20 vendor to:

21 (a) Collect claims data from data suppliers as provided in RCW  
22 43.371.030;

23 (b) Design data collection mechanisms with consideration for the  
24 time and cost incurred by data suppliers and others in submission and  
25 collection and the benefits that measurement would achieve, ensuring  
26 the data submitted meet quality standards and are reviewed for  
27 quality assurance;

28 (c) Ensure protection of collected data and store and use any  
29 data in a manner that protects patient privacy and complies with this  
30 section. All patient-specific information must be deidentified with  
31 an up-to-date industry standard encryption algorithm;

32 (d) Consistent with the requirements of this chapter, make  
33 information from the database available as a resource for public and  
34 private entities, including carriers, employers, providers,  
35 hospitals, and purchasers of health care;

36 (e) Report performance on cost and quality pursuant to RCW  
37 43.371.060 using, but not limited to, the performance measures  
38 developed under RCW 41.05.690;

1 (f) Develop protocols and policies, including prerelease peer  
2 review by data suppliers, to ensure the quality of data releases and  
3 reports;

4 (g) Develop a plan for the financial sustainability of the  
5 database as may be reasonable and customary as compared to other  
6 states' databases and charge fees for reports and data files as  
7 needed to fund the database. Any fees must be approved by the  
8 authority and should be comparable, accounting for relevant  
9 differences across data requests and uses. The lead organization may  
10 not charge providers or data suppliers fees other than fees directly  
11 related to requested reports and data files; and

12 (h) Convene advisory committees with the approval and  
13 participation of the authority, including: (i) A committee on data  
14 policy development; and (ii) a committee to establish a data release  
15 process consistent with the requirements of this chapter and to  
16 provide advice regarding formal data release requests. The advisory  
17 committees must include in-state representation from key provider,  
18 hospital, public health, health maintenance organization, large and  
19 small private purchasers, consumer organizations, and the two largest  
20 carriers supplying claims data to the database.

21 (6) The lead organization governance structure and advisory  
22 committees for this database must include representation of the  
23 third-party administrator of the uniform medical plan. A payer,  
24 health maintenance organization, or third-party administrator must be  
25 a data supplier to the all-payer health care claims database to be  
26 represented on the lead organization governance structure or advisory  
27 committees.

28 **Sec. 3.** RCW 43.371.050 and 2019 c 319 s 5 are each amended to  
29 read as follows:

30 (1) Except as otherwise required by law, claims or other data  
31 from the database shall only be available for retrieval in processed  
32 form to public and private requesters pursuant to this section and  
33 shall be made available within a reasonable time after the request.  
34 Each request for claims data must include, at a minimum, the  
35 following information:

36 (a) The identity of any entities that will analyze the data in  
37 connection with the request;

1 (b) The stated purpose of the request and an explanation of how  
2 the request supports the goals of this chapter set forth in RCW  
3 43.371.020(1);

4 (c) A description of the proposed methodology;

5 (d) The specific variables requested and an explanation of how  
6 the data is necessary to achieve the stated purpose described  
7 pursuant to (b) of this subsection;

8 (e) How the requester will ensure all requested data is handled  
9 in accordance with the privacy and confidentiality protections  
10 required under this chapter and any other applicable law;

11 (f) The method by which the data will be destroyed at the  
12 conclusion of the data use agreement;

13 (g) The protections that will be utilized to keep the data from  
14 being used for any purposes not authorized by the requester's  
15 approved application; and

16 (h) Consent to the penalties associated with the inappropriate  
17 disclosures or uses of direct patient identifiers((~~7~~)) or indirect  
18 patient identifiers(~~((, or proprietary financial information))~~) adopted  
19 under RCW 43.371.070(1).

20 (2) The lead organization may decline a request that does not  
21 include the information set forth in subsection (1) of this section  
22 that does not meet the criteria established by the lead  
23 organization's data release advisory committee, or for reasons  
24 established by rule.

25 (3) Except as otherwise required by law, the authority shall  
26 direct the lead organization and the data vendor to maintain the  
27 confidentiality of claims or other data it collects for the database  
28 that include (~~((proprietary financial information,))~~) direct patient  
29 identifiers, indirect patient identifiers, or any combination  
30 thereof. Any entity that receives claims or other data must also  
31 maintain confidentiality and may only release such claims data or any  
32 part of the claims data if:

33 (a) The claims data does not contain (~~((proprietary financial  
34 information,))~~) direct patient identifiers, indirect patient  
35 identifiers, or any combination thereof; and

36 (b) The release is described and approved as part of the request  
37 in subsection (1) of this section.

38 (4) The lead organization shall, in conjunction with the  
39 authority and the data vendor, create and implement a process to

1 govern levels of access to and use of data from the database  
2 consistent with the following:

3 (a) Claims or other data that include (~~proprietary financial~~  
4 ~~information,~~) direct patient identifiers, indirect patient  
5 identifiers, unique identifiers, or any combination thereof may be  
6 released only to the extent such information is necessary to achieve  
7 the goals of this chapter set forth in RCW 43.371.020(1) to  
8 researchers with approval of an institutional review board upon  
9 receipt of a signed data use and confidentiality agreement with the  
10 lead organization. A researcher or research organization that obtains  
11 claims data pursuant to this subsection must agree in writing not to  
12 disclose such data or parts of the data set to any other party,  
13 including affiliated entities, and must consent to the penalties  
14 associated with the inappropriate disclosures or uses of direct  
15 patient identifiers(~~(,)~~) or indirect patient identifiers(~~(, — or~~  
16 ~~proprietary financial information)~~) adopted under RCW 43.371.070(1).

17 (b) Claims or other data that do not contain direct patient  
18 identifiers, but that may contain (~~proprietary financial~~  
19 ~~information,~~) indirect patient identifiers, unique identifiers, or  
20 any combination thereof may be released to:

21 (i) Federal, state, tribal, and local government agencies upon  
22 receipt of a signed data use agreement with the authority and the  
23 lead organization(~~(. — Federal, state, tribal, and local government~~  
24 ~~agencies that obtain claims data pursuant to this subsection are~~  
25 ~~prohibited from using such data in the purchase or procurement of~~  
26 ~~health benefits for their employees))~~);

27 (ii) Any entity when functioning as the lead organization under  
28 the terms of this chapter; (~~and~~)

29 (iii) The Washington health benefit exchange established under  
30 chapter 43.71 RCW, upon receipt of a signed data use agreement with  
31 the authority and the lead organization as directed by rules adopted  
32 under this chapter; and

33 (iv) Agencies, researchers, and other entities as approved by the  
34 lead organization upon receipt of a signed data use agreement with  
35 the authority and the lead organization.

36 (~~Claims or other data that do not contain proprietary~~  
37 ~~financial information, direct patient identifiers, or any combination~~  
38 ~~thereof, but that may contain indirect patient identifiers, unique~~  
39 ~~identifiers, or a combination thereof may be released to agencies,~~  
40 ~~researchers, and other entities as approved by the lead organization~~

1 upon receipt of a signed data use agreement with the lead  
2 organization.

3 ~~(d))~~ Claims or other data that do not contain direct patient  
4 identifiers, indirect patient identifiers, ~~((proprietary financial~~  
5 ~~information,))~~ or any combination thereof may be released upon  
6 request.

7 (5) Reports utilizing data obtained under this section may not  
8 contain ~~((proprietary financial information,))~~ direct patient  
9 identifiers, indirect patient identifiers, or any combination  
10 thereof. Nothing in this subsection (5) may be construed to prohibit  
11 the use of geographic areas with a sufficient population size or  
12 aggregate gender, age, medical condition, or other characteristics in  
13 the generation of reports, so long as they cannot lead to the  
14 identification of an individual.

15 ~~(6) ((Reports issued by the lead organization at the request of~~  
16 ~~providers, facilities, employers, health plans, and other entities as~~  
17 ~~approved by the lead organization may utilize proprietary financial~~  
18 ~~information to calculate aggregate cost data for display in such~~  
19 ~~reports. The authority shall approve by rule a format for the~~  
20 ~~calculation and display of aggregate cost data consistent with this~~  
21 ~~chapter that will prevent the disclosure or determination of~~  
22 ~~proprietary financial information. In developing the rule, the~~  
23 ~~authority shall solicit feedback from the stakeholders, including~~  
24 ~~those listed in RCW 43.371.020(5)(h), and must consider, at a~~  
25 ~~minimum, data presented as proportions, ranges, averages, and~~  
26 ~~medians, as well as the differences in types of data gathered and~~  
27 ~~submitted by data suppliers.~~

28 ~~(7))~~ Recipients of claims or other data under subsection (4) of  
29 this section must agree in a data use agreement or a confidentiality  
30 agreement to, at a minimum:

31 (a) Take steps to protect data containing direct patient  
32 identifiers, indirect patient identifiers, ~~((proprietary financial~~  
33 ~~information,))~~ or any combination thereof as described in the  
34 agreement;

35 (b) Not redisclose the claims data except pursuant to subsection  
36 (3) of this section;

37 (c) Not attempt to determine the identity of any person whose  
38 information is included in the data set or use the claims or other  
39 data in any manner that identifies any individual or their family or  
40 attempt to locate information associated with a specific individual;

(d) Destroy claims data at the conclusion of the data use agreement; and

(e) Consent to the penalties associated with the inappropriate disclosures or uses of direct patient identifiers((7)) or indirect patient identifiers((~~7~~ or proprietary financial information)) adopted under RCW 43.371.070(1).

**Sec. 4.** RCW 43.371.060 and 2020 c 131 s 1 are each amended to read as follows:

(1)(a) Under the supervision of and through contract with the authority, the lead organization shall prepare health care data reports using the database and the statewide health performance and quality measure set. Prior to the lead organization releasing any health care data reports that use claims data, the lead organization must submit the reports to the authority for review.

(b) By October 31st of each year, the lead organization shall submit to the director a list of reports it anticipates producing during the following calendar year. The director may establish a public comment period not to exceed thirty days, and shall submit the list and any comment to the appropriate committees of the legislature for review.

(2)(a) Health care data reports that use claims data prepared by the lead organization for the legislature and the public should promote awareness and transparency in the health care market by reporting on:

(i) Whether providers and health systems deliver efficient, high quality care; and

(ii) Geographic and other variations in medical care and costs as demonstrated by data available to the lead organization.

(b) Measures in the health care data reports should be stratified by demography, income, language, health status, and geography when feasible with available data to identify disparities in care and successful efforts to reduce disparities.

(c) Comparisons of costs among providers and health care systems must account for differences in the case mix and severity of illness of patients and populations, as appropriate and feasible, and must take into consideration the cost impact of subsidization for uninsured and government-sponsored patients, as well as teaching expenses, when feasible with available data.

(3) The lead organization may not publish any data or health care data reports that:

- (a) Directly or indirectly identify individual patients;
- (b) ~~((Disclose a carrier's proprietary financial information;~~  
~~(e)))~~ Compare performance in a report generated for the general public that includes any provider in a practice with fewer than four providers; or
- ~~((d)))~~ (c) Contain medicaid data that is in direct conflict with the biannual medicaid forecast.

(4) The lead organization may not release a report that compares and identifies providers, hospitals, or data suppliers unless:

(a) It allows the data supplier, the hospital, or the provider to verify the accuracy of the information submitted to the data vendor, comment on the reasonableness of conclusions reached, and submit to the lead organization and data vendor any corrections of errors with supporting evidence and comments within thirty days of receipt of the report;

(b) It corrects data found to be in error within a reasonable amount of time; and

(c) The report otherwise complies with this chapter.

(5) The authority and the lead organization may use claims data to identify and make available information on payers, providers, and facilities, but may not use claims data to recommend or incentivize direct contracting between providers and employers.

(6) The lead organization shall make information about claims data related to the provision of air ambulance service available on a website that is accessible to the public in a searchable format by geographic region, provider, and other relevant information.

(7)(a) The lead organization shall distinguish in advance to the authority when it is operating in its capacity as the lead organization and when it is operating in its capacity as a private entity. Where the lead organization acts in its capacity as a private entity, it may only access data pursuant to RCW 43.371.050(4) (b) ~~((r)))~~ (iv) or (c) ~~((r or (d)))~~.

(b) Except as provided in RCW 43.371.050(4), claims or other data that contain direct patient identifiers ~~((or proprietary financial information))~~ must remain exclusively in the custody of the data vendor and may not be accessed by the lead organization.



1       **Sec. 5.** RCW 43.371.070 and 2019 c 319 s 7 are each amended to  
2 read as follows:

3       (1) The director shall adopt any rules necessary to implement  
4 this chapter, including:

5       (a) Definitions of claim and data files that data suppliers must  
6 submit to the database, including: Files for covered medical  
7 services, pharmacy claims, and dental claims; member eligibility and  
8 enrollment data; and provider data with necessary identifiers;

9       (b) Deadlines for submission of claim files;

10       (c) Penalties for failure to submit claim files as required;

11       (d) Procedures for ensuring that all data received from data  
12 suppliers are securely collected and stored in compliance with state  
13 and federal law;

14       (e) Procedures for ensuring compliance with state and federal  
15 privacy laws;

16       (f) Procedures for establishing appropriate fees;

17       (g) Procedures for data release;

18       (h) Penalties associated with the inappropriate disclosures or  
19 uses of direct patient identifiers((~~r~~)) and indirect patient  
20 identifiers((~~r and proprietary financial information~~)); and

21       (i) A minimum reporting threshold below which a data supplier is  
22 not required to submit data.

23       (2) The director may not adopt rules, policies, or procedures  
24 beyond the authority granted in this chapter.

25       **Sec. 6.** RCW 43.371.090 and 2024 c 54 s 50 are each amended to  
26 read as follows:

27       (1) To ensure the database is meeting the needs of state agencies  
28 and other data users, the authority shall convene a state agency  
29 coordinating structure, consisting of state agencies with related  
30 data needs and the Washington health benefit exchange to ensure  
31 effectiveness of the database and the agencies' programs. The  
32 coordinating structure must collaborate in a private/public manner  
33 with the lead organization and other partners key to the broader  
34 success of the database. The coordinating structure shall advise the  
35 authority and lead organization on the development of any database  
36 policies and rules relevant to agency data needs.

37       (2) The office must participate as a key part of the coordinating  
38 structure and evaluate progress towards meeting the goals of the  
39 database, and, as necessary, recommend strategies for maintaining and

1 promoting the progress of the database in meeting the intent of this  
2 section, and report its findings ((~~biennially~~)) every five years to  
3 the governor and the legislature. The authority shall facilitate the  
4 office obtaining the information needed to complete the report in a  
5 manner that is efficient and not overly burdensome for the parties.  
6 The authority must provide the office with access to database  
7 processes, procedures, nonproprietary methodologies, and outcomes to  
8 conduct the review and issue the ((~~biennial~~)) five-year report. The  
9 ((~~biennial~~)) five-year review shall assess, at a minimum the  
10 following:

11 (a) The list of approved agency use case projects and related  
12 data requirements under RCW 43.371.050(4);

13 (b) Successful and unsuccessful data requests and outcomes  
14 related to agency and nonagency health researchers pursuant to RCW  
15 43.371.050(4);

16 (c) Online data portal access and effectiveness related to  
17 research requests and data provider review and reconsideration;

18 (d) Adequacy of data security and policy consistent with the  
19 policy of Washington technology solutions; and

20 (e) Timeliness, adequacy, and responsiveness of the database with  
21 regard to requests made under RCW 43.371.050(4) and for potential  
22 improvements in data sharing, data processing, and communication.

23 (3) To promote the goal of improving health outcomes through  
24 better cost and quality information, the authority, in consultation  
25 with the agency coordinating structure, the office, lead  
26 organization, and data vendor shall make recommendations to the  
27 Washington state performance measurement coordinating committee as  
28 necessary to improve the effectiveness of the state common measure  
29 set as adopted under RCW 70.320.030.

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# Care coordination

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Allows counselors, marriage and family therapists, and social workers to share patient information with other providers when operating in their professional capacity.

## Summary

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Amends RCW [18.225.105](#) and [18.19.180](#) to permit disclosure of information when otherwise permitted by RCW [70.02](#), Washington's omnibus health care information access and disclosure rule for medical records.

## Background

RCW 18.225.105 and RCW 18.19.180 restrict the sharing of patient information amongst providers. Providers have notified the Health Care Authority (HCA) that these restrictions limit care coordination and create barriers to treatment.

Currently, counselors, marriage and family therapists, and social workers receive information about a patient from other licensed practitioners, yet they cannot share that same information with other providers without the patient's consent (with very narrow exceptions).

This makes information sharing for these providers far more restricted than [Health Insurance Portability and Accountability Act \(HIPAA\)](#) rules. Valid patient consent cannot always be reasonably obtained, which is why HIPAA allows for sharing without consent for treatment and health care operations.

## Equity

Underserved and marginalized communities need more care and better care coordination. Removing the barriers to information sharing would allow frontline providers to better serve vulnerable communities.

## Fiscal impact

No fiscal impact.

See table on the next page for when disclosure is permitted.

# Care coordination

## When is disclosure permitted?

Law	Summary	Who must comply?	Protected info
HIPAA	<ul style="list-style-type: none"> <li>National standard protecting sensitive patient health information from being disclosed without the patient's consent or knowledge, subject to certain exceptions.</li> </ul>	<ul style="list-style-type: none"> <li>Health care providers</li> <li>Health plans</li> <li>Health care clearinghouses</li> <li>Business associates</li> </ul>	<ul style="list-style-type: none"> <li>Protected health information (PHI)</li> <li>Health records, including: <ul style="list-style-type: none"> <li>Electronic</li> <li>Paper</li> <li>Oral</li> </ul> </li> </ul>
RCW 70.02	<p>The Uniform Health Care Information Act (UHCIA):</p> <ul style="list-style-type: none"> <li>Provides confidentiality protection for medical records and patients' health care information (HCI).</li> <li>Requires consent in most cases for release of records or disclosure of information, subject to certain exceptions.</li> </ul>	<ul style="list-style-type: none"> <li>Health care providers</li> </ul>	<ul style="list-style-type: none"> <li>HCI functions very similarly to PHI.</li> <li>HCI means any information, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a patient and directly relates to the patient's health care.</li> </ul>
RCW 18.225/.19.180	<ul style="list-style-type: none"> <li>Specific state laws that prohibit professionals licensed under these laws from sharing any information acquired from other health care providers in nearly all circumstances, with very specific exceptions.</li> <li>These laws are much more restrictive than HIPAA or RCW 70.02.</li> </ul>	<ul style="list-style-type: none"> <li>Mental health counselors</li> <li>Marriage and family therapists</li> <li>Social workers</li> <li>Counselors</li> </ul>	

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**BILL REQUEST - CODE REVISER'S OFFICE**

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BILL REQ. #: Z-0675.1/24

ATTY/TYPIST: CC:jlb

BRIEF DESCRIPTION: Addressing the disclosure of health information  
for care coordination.

1       AN ACT Relating to addressing the disclosure of health  
2 information for care coordination; and amending RCW 18.225.105 and  
3 18.19.180.

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

5       **Sec. 1.** RCW 18.225.105 and 2020 c 302 s 115 are each amended to  
6 read as follows:

7       A person licensed under this chapter shall not disclose the  
8 written acknowledgment of the disclosure statement pursuant to RCW  
9 18.225.100, nor any information acquired from persons consulting the  
10 individual in a professional capacity when the information was  
11 necessary to enable the individual to render professional services to  
12 those persons except:

13       (1) With the written authorization of that person or, in the case  
14 of death or disability, the person's personal representative;

15       (2) If the person waives the privilege by bringing charges  
16 against the person licensed under this chapter;

17       (3) In response to a subpoena from the secretary. The secretary  
18 may subpoena only records related to a complaint or report under RCW  
19 18.130.050;

20       (4) As required under chapter 26.44 or 74.34 RCW or RCW 71.05.217  
21 (6) and (7); ((~~or~~))

1       (5) When disclosure of health care information is permitted under  
2 chapter 70.02 RCW; or

3       (6) To any individual if the person licensed under this chapter  
4 reasonably believes that disclosure will avoid or minimize an  
5 imminent danger to the health or safety of the individual or any  
6 other individual; however, there is no obligation on the part of the  
7 provider to so disclose.

8       **Sec. 2.** RCW 18.19.180 and 2023 c 425 s 17 are each amended to  
9 read as follows:

10       An individual credentialed under this chapter shall not disclose  
11 the written acknowledgment of the disclosure statement pursuant to  
12 RCW 18.19.060 nor any information acquired from persons consulting  
13 the individual in a professional capacity when that information was  
14 necessary to enable the individual to render professional services to  
15 those persons except:

16       (1) With the written consent of that person or, in the case of  
17 death or disability, the person's personal representative, other  
18 person authorized to sue, or the beneficiary of an insurance policy  
19 on the person's life, health, or physical condition;

20       (2) That a person credentialed under this chapter is not required  
21 to treat as confidential a communication that reveals the  
22 contemplation or commission of a crime or harmful act;

23       (3) If the person is a minor, and the information acquired by the  
24 person credentialed under this chapter indicates that the minor was  
25 the victim or subject of a crime, the person credentialed may testify  
26 fully upon any examination, trial, or other proceeding in which the  
27 commission of the crime is the subject of the inquiry;

28       (4) If the person waives the privilege by bringing charges  
29 against the person credentialed under this chapter;

30       (5) In response to a subpoena from a court of law or the  
31 secretary. The secretary may subpoena only records related to a  
32 complaint or report under chapter 18.130 RCW; ~~((or))~~

33       (6) As required under chapter 26.44 RCW; or

34       (7) When disclosure of health care information is permitted under  
35 chapter 70.02 RCW.

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- Aligns the authority for offering certain optional supplemental benefits between the Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) programs.
- Removes the requirement that the PEB Board offer a group long-term care (LTC) insurance product.

## Summary

The SEB Board can provide numerous optional benefits, so long as they are employee-paid and voluntary. Prior to implementing SEBB, many school districts offered additional benefits. During SEBB implementation, these benefits were incorporated as voluntary offerings.

This bill aligns the benefits-offering authority for the PEB Board as it currently exists for the SEB Board. This includes the ability for the PEB Board to offer voluntary and employee-paid LTC insurance and property, accident, or casualty insurance.

- Emergency transportation
- Identity protection
- Legal aid
- LTC insurance
- Noncommercial personal automobile insurance
- Personal homeowner's or renter's insurance
- Pet insurance
- Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance
- Travel insurance

This would allow the PEB Board to maintain authority to offer property insurance, accident and casualty insurance, and LTC insurance as an optional, employee-paid benefit, along with several potential insurance product lines that the SEB Board already has authority to offer.

## LTC insurance

Since 1998, the PEB Board has been required by [RCW 41.05.065 \(10\)](#) to offer LTC insurance as a voluntary benefit to PEBB members. However, since 2014, PEBB has not been able to comply with the statute due to a lack of any large-group market LTC insurance products being offered in the state. PEBB annually checks with the Office of the Insurance Commissioner to determine whether there are any large-group LTC plans being offered in Washington.

Additionally, since enactment of the original PEBB LTC requirement, the state has established the WA Cares program, which offers statewide LTC insurance, including for PEBB and SEBB members.

## Fiscal impact

There are no fiscal impacts for this bill. The PEB Board's ability to offer any additional benefits is subject to the availability of funding to study and procure a new benefit. Any new benefit offered under this new authority would be fully paid for by the employee.



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**BILL REQUEST - CODE REVISER'S OFFICE**

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BILL REQ. #: Z-0142.1/25

ATTY/TYPIST: KS:eab

BRIEF DESCRIPTION: Concerning benefits authorized to be offered by  
the public employees' benefits board.

1       AN ACT Relating to benefits authorized to be offered by the  
2 public employees' benefits board; and amending RCW 41.05.065.

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

4       **Sec. 1.** RCW 41.05.065 and 2018 c 260 s 12 are each amended to  
5 read as follows:

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

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

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

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

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

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

15 (e) Effective coordination of benefits; and

16 (f) Minimum standards for insuring entities.

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

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

39 (a) Except as provided in (b) through (e) of this subsection, an  
40 employee is eligible for benefits from the date of employment if the

1 employing agency anticipates he or she will work an average of at  
2 least eighty hours per month and for at least eight hours in each  
3 month for more than six consecutive months. An employee determined  
4 ineligible for benefits at the beginning of his or her employment  
5 shall become eligible in the following circumstances:

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

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

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

31 (c) Faculty are eligible as follows:

32 (i) Faculty who the employing agency anticipates will work half-  
33 time or more for the entire instructional year or equivalent nine-  
34 month period are eligible for benefits from the date of employment.  
35 Eligibility shall continue until the beginning of the first full  
36 month of the next instructional year, unless the employment  
37 relationship is terminated, in which case eligibility shall cease the  
38 first month following the notice of termination or the effective date  
39 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):

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

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

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

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

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

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

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

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

32 (j) Except for an employee eligible for benefits under (b) or  
33 (c)(ii) of this subsection, an employee who has established  
34 eligibility for benefits under this section shall remain eligible for  
35 benefits each month in which he or she is in pay status for eight or  
36 more hours, if (i) he or she remains in a benefits-eligible position  
37 and (ii) leave from the benefits-eligible position is approved by the  
38 employing agency. A benefits-eligible seasonal employee is eligible  
39 for the employer contribution in any month of his or her season in  
40 which he or she is in pay status eight or more hours during that

1 month. Eligibility ends if these conditions are not met, the  
2 employment relationship is terminated, or the employee voluntarily  
3 transfers to a noneligible position.

4 (k) For the purposes of this subsection, the public employees'  
5 benefits board shall define "benefits-eligible position."

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

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

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

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

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

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

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

36 (8) Employees shall choose participation in one of the health  
37 care benefit plans developed by the public employees' benefits board  
38 and may be permitted to waive coverage under terms and conditions  
39 established by the public employees' benefits board.

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

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

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

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



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

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

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

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

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

35 (11)) In addition to the benefits offering authority under this  
36 chapter, the public employees' benefits board may study, establish  
37 evaluation criteria, and, subject to the availability of funding,  
38 offer the following employee-paid, voluntary benefits:

39 (a) Emergency transportation;

40 (b) Identity protection;

1       (c) Legal aid;  
2       (d) Long-term care insurance;  
3       (e) Noncommercial personal automobile insurance;  
4       (f) Personal homeowner's or renter's insurance;  
5       (g) Pet insurance;  
6       (h) Specified disease or illness-triggered fixed payment  
7 insurance, hospital confinement fixed payment insurance, or other  
8 fixed payment insurance offered as an independent, noncoordinated  
9 benefit regulated by the office of the insurance commissioner; and  
10       (i) Travel insurance.

11       (10) The public employees' benefits board may establish penalties  
12 to be imposed by the authority when the eligibility determinations of  
13 an employing agency fail to comply with the criteria under this  
14 chapter.

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