2590-S AMH SPRE H4499.6

SHB 2590 - H AMD **0063 FAILED 2/12/92**
By Representative Sprenkle

Strike everything after the enacting clause and insert the following:

"PART I

FINDINGS AND DEFINITIONS"

"NEW SECTION. **Sec. 101.** (1) The legislature finds that comprehensive, appropriate, and affordable health services should be available to all Washington residents. The legislature further finds that the extraordinary health services available to most Washington state residents both in quality and timeliness are not available to many in an affordable, timely, or dignified manner, and that the costs of the existing system have created an unsustainable burden to individuals, business, and government.

(2) The legislature further finds that the existing system lacks the ability to provide affordable, high quality services because of the design of the health services delivery system and other important factors, which include:

(a) An aging population and public expectations of the health care system;

(b) New technologies for diagnosis and treatment;

(c) Unhealthy lifestyles related specifically to diet, lack of exercise, stress, and inappropriate or excessive use of tobacco products, and drugs and alcohol;

(d) Defensive medicine;

(e) New disease conditions, such as AIDS; and

(f) The lack of incentives for most health services providers and consumers to use health services cost-effectively.

(3) The legislature recognizes that without obtaining optimum value for the money spent on health services, universal access will not be achievable. A substantial increase in value can be achieved by modifying current health services reimbursement, and altering the type and amount of copayment and premium responsibilities held by individuals.

(4) The legislature finds there are two major approaches to managing health services costs -- strict regulation of providers, or giving individuals and providers much more financial accountability in health care decision making. Significantly greater choice and flexibility for individuals and providers can be maintained through accountability, than through regulation.

(5) The legislature further finds that changes in the health services system must make every effort to sustain and encourage those aspects of the current system that result in high technical quality and consumer responsiveness, while eliminating inefficiencies and inequities.

(6) The legislature further finds that individuals, employers, and providers who currently have or provide affordable access to quality care, highly value that right, and that change should be accomplished in a manner that permits ongoing evaluation and modification in order to accomplish system transformation with as little disruption and as much continuity as possible.

(7) The legislature further finds that most employers that provide health care coverage assume a disproportionate share of costs as compared to other industrialized nations and that if an employment-

based health insurance system is to be used, all employers should participate, with sensitivity to their ability to pay.

(8) The legislature further finds that all health services consumers must share in the cost of health services according to their ability to pay and that, to the extent possible, no individual or employer should be confronted with the threat of extreme financial hardship because of the cost of health services.

(9) The legislature recognizes that comprehensive strategies should be developed to eliminate those aspects of defensive medicine that add to the cost, but not the quality of health services. While the Washington state health care cost control and access commission is developing such strategies, the legislature finds that the development and implementation of practice parameters is one part of a comprehensive strategy that should be undertaken.

(10) The legislature further finds that the existing health services delivery system is incapable of providing cost-effective services and that although much, if not all, of the additional costs of providing universal access might be achieved through increasing its efficiency, this will require time and, at least initially, additional revenue will be required to expand access and reconfigure the existing delivery system."

"NEW SECTION. **Sec. 102.** DEFINITIONS. As used in this chapter and sections 402 through 414 of this act, unless the context clearly requires otherwise:

(1) "Capitated rate" means the level of payment for provision of a health care benefits package, paid to an organized delivery system, on a monthly basis, for each individual enrolled in such organized delivery system.

(2) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment or surgical facilities licensed under chapter 70.41 RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations, but does not include Christian Science sanatoriums operated, listed, or certified by the First Church of Christ Scientist, Boston, Massachusetts.

(3) "Health care provider" or "provider" means either:

(a) A physician licensed under chapter 18.71 or 18.57 RCW or any other licensed, certified, or registered health professional regulated under chapter 18.130 RCW who the commission identifies as appropriate to provide health services;

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(4) "Insurer" means a disability group insurer regulated under chapter 48.21 or 48.22 RCW, a health care services contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020.

(5) "Organized delivery system" means a health care organization, composed of health care providers, health care facilities, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract to an insurer, to the state, or to a private purchaser, a health care benefits package, and rendered by health care providers, for a prepaid,

capitated rate to a defined patient population on or after July 1, 1992. Physicians participating in an organized delivery system shall be financially at risk for utilization of pharmaceuticals, laboratory and radiological services, procedures, and inpatient and outpatient health care facilities by the patients of such system, or the employer of such physicians shall be financially at risk for such services.

(6) "Standard uniform benefits package" means health services and benefits defined by the state health policy council pursuant to section 202 of this act."

"PART II

STATE AND REGIONAL HEALTH POLICY COUNCILS"

"NEW SECTION. **Sec. 201.** (1) There is established the state health policy council composed of thirteen members. Twelve members shall be appointed by the governor and confirmed by the senate. In addition, the administrator of the health care authority or the administrator's designee shall serve as a member. In making these appointments, the governor shall ensure that one-third of the members represent health care purchasers, one-third of the members represent health care consumers, one of which represents public health interests, and one-third of the members represent health care providers and health care facilities. Of the appointed members, at least one shall be selected from each of the congressional districts in Washington state. Members shall serve four-year terms. Of the initial members appointed to the council, four shall serve for two years, four shall serve for three years, and four shall serve for four years. Thereafter, members shall be appointed to four-year terms. Vacancies shall be filled by appointment for the remainder of the unexpired term of the position being vacated. The chair of the council shall serve at the pleasure of

the governor and shall be a member other than the administrator of the health care authority.

(2) The members, exclusive of the chair and the administrator of the health care authority, shall be compensated as provided in RCW 43.03.250. The members, exclusive of the chair and the administrator of the health care authority, shall be reimbursed for travel expenses as provided in RCW 43.03.050 and 43.03.060.

(3) The chair of the council shall be a full-time employee responsible for the administration of all functions of the council, including hiring and terminating staff, contracting, coordinating with the governor, the legislature, and other state and local entities, and the delegation of responsibilities as deemed appropriate. The salary of the chair shall be fixed by the governor, subject to RCW 43.03.040.

(4) The chair shall prepare a budget and a work plan, which are subject to review and approval by the council."

"NEW SECTION. **Sec. 202.** The council shall have the following powers and duties:

(1) To implement, in conjunction with the state and federal governments and medical specialty organizations, giving priority to those practice areas (a) with the highest costs; or (b) making the greatest contribution to malpractice liability premiums and defensive medicine costs, practice parameters for purposes of inclusion in the standard uniform benefits package developed pursuant to subsection (4) of this section;

(2) To establish total annual health care services expenditure targets using comprehensive data from previous years. In carrying out this duty, the council shall define health services cost centers in categories that permit the development of cost identification and cost control strategies, by individual health service and collectively. The

1993 expenditure target shall be based on total health services expenditures in Washington for calendar year 1991, adjusted for the amount of actual growth in total health care services expenditures between 1991 and 1992 as determined by the office of financial management. Thereafter, the expenditure target shall be allowed to grow by no more than the amount of actual growth in total health care services expenditures between 1991 and 1992, minus two percentage points per year for each succeeding year until the annual rate of increase is no greater than the growth in the United States consumer price index plus real per capita income growth, as determined by the office of financial management. The council shall develop a two-year plan and a six-year plan to keep total health expenditures within the targets established in this subsection, and report these plans to appropriate committees of the legislature on or before January 1, 1994;

(3) To monitor the actual growth in total annual health care costs and report to appropriate committees of the legislature by September 1 of each year, beginning in 1994, on the extent to which health care costs for the previous calendar year deviated from the expenditure targets set forth in subsection (2) of this section;

(4) To establish a proposed standard uniform benefits package for all Washington state residents for submission to the legislature on or before January 1, 1994, which would constitute the minimum benefits package that could be offered by private insurers. The council shall be guided by the following criteria in establishing or revising the standard uniform benefits package:

(a) Proven preventive strategies should be incorporated in the package;

(b) Highest priority should be given to appropriate and effective health services that improve the health of the overall population;

(c) Individuals should share in the costs of health services based on their ability to pay, as an incentive to appropriately utilize health services;

(5) To establish procedures to determine the specific schedule of health services to be included in the standard uniform benefits package. To assist the council in this task, it may periodically establish health service review panels for specified periods of time to review existing information on need, efficacy, and cost-effectiveness of specific services and treatments. These panels shall take into consideration available practice parameters and information relating to appropriate use of expensive technology;

(6) To establish standards prohibiting conflict of interest by health care providers. These standards shall be designed to control inappropriate behavior by health care providers that results in financial gain at the expense of consumers, insurers or purchasers, and shall specifically address payments for laboratory and radiology services. These standards shall not apply to health care services provided through an organized delivery system, and they are not intended to inhibit the efficient operation of other health care providers;

(7) To provide ample opportunity for public participation in initial development of the standard uniform benefits package, and to provide, on a biannual basis, for public participation in a review of the scope of the standard uniform benefits package. Regional health policy councils established as provided in section 205 of this act shall be an integral part of the public participation plan developed by the council;

(8) To establish strategies to address major health care cost centers, including but not limited to use of pharmaceuticals,

application of new or expensive technologies and procedures, and intensive management of extremely ill persons;

(9) To develop guidelines for appropriate and consistent utilization review procedures;

(10) To enter into, amend, and terminate contracts with individuals, corporations, or research institutions for the purposes of this chapter;

(11) To receive such gifts, grants, and endowments, in trust or otherwise, for the use and benefit of the purposes of the council. The council may expend the same or any income therefrom according to the terms of the gifts, grants, or endowments;

(12) To conduct studies and research necessary to carry out the duties of the council;

(13) To obtain information regarding health services cost, delivery, and utilization from state and local agencies, boards, and commissions;

(14) To adopt necessary rules in accordance with chapter 34.05 RCW to carry out the purposes of this chapter; and

(15) To prepare a biennial budget request for consideration by the governor and the legislature."

"NEW SECTION. **Sec. 203.** The council shall develop and adopt criteria for a personal health services data and information system or systems that support its purposes under this chapter and that are operated and maintained by the department of health. As part of the design stage for this development, the council shall consider the personal health services data needed by consumers, purchasers, payers, employers, and health services providers including that currently collected by public or private entities in the state.

To the extent practicable, the criteria shall be consistent with any requirements of the federal government in its administration of the medicare and medicaid programs. The criteria shall also be consistent with any requirements of state and local health agencies in their roles of gathering and analyzing public health statistics and developing programs to address public health needs. The criteria should make use of, to the extent feasible, definitions and data elements from existing public or private health services data systems. The purpose of such coordination is to minimize any unduly burdensome reporting requirements imposed upon the public or private sources of such data."

"NEW SECTION. **Sec. 204.** A new section is added to chapter 70.170 RCW to read as follows:

(1) The department is responsible for the implementation and custody of a state-wide personal health services data and information system. The data elements, specifications, and other design features of this data system shall be consistent with criteria adopted by the state health policy council. The department shall provide the council with reasonable assistance in the development of these criteria, and shall provide the council with periodic progress reports related to the implementation of the system or systems related to those criteria.

(2) The department shall coordinate the development and implementation of the personal health services data and information system with related private activities and with the implementation activities of the data sources identified by the council. Such coordination may include contracts with existing public or private data systems for reporting or managing required data sets. The department shall assist the council in establishing reasonable timeframes for the completion of system development and system implementation."

"NEW SECTION. **Sec. 205.** (1) On or before January 1, 1993, each local public health department or health district in the state of Washington shall establish a regional health policy council composed of not less than seven members. In counties served by local public health departments, members shall be appointed by the county legislative authority for such county. In counties that are part of a public health district, members shall be appointed by the board of health for such district. In making these appointments, the county legislative authority or board of health shall ensure that two of the members represent health care purchasers, three of the members represent health care consumers, one of which represents public health interests, and two of the members represent health care providers and health care facilities. The chair of the council shall be selected from among its members by the members.

(2) Regional health policy councils shall have the following duties:

(a) To advise the state health policy council on the development or acquisition of new facilities and new technologies, to be located in the jurisdiction of the public health department or health district, that require major capital investment or will have an immediate or significant potential impact on health services delivery costs;

(b) To identify shortages of health care practitioners and health services in the jurisdiction of the council and to report such findings to the state health policy council;

(c) To advise the state health policy council on problems of access to health services in the jurisdiction of the council;

(d) To advise the state health policy council on such other matters as the state council deems necessary."

"NEW SECTION. **Sec. 206.** (1) The members of each regional health policy council shall be reimbursed for travel expenses as provided in RCW 43.03.050 and 43.03.060.

(2) Such travel expenses shall be charged to and paid from the budget of the state health policy council."

"NEW SECTION. **Sec. 207.** A new section is added to chapter 4.24 RCW to read as follows:

(1) The state health policy council established under section 201 of this act, in consultation with obstetrical medical specialty organizations and appropriate governmental entities, shall develop practice parameters in obstetrics for purposes of the health care liability demonstration project set forth in this section. The obstetrical practice parameters shall define appropriate clinical indications and methods of treatment. The parameters shall be consistent with appropriate standards of care and levels of quality. On or before July 1, 1993, the medical disciplinary board shall review the parameters, approve the parameters, and adopt them as rules under chapter 34.05 RCW.

(2) Any physician who practices obstetrics in Washington state shall file notice with the medical disciplinary board on or before November 1, 1993, indicating whether he or she elects to participate in the project.

(3) In any claim for professional negligence against a participating physician or the employer of a participating physician that is related to the practice of obstetrics, in which a violation of a standard of care is alleged, the practice parameters developed and adopted under this section shall constitute the standard of care. The practice parameters may be introduced into evidence by the plaintiff as

the standard of care, and by the participating physician or the participating physician's employer as an affirmative defense.

(4) Nothing in this section alters the burdens of proof in existence as of June 30, 1993, in professional negligence proceedings.

(5) This section applies to causes of action accruing after January 1, 1994."

"NEW SECTION. **Sec. 208.** The legislative budget committee, in consultation with the health care policy committees of the legislature, shall conduct directly or by a contract a study to determine the desirability and feasibility of consolidating the following program services into the standard uniform benefits package established pursuant to section 202 of this act:

(1) Medical services in the worker's compensation program of the department of labor and industries; and

(2) Long-term care services in the developmental disabilities, mental health, and aging and adult services programs of the department of social and health services.

The report shall be made to the governor, and the appropriate committees of the legislature and the council by September 1, 1993."

"PART III

ACCESS

BASIC HEALTH PLAN"

"**Sec. 301.** RCW 70.47.010 and 1987 1st ex.s. c 5 s 3 are each amended to read as follows:

(1) The legislature finds that:

(a) A significant percentage of the population of this state does not have reasonably available insurance or other coverage of the costs of necessary basic health care services;

(b) This lack of basic health care coverage is detrimental to the health of the individuals lacking coverage and to the public welfare, and results in substantial expenditures for emergency and remedial health care, often at the expense of health care providers, health care facilities, and all purchasers of health care, including the state; and

(c) The use of managed health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state generally, and by low-income pregnant women who are an especially vulnerable population, along with their children, and who need greater access to managed health care.

(2) The purpose of this chapter is to provide necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization of necessary health care services. To that end, this chapter establishes a program to be made available to those residents under sixty-five years of age not otherwise eligible for medicare with gross family income at or below two hundred percent of the federal poverty guidelines who share in the cost of receiving basic health care services from a managed health care system.

(3) It is not the intent of this chapter to provide health care services for those persons who are presently covered through private employer-based health plans, nor to replace employer-based health plans. Further, it is the intent of the legislature to expand, wherever possible, the availability of private health care coverage and to discourage the decline of employer-based coverage.

(4) ((~~The program authorized under this chapter is strictly limited in respect to the total number of individuals who may be allowed to~~

~~participate and the specific areas within the state where it may be established. All such restrictions or limitations shall remain in full force and effect until quantifiable evidence based upon the actual operation of the program, including detailed cost benefit analysis, has been presented to the legislature and the legislature, by specific act at that time, may then modify such limitations~~)) (a) It is the purpose of this chapter to acknowledge the initial success of this program that has (i) assisted thousands of families in their search for affordable health care; (ii) demonstrated that low-income uninsured families are willing, indeed eager, to pay for their own health care coverage to the extent of their ability to pay; and (iii) proved that local health care providers are willing to enter into a public/private partnership as they configure their own professional and business relationships into a managed health care system.

(b) As a consequence, but always limited to the extent to which funds might be available to subsidize the costs of health services for those in need, enrollment limitations have been modified and the program shall be expanded to additional geographic areas of the state. In addition, the legislature intends to extend an option to enroll to certain citizens with gross family income of less than three hundred percent of the federal poverty level within the state who reside in communities where the plan is operational and who wish to exercise the opportunity to purchase health care coverage through the program if it is done at no cost to the state."

"**Sec. 302.** RCW 70.47.020 and 1987 1st ex.s. c 5 s 4 are each amended to read as follows:

As used in this chapter:

(1) "Washington basic health plan" or "plan" means the system of enrollment and payment on a prepaid capitated basis for basic health

care services, administered by the plan administrator through participating managed health care systems, created by this chapter.

(2) "Administrator" means the Washington basic health plan administrator.

(3) "Managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the administrator and rendered by duly licensed providers, on a prepaid capitated basis to a defined patient population enrolled in the plan and in the managed health care system.

(4) "Enrollee" means an individual, or an individual plus the individual's spouse and/or dependent children, all under the age of sixty-five and not otherwise eligible for medicare, who resides in an area of the state served by a managed health care system participating in the plan, whose gross family income at the time of enrollment does not exceed twice the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services, who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan. Nonsubsidized enrollees shall be considered enrollees unless otherwise specified.

(5) "Nonsubsidized enrollee" includes any enrollee who originally enrolled subject to the income limitations specified in subsection (4) of this section, but who subsequently pays the full unsubsidized premium as set forth in RCW 70.47.060(9); and an individual, or an individual plus the individual's spouse and/or dependent children all under the age of sixty-five and not otherwise eligible for medicare who resides in an area of the state served by a managed health care system participating in the plan, has gross family income of less than three

hundred percent of the federal poverty level and who chooses to obtain basic health care coverage from a particular managed health care system in return for payment of the full unsubsidized premium, as set forth in RCW 70.47.060 (10) and (11).

(6) "Subsidy" means the difference between the amount of periodic payment the administrator makes((~~, from funds appropriated from the basic health plan trust account,~~)) to a managed health care system on behalf of an enrollee plus the administrative cost to the plan of providing the plan to that enrollee, and the amount determined to be the enrollee's responsibility under RCW 70.47.060(2).

((~~(6)~~)) (7) "Premium" means a periodic payment, based upon gross family income and determined under RCW 70.47.060(2), which an enrollee makes to the plan as consideration for enrollment in the plan.

((~~(7)~~)) (8) "Rate" means the per capita amount, negotiated by the administrator with and paid to a participating managed health care system, that is based upon the enrollment of enrollees in the plan and in that system."

"**Sec. 303.** RCW 70.47.030 and 1991 sp.s. c 13 s 68 and 1991 sp.s. c 4 s 1 are each reenacted and amended to read as follows:

(1) The basic health plan trust account is hereby established in the state treasury. ((~~All~~)) Any nongeneral fund-state funds collected for this program shall be deposited in the basic health plan trust account and may be expended without further appropriation. Moneys in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of enrollees in the plan and payment of costs of administering the plan. After July 1, 1991, the administrator shall not expend or encumber for an ensuing fiscal period amounts exceeding ninety-five

percent of the amount anticipated to be spent for purchased services during the fiscal year.

(2) The basic health plan subscription account is created in the custody of the state treasurer. Moneys in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of nonsubsidized enrollees in the plan and payment of costs of administering the plan. The account is subject to allotment procedures under chapter 43.88 RCW, but no appropriation is required for expenditures.

(3) The administrator shall take every precaution to see that none of the moneys in the separate accounts created in this section or that any premiums paid by either subsidized or nonsubsidized enrollees are commingled in any way."

"**Sec. 304.** RCW 70.47.060 and 1991 sp.s. c 4 s 2 and 1991 c 3 s 339 are each reenacted and amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, and other services that may be necessary for basic health care, which enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care, shall include all services necessary for prenatal, postnatal, and well-child care, and shall include a separate schedule of basic health care services for children, eighteen years of age and younger, for those enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the

guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.42.080, and such other factors as the administrator deems appropriate. On or after July 1, 1995, the standard uniform benefits package adopted pursuant to section 202 of this act shall be implemented by the administrator as the schedule of covered basic health care services.

(2)(a) To design and implement a structure of periodic premiums due the administrator from enrollees that is based upon gross family income, giving appropriate consideration to family size as well as the ages of all family members. The enrollment of children shall not require the enrollment of their parent or parents who are eligible for the plan. A third party may pay the premium, rate, or other amount determined by the administrator on behalf of any enrollee, by arrangement with the enrollee, and through a mechanism acceptable to the administrator.

(b) Any premium, rate, or other amount determined to be due from nonsubsidized enrollees shall be in an amount equal to the amount negotiated by the administrator with the participating managed health care system for the plan plus the administrative cost of providing the plan to those enrollees.

(3) To design and implement a structure of ((~~nominal~~)) copayments due a managed health care system from enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(4) To design and implement, in concert with a sufficient number of potential providers in a discrete area, an enrollee financial participation structure, separate from that otherwise established under this chapter, that has the following characteristics:

(a) ((~~Nominal~~)) Premiums that are based upon ability to pay, but not set at a level that would discourage enrollment;

(b) A ((~~modified fee-for-services~~)) payment schedule for providers;

(c) Coinsurance rates that are established based on specific service and procedure costs and the enrollee's ability to pay for the care. However, coinsurance rates for families with incomes below one hundred twenty percent of the federal poverty level shall be nominal. No coinsurance shall be required for specific proven prevention programs, such as prenatal care. The coinsurance rate levels ((~~shall~~)) should not have a measurable negative effect upon the enrollee's health status; and

(d) A case management system that fosters a provider-enrollee relationship whereby, in an effort to control cost, maintain or improve the health status of the enrollee, and maximize patient involvement in her or his health care decision-making process, every effort is made by the provider to inform the enrollee of the cost of the specific services and procedures and related health benefits.

The potential financial liability of the plan to any such providers shall not exceed in the aggregate an amount greater than that which might otherwise have been incurred by the plan on the basis of the number of enrollees multiplied by the average of the prepaid capitated rates negotiated with participating managed health care systems under RCW 70.47.100 and reduced by any sums charged enrollees on the basis of the coinsurance rates that are established under this subsection.

(5) To limit enrollment of persons who qualify for subsidies so as to prevent an overexpenditure of appropriations for such purposes. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment until the administrator finds the danger no longer exists.

(6) To adopt a schedule for the orderly development of the delivery of services and availability of the plan to residents of the state, subject to the limitations contained in RCW 70.47.080 or any act appropriating funds for the plan.

In the selection of any area of the state for ((~~the initial~~)) operation of the plan, the administrator shall take into account the levels and rates of unemployment in different areas of the state, the need to provide basic health care coverage to a population reasonably representative of the portion of the state's population that lacks such coverage, and the need for geographic, demographic, and economic diversity.

Before July 1, ((~~1988~~)) 1994, the administrator shall endeavor to secure participation contracts with managed health care systems in ((~~discrete geographic areas within at least five~~)) all congressional districts.

(7) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state.

(8) To receive periodic premiums from enrollees, deposit them in the basic health plan operating account, keep records of enrollee status, and authorize periodic payments to managed health care systems

on the basis of the number of enrollees participating in the respective managed health care systems.

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and at least annually thereafter, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. An enrollee who remains current in payment of the sliding-scale premium, as determined under subsection (2) of this section, and whose gross family income has risen above twice the federal poverty level but is less than three hundred percent of the federal poverty level, may continue enrollment ((~~unless and until the enrollee's gross family income has remained above twice the poverty level for six consecutive months,~~)) by making full payment at the unsubsidized rate required for the managed health care system in which he or she may be enrolled plus the administrative cost of providing the plan to that enrollee. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to re-enroll in the plan.

(10) To accept applications from small business owners with less than fifty employees regularly scheduled to work more than twenty hours per week for at least twenty-six weeks per year, on behalf of themselves and their employees who reside in an area served by the plan subject to the following conditions and limitations:

(a) Employees enrolled must be under sixty-five years of age and not otherwise eligible for medicare;

(b) Employees enrolled must have gross family income of less than three hundred percent of the federal poverty level;

(c) The administrator may require that all or a substantial majority of the eligible employees of any such small business enroll in the plan and establish such other procedures as may be necessary to facilitate the orderly enrollment of such groups in the plan and into a managed health care system;

(d) Any small business choosing to enroll its employees in the plan must pay, at a minimum, fifty percent of the monthly amount determined to be due to the plan by the administrator for each employee and his or her eligible dependents. The administrator shall adjust the amount determined to be due on behalf of or from all such enrollees whenever the amount negotiated by the administrator with the participating managed health care system or systems is modified or the administrative cost of providing the plan to such enrollees changes. Any amounts due under this subsection shall be deposited in the basic health plan subscription account; and

(e) Enrolled employees of small business groups who have gross family income of less than two hundred percent of the federal poverty level shall receive a subsidy from the plan for an income-adjusted portion of the amount that is the enrollee’s responsibility as a member of such small business group. Enrolled employees of small business groups who have gross family income greater than two hundred percent of the federal poverty level, but less than three hundred percent of the federal poverty level shall be a nonsubsidized enrollee.

(11) On and after July 1, 1994, to accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, who have gross

family income of less than three hundred percent of the federal poverty level, are under sixty-five years of age and not otherwise eligible for medicare, who wish to enroll in the plan at no cost to the state, and who choose to obtain basic health care coverage and services from a managed health care system participating in the plan. Any such nonsubsidized enrollee must pay the plan whatever amount is negotiated by the administrator with the participating managed health care system and the administrative cost of providing the plan to such enrollees and shall not be eligible for any subsidy from the plan.

(12) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the administrator shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant.

((~~(11)~~)) (13) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed

health care systems and to the ((~~administrator~~)) plan. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

((~~(12)~~)) (14) To monitor the access that state residents have to adequate and necessary health care services, determine the extent of any unmet needs for such services or lack of access that may exist from time to time, and make such reports and recommendations to the legislature as the administrator deems appropriate.

((~~(13)~~)) (15) To evaluate the effects this chapter has on private employer-based health care coverage and to take appropriate measures consistent with state and federal statutes that will discourage the reduction of such coverage in the state.

((~~(14)~~)) (16) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

((~~(15)~~)) (17) To provide, consistent with available resources, technical assistance for rural health activities that endeavor to develop needed health care services in rural parts of the state."

"**Sec. 305.** RCW 70.47.080 and 1987 1st ex.s. c 5 s 10 are each amended to read as follows:

On and after July 1, 1988, the administrator shall accept for enrollment applicants eligible to receive covered basic health care services from the respective managed health care systems which are then participating in the plan. ((~~The administrator shall not allow the total enrollment of those eligible for subsidies to exceed thirty thousand.~~))

Thereafter, ((~~total~~)) average monthly subsidized enrollment of those eligible for subsidies during any biennium shall not exceed the

number established by the legislature in any act appropriating funds to the plan, and total subsidized enrollment shall not result in expenditures that exceed the total amount that has been made available by the legislature in any act appropriating funds to the plan.

Before July 1, ((~~1988~~)) 1994, the administrator shall endeavor to secure participation contracts from managed health care systems in ((~~discrete geographic areas within at least five~~)) all congressional districts of the state and in such manner as to allow residents of both urban and rural areas access to enrollment in the plan. The administrator shall make a special effort to secure agreements with health care providers in one such area that meets the requirements set forth in RCW 70.47.060(4).

The administrator shall at all times closely monitor growth patterns of enrollment so as not to exceed that consistent with the orderly development of the plan as a whole, in any area of the state or in any participating managed health care system.

The annual or biennial enrollment limitations derived from operation of the plan under this section do not apply to nonsubsidized enrollees as defined in RCW 70.47.020(5)."

"**Sec. 306.** RCW 70.47.120 and 1987 1st ex.s. c 5 s 14 are each amended to read as follows:

In addition to the powers and duties specified in RCW 70.47.040 and 70.47.060, the administrator has the power to enter into contracts for the following functions and services:

(1) With public or private agencies, to assist the administrator in her or his duties to design or revise the schedule of covered basic health care services, and/or to monitor or evaluate the performance of participating managed health care systems.

(2) With public or private agencies, to provide technical or professional assistance to health care providers, particularly public or private nonprofit organizations and providers serving rural areas, who show serious intent and apparent capability to participate in the plan as managed health care systems.

(3) With public or private agencies, including health care service contractors registered under RCW 48.44.015, and doing business in the state, for marketing and administrative services in connection with participation of managed health care systems, enrollment of enrollees, billing and collection services to the administrator, and other administrative functions ordinarily performed by health care service contractors, other than insurance except that the administrator may purchase or arrange for the purchase of reinsurance, or self-insure for reinsurance, on behalf of its participating managed health care systems. Any activities of a health care service contractor pursuant to a contract with the administrator under this section shall be exempt from the provisions and requirements of Title 48 RCW."

"NEW SECTION. **Sec. 307.** The following acts or parts of acts are each repealed:

(1) RCW 43.131.355 and 1987 1st ex.s. c 5 s 24; and

(2) RCW 43.131.356 and 1987 1st ex.s. c 5 s 25."

"PART IV

HEALTH INSURANCE REFORM"

"NEW SECTION. **Sec. 401.** The legislature finds that in order to make the cost of health coverage more affordable and accessible to individuals and to businesses and their employees, certain marketing and underwriting practices by disability insurers, health care service

contractors, and health maintenance organizations must be reformed and more aggressively regulated. Such reforms work in the public interest and guarantee coverage to individuals, and businesses, their employees and employees' dependents. Practices that hinder access to, affordability of, and equity in health insurance coverage are unacceptable.

It is the intent of the legislature to prohibit certain discriminatory practices, and to require that insurers use community rating methods, at least for individuals, and small business owners and their employees, that more broadly pool and distribute risk, which is a fundamental principle of health insurance coverage."

"NEW SECTION. **Sec. 402.** A new section is added to Title 48 RCW to read as follows:

For the purposes of sections 403, 404, and 405 of this act "small business entity" means a business that employs less than fifty individuals who reside in Washington state and are regularly scheduled to work at least twenty or more hours per week for at least twenty-six weeks per year. For purposes of determining the number of employees of an entity, all employees, owners, or principals of all branches and divisions of the principal entity shall be included and may not be segregated by division, job responsibilities, employment status, or on any other basis."

"NEW SECTION. **Sec. 403.** A new section is added to chapter 48.21 RCW to read as follows:

Every disability insurer that provides group disability insurance for health care services under this chapter shall make available to all individuals and business entities in this state the opportunity to enroll as an individual or a group in an insured plan without medical

underwriting except as provided in this section. Such plan shall: (1) Allow all such individuals and groups to continue participation on a guaranteed renewable basis; (2) not exclude or discriminate in rate making or in any other way against any category of business, trade, occupation, employment skill, or vocational or professional training; and (3) not exclude or discriminate in rate making or in any other way against any individual, or employee or dependent within a group on the basis of health status or condition. Disability insurers may adopt a differential rate based only upon actual costs of providing health care that are identifiable by age, sex, or on a major geographical basis, and may adopt exclusions for preexisting conditions limited to not more than six months and applicable only to those individuals who have not been insured in the previous three months and have not been continuously insured long enough to satisfy a six-month waiting period. In addition, every disability insurer shall allow individuals and small business entities the opportunity to enroll as a group in an insured plan that uses community rating to establish the premium and may extend to larger sized businesses a similar opportunity to be included within a community rated pool.

An individual or family member who participates as an employee member of a group covered under this section for more than six consecutive months who then terminates his or her employment relationship and wishes to continue the same amount of health care coverage in the same plan shall be allowed that opportunity on an individual or family basis, depending on the coverage provided during active employment. The cost of such individual conversion or continuation coverage shall not exceed one hundred five percent of the rate for active members of the group."

"NEW SECTION. **Sec. 404.** A new section is added to chapter 48.44 RCW to read as follows:

Every health care service contractor that provides coverage under group health care service contracts under this chapter shall make available to all individuals and business entities in this state the opportunity to enroll as an individual or a group in a health service contract without medical underwriting except as provided in this section. The health service contract shall: (1) Allow all such individuals and groups to continue participation on a guaranteed renewable basis; (2) not exclude or discriminate in rate making or in any other way against any category of business, trade, occupation, employment skill, or vocational or professional training; and (3) not exclude or discriminate in rate making or in any other way against any individual, or employee or employee's dependent within the group on the basis of health status or condition. Health care service contractors may adopt a differential rate based only upon actual costs of providing health care that are identifiable by age, sex, or on a major geographical basis, and may adopt exclusions for preexisting conditions limited to not more than six months and applicable only to those individuals who have not been insured in the previous three months and have not been continuously insured long enough to satisfy a six-month waiting period. In addition, every health care service contractor shall allow individuals and small business entities the opportunity to enroll as a group in an insured plan that uses community rating to establish the premium and may extend to larger sized businesses a similar opportunity to be included within a community rated pool.

An individual or family member who participates as an employee member of a group covered under this section for more than six consecutive months who then terminates his or her employment relationship and wishes to continue the same amount of health care

coverage in the same plan shall be allowed that opportunity on an individual or family basis, depending on the coverage provided during active employment. The cost of such individual conversion or continuation coverage shall not exceed one hundred five percent of the rate for active members of the group."

"NEW SECTION. **Sec. 405.** A new section is added to chapter 48.46 RCW to read as follows:

Every health maintenance organization that provides coverage under group health maintenance organization agreements under this chapter shall make available to all individuals and business entities in this state the opportunity to enroll as an individual or a group in a health maintenance organization agreement without medical underwriting except as provided in this section. Such agreements shall: (1) Allow all such individuals and groups to continue participation on a guaranteed renewable basis; (2) not exclude or discriminate in rate making or in any other way against any category of business, trade, occupation, employment skill, or vocational or professional training; and (3) not exclude or discriminate in rate making or in any other way against any individual, or employee or employee's dependent within the group on the basis of health status or condition. Such health maintenance organizations may adopt a differential rate based only upon actual costs of providing health care that are identifiable by age, sex, or on a major geographical basis, and may adopt exclusions for preexisting conditions limited to not more than six months and applicable only to those individuals who have not been insured in the previous three months and have not been continuously insured long enough to satisfy a six-month waiting period. In addition, every health maintenance organization shall allow individuals and small business entities the opportunity to enroll as a group in an insured plan that uses community

rating to establish the premium and may extend to larger sized businesses a similar opportunity to be included within a community rated pool.

An individual or family member who participates as an employee member of a group covered under this section for more than six consecutive months who then terminates his or her employment relationship and wishes to continue the same amount of health care coverage in the same plan shall be allowed that opportunity on an individual or family basis, depending on the coverage provided during active employment. The cost of such continuation or conversion coverage shall not exceed one hundred five percent of the rate for active members of the group."

"NEW SECTION. **Sec. 406.** A new section is added to chapter 48.21 RCW to read as follows:

Notwithstanding other sections of this chapter, beginning January 1, 1995, and thereafter, the standard uniform benefits package adopted pursuant to section 202 of this act and from time to time revised by the state health policy council shall become the minimum benefit package required of any policy under this chapter. The standard uniform benefits package shall be priced separately from any other benefits offered or contracted."

"NEW SECTION. **Sec. 407.** A new section is added to chapter 48.44 RCW to read as follows:

Notwithstanding other sections of this chapter, beginning January 1, 1995, and thereafter, the standard uniform benefits package adopted pursuant to section 202 of this act and from time to time revised by the state health policy council shall become the minimum benefit package required of any plan under this chapter. The standard uniform

benefits package shall be priced separately from any other benefits offered or contracted."

"NEW SECTION. **Sec. 408.** A new section is added to chapter 48.46 RCW to read as follows:

Notwithstanding other sections of this chapter, beginning January 1, 1995, and thereafter, the standard uniform benefits package adopted pursuant to section 202 of this act and from time to time revised by the state health policy council shall become the minimum benefit package required of any plan under this chapter. The standard uniform benefits package shall be priced separately from any other benefits offered or contracted."

"NEW SECTION. **Sec. 409.** A new section is added to Title 48 RCW to read as follows:

The insurance commissioner shall develop a reinsurance mechanism for organized delivery systems that does not impact the enrollee, enables insurers to share risk, and allows those insurers that assume the entire risk for their enrolles to opt out of the mechanism. It must support itself entirely from funds generated from the participating insurers."

"PART V

STATE-PURCHASED HEALTH SERVICES"

"**Sec. 501.** RCW 41.05.011 and 1990 c 222 s 2 are each amended to read as follows:

Unless the context clearly requires otherwise, the definitions in this section shall apply throughout this chapter.

(1) "Administrator" means the administrator of the authority.

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

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

(4) "Insuring entity" means an insurance carrier as defined in chapter 48.21 or 48.22 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.

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

(6) "Employee" includes all full-time and career seasonal 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; and includes any or all part-time and temporary employees under the terms and conditions established under this chapter by the authority; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature or of the legislative authority of any county, city, or town who are elected to office after February 20, 1970. "Employee" also includes employees of a county, municipality, or other political subdivision of the state if the legislative authority of the county, municipality, or other political subdivision of the state seeks and receives the approval of the authority to provide any of its insurance programs by contract with the

authority, as provided in RCW 41.04.205, and employees of a school district if the board of directors of the school district seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority as provided in RCW 28A.400.350.

(7) "Board" means the state employees' benefits board established under RCW 41.05.055.

(8) "Organized delivery system" means a health care organization, composed of health care providers, health care facilities, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract, an employee health care benefits plan under this chapter to a defined group of employees, for a prepaid, capitated rate on or after July 1, 1992. Physicians participating in an organized delivery system shall be financially at risk for utilization of pharmaceuticals, laboratory and radiological services, procedures, and inpatient and outpatient health care facilities by the patients of such system, or the employer of such physicians shall be financially at risk for such services."

"NEW SECTION. **Sec. 502.** A new section is added to chapter 41.05 RCW to read as follows:

(1) The state employees' benefits board shall develop an employee health care benefits plan, which shall be offered to employees as an optional plan, beginning July 1, 1993. The plan shall include the following:

(a) Categories of covered services equivalent to other health care benefits plans offered to employees;

(b) Financial participation in the cost of health care services, as follows:

(i) Premium sharing equal to fifty percent of the premium attributable to the plan;

(ii) Individual financial participation payments, including copayments of thirty percent for all health care services, supplies, and pharmaceuticals covered by the plan, other than preventive care and inpatient hospital services; and

(iii) Maximum annual out-of-pocket cost limits for individual financial participation, adjusted for total family income and family size. Financial participation in the cost of health care services under the plan shall not create barriers to the utilization of appropriate services;

(c) Establishment of individual medical accounts funded by the state for each employee participating in the plan, from which premiums and other out-of-pocket costs for health care services can be paid. The state’s monthly contribution to each employee’s individual medical account shall equal sixty percent of the capitated rate paid to an organized delivery system for the plan. Any annual unexpended balance shall be placed in the employee’s retirement account or carried over to the next year for health services expenses;

(d) Establishment of a revolving loan fund in the custody of the state treasurer. Expenditures from the fund may be used only to provide low-interest hardship loans to employees participating in the plan. Employees participating in the plan may apply for a loan from the fund to pay for health care services that exceed amounts in his or her individual medical account, but are less than his or her maximum annual out-of-pocket cost limit.

(2) To the greatest extent practicable, the health care authority shall offer the health care benefit plan developed pursuant to this section in the most populous counties of the state. The plan need not be offered state-wide."

"NEW SECTION. **Sec. 503.** A new section is added to chapter 41.05 RCW to read as follows:

(1) In addition to those requirements applicable to insurers set forth in Title 48 RCW, the health care authority shall develop certification standards for organized delivery systems consistent with the requirements and purposes of this act.

(2) The health care authority shall contract with at least one organized delivery system in each of the most populous counties of the state for the provision of health care benefits to employees. To the greatest extent possible, enrollment in one or more organized delivery systems shall be offered as a choice to employees state-wide. The health care authority shall develop strong financial incentives to encourage employee enrollment in organized delivery systems.

(3) Organized delivery systems shall receive payment for state employees' health care benefits plans through a capitated rate. The capitated rate paid to an organized delivery system established after July 1, 1992, shall be no less than the average per capita costs of care during fiscal year 1992 for enrollees in the existing health care authority indemnity plan, increased by eight per cent per annum for each of the first three years of the contract with the organized delivery system. For organized delivery systems established prior to July 1, 1992, and for all organized delivery systems that have contracted with the state for more than three years, the capitated rate for the health care benefit plan shall be no less than that offered by private employers for equivalent coverage. At regular and appropriate intervals, not to exceed one fiscal year, each organized delivery system will be retroactively reimbursed for those major medical expenses, such as transplants, major catastrophic injuries or illness and pregnancies, that occurred at a rate in excess of the actuarially predicted rate of occurrence upon which the capitated rate was based.

(4) To encourage the development of additional organized delivery system capacity, the health care authority shall work in cooperation with the basic health plan, the department of social and health services, and local school districts, to promote the development of new, and expansion of existing, organized delivery systems. The health care authority shall coordinate these activities state-wide."

"NEW SECTION. **Sec. 504.** A new section is added to chapter 41.05 RCW to read as follows:

For all employee health care benefit plans offered to employees that are not provided through an organized delivery system, the following requirements shall be established, effective July 1, 1993:

(1) For reimbursement of physician services, the medicare resource-based relative value scale at a conversion factor of one, adjusted for characteristics of the employee population, shall be adopted. Payments to physicians under this subsection shall be indexed annually to the United States consumer price index;

(2) To the extent to which such an approach is feasible and cost-effective, individual case management shall be used for high cost cases;

(3) As practice parameters are developed and adopted as provided in section 202 of this act, reimbursement will be provided only for services provided that are consistent with such parameters; and

(4) New diagnostic and therapeutic measures developed after July 1, 1992, that will increase, or have a significant likelihood of resulting in increased health services costs, may be reviewed by the health care authority before being eligible for reimbursement through an employee health care benefits plan."

"NEW SECTION. **Sec. 505.** A new section is added to chapter 41.05 RCW to read as follows:

Effective July 1, 1993, the health care authority shall implement uniform administrative procedures for health care benefit plans offered to employees under this chapter. The procedures shall address the following:

(1) Enrollment procedures;

(2) Reports to enrollees;

(3) Billing procedures, including the use of uniform billing forms;

(4) Claims payment procedures;

(5) Organized delivery systems and health care provider and facility contracting procedures; and

(6) Monitoring and auditing procedures."

"NEW SECTION. **Sec. 506.** (1) The health care authority, in cooperation with the basic health plan and the department of social and health services, shall develop a pilot project in at least two discrete geographic areas of the state. The pilot project shall offer a health care benefits plan with financial participation in the cost of health services by individual project participants who are eligible for the basic health plan or medical assistance at the levels set forth in section 502(1)(b) of this act. The pilot project shall be implemented on or before July 1, 1993. If a federal waiver authorizing the participation of medical assistance recipients in the pilot project has not been obtained by that date, the project shall be implemented without the participation of medical assistance recipients.

(2) On or before December 31, 1994, the health care authority shall report to appropriate committees of the legislature on the status and experience of the pilot project."

"NEW SECTION. **Sec. 507.** A new section is added to chapter 41.05 RCW to read as follows:

In carrying out its duties under this act, the health care authority shall make a continuing effort to utilize the services of private contractors."

"NEW SECTION. **Sec. 508.** A new section is added to chapter 41.05 RCW to read as follows:

Notwithstanding other provisions of this chapter, effective July 1, 1995, the standard uniform benefits package adopted pursuant to section 202 of this act and from time to time revised by the state health policy council shall become the benefit package offered to employees under this chapter."

"NEW SECTION. **Sec. 509.** A new section is added to chapter 28A.400 RCW to read as follows:

Notwithstanding other provisions of this chapter, effective July 1, 1995, the standard uniform benefits package adopted pursuant to section 202 of this act and from time to time revised by the state health policy council shall become the benefit package offered to school district employees under this chapter."

"NEW SECTION. **Sec. 510.** The health care authority shall evaluate the effects upon health care cost and access of the provisions of sections 501 through 505 of this act and shall submit its report to the legislature and the state health policy council no later than December 31, 1994."

"PART VI

MISCELLANEOUS"

"NEW SECTION. **Sec. 601.** Part headings as used in this act constitute no part of the law."

"NEW SECTION. **Sec. 602.** Sections 101, 102, 201 through 203, 205, 206, and 208 of this act shall constitute a new chapter in Title 70 RCW."

"NEW SECTION. **Sec. 603.** Sections 301 through 307 and 401 through 406 of this act shall take effect July 1, 1992."

"NEW SECTION. **Sec. 604.** 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."

SHB 2590 - H AMD
By Representative Sprenkle

On page 1, line 1 of the title, after "care;" strike the remainder of the title and insert "amending RCW 70.47.010, 70.47.020, 70.47.080, 70.47.120, and 41.05.011; reenacting and amending RCW 70.47.030 and 70.47.060; adding a new section to chapter 70.170 RCW; adding a new section to chapter 4.24 RCW; adding new sections to Title 48 RCW; adding new sections to chapter 48.21 RCW; adding new sections to chapter 48.44 RCW; adding new sections to chapter 48.46 RCW; adding new sections to chapter 41.05 RCW; adding a new section to chapter 28A.400 RCW; adding a new chapter to Title 70 RCW; creating new sections;

repealing RCW 43.131.355 and 43.131.356; and providing an effective date."