ENGROSSED SENATE BILL 6089

State of Washington 52nd Legislature 1992 Regular Session

By Senators West, M. Kreidler, Patterson, Bailey, Vognild, Madsen, Talmadge, Johnson and McMullen; by request of Governor Gardner

Read first time 01/15/92. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to health care; amending RCW 70.47.010, 70.47.020, 70.47.080, 70.47.120, 70.47.115, 41.05.011, 41.05.065, 70.170.010, 70.170.020, 70.170.030, 70.170.040, 70.170.050, 70.170.070, 70.170.100, 70.170.110, 7.70.070, 19.68.010, 41.04.250, 48.14.022, 48.41.040, 18.130.040, 18.130.175, 18.64.160, 18.64A.050, and 70.42.080; reenacting and amending RCW 70.47.030 and 70.47.060; adding new sections to chapter 74.09 RCW; adding new sections to chapter 41.05 RCW; adding new sections to chapter 70.170 RCW; adding a new section to chapter 18.130 RCW; adding a new section to chapter 48.20 RCW; adding a new section to chapter 48.21 RCW; adding a new section to chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; adding a new section to chapter 48.84 RCW; adding a new section to Title 51 RCW; adding a new section to chapter 18.64 RCW; adding a new section to chapter 18.64A RCW; adding a new section to chapter 70.47 RCW; adding a new section to chapter 7.70 RCW; adding new sections to chapter 43.70 RCW; adding a new section to chapter 82.04 RCW; adding a new section to

chapter 84.36 RCW; adding a new chapter to Title 48 RCW; adding a new chapter to Title 18 RCW; creating new sections; repealing RCW 18.64.260, 43.131.355, 43.131.356, and 70.170.080; prescribing penalties; providing effective dates; and declaring an emergency.

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

"TABLE OF CONTENTS

"PART I - HEALTH CARE COST AND ACCESS COMMISSION"

NEW SECTION. **Sec. 1.** DUTIES AND RESPONSIBILITIES. In addition to the duties and responsibilities specified in House Concurrent Resolution No. 4443 adopted by the legislature in 1990, the health care cost and access commission authorized therein shall in its report to

the legislature and the governor on November 1, 1992, include the following:

(1) Proposed alternative uniform health care benefit plans that the legislature should consider, including estimates of the cost of each alternative plan and recommendations on the amount of enrollee copayments, deductibles, and premium sharing that should be required;

(2) An analysis of the effects and implications of the federal Employee's Retirement Income Security Act (ERISA) self-funding provisions on health care costs and the need for changes in federal law;

(3) Proposed optional strategies and administrative approaches for addressing in an ongoing manner such health care system issues as: Controlling health care services and administrative costs; using high cost medical technologies; assuring health care quality; assuring local and state level capabilities with respect to health promotion, disease and injury prevention interventions; and expanding health care services to the uninsured. The recommendations shall not be limited to proposing that an independent state commission perform such responsibilities and authorities and the recommendations shall identify optional configurations of existing private and governmental entities that could perform such functions in an effective and coordinated manner. Such strategies shall assure meaningful involvement and review by relevant public and private interests including the legislature;

(4) Evaluation of the use of a voucher payment system for medicaid enrollees to enable the purchase of private insurance. The evaluation shall include an analysis of the potential availability of private insurance for this population, strategies to make private group insurance more available, strategies to encourage the use of managed care, strategies to allow the categorically needy portions of the medicaid population to use vouchers should it be deemed financially

inappropriate for the medically needy population, and recommendations on the need for federal Title XIX medicaid waivers to allow this population to use vouchers; and

(5) Proposed optional strategies that allow for the establishment of annual health care expenditure targets to encourage the purchase and use of appropriate and effective personal health care services.

"PART II - BASIC HEALTH PLAN"

Sec. 2. 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 <u>or make available</u> 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~~)) three hundred percent of the federal poverty guidelines~~,~~ except as provided for in RCW 70.47.060(11)(b), who share in a portion of the cost or who pay the full 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 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 care system.

(b) As a consequence, the legislature intends to make the program available to individuals in the state with incomes below three hundred

percent of federal poverty guidelines, except as provided for in RCW 70.47.060(11)(b), who reside in communities where the plan is operational and who collectively or individually wish to exercise the opportunity to purchase health care coverage through the program if it is done at no cost to the state. It is also the intent of the legislature to allow employers and other financial sponsors to financially assist such individuals purchase health care through the program.

Sec. 3. 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" means an enrollee who pays the full premium for participation in the plan and shall not be eligible for any subsidy from the plan.

(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. 4. 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. All receipts from amounts due under RCW 70.47.060 (11) and (12) shall be deposited into the account. Funds 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 administrating 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 funds in the separate accounts created in this section or that any premiums paid either by subsidized or nonsubsidized enrollees are commingled in any way, except that the administrator may combine funds designated for administration of the plan into a single administrative account.

Sec. 5. 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.

(2) 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) An employer or other financial sponsor may, with the approval of the administrator, pay the premium on behalf of any enrollee, by arrangement with the enrollee and through a mechanism acceptable to the administrator, but in no case shall the payment made on behalf of the enrollee exceed eighty percent of total premiums due from the enrollee.

(b) Premiums due from nonsubsidized enrollees, who are not otherwise eligible to be enrollees, shall be in an amount equal to the cost charged by the managed health care system provider to the state 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 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)(a) To limit the payment of a subsidy to an enrollee, as defined in RCW 70.47.020, whose gross family income at the time of enrollment does not exceed twice the federal poverty level adjusted for family size and determined annually by the federal department of health and human services.

(b) Except as provided for in subsection (11)(b) of this section, to limit participation of nonsubsidized enrollees in the plan to those whose family incomes at the time of enrollment does not exceed three times the federal poverty level adjusted for family size and determined annually by the federal department of health and human services.

(7) 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.

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, the administrator shall endeavor to secure participation contracts with managed health care systems in discrete geographic areas within at least five congressional districts.~~

~~(7)~~)) (8) 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)~~)) (9) 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)~~)) (10) 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. Except as provided for in subsection (11)(b) of this section, 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~~)) three times the federal poverty level, may continue enrollment unless and until the enrollee's gross family income has remained above ((~~twice~~)) three times the poverty level for ((~~six~~)) eighteen consecutive months, by making 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)~~)) (11)(a) To accept applications from small business owners on behalf of themselves and their employees, spouses, and dependent children who reside in an area served by the plan. The administrator may require all or the substantial majority of the eligible employees of such businesses to enroll in the plan and establish those procedures necessary to facilitate the orderly enrollment of groups in the plan and into a managed health care system. For the purposes of this subsection, an employee means an individual who regularly works for the employer for at least twenty hours per week. Such businesses shall have less than fifty employees and enrollment shall be limited to those not otherwise eligible for medicare, whose gross family income at the time of enrollment does not exceed three times the federal poverty level as adjusted for family size and determined by the federal department of health and human services, who wish to enroll in the plan at no cost to the state and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. 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. No enrollee of a small business group shall be eligible for any subsidy from the plan and at no time shall the

administrator allow the credit of the state or funds from the trust account to be used or extended on their behalf.

(b) Notwithstanding income limitations provided for in (a) of this subsection, when seventy-five percent or more of employees in a small business at the time of enrollment have gross family incomes that do not exceed three times the federal poverty level as adjusted for family size and determined by the federal department of health and human services, all employees in the small business will be eligible for enrollment under this subsection. The plan shall annually require participating small businesses enrolled under this subsection (11)(b) to provide evidence of gross family incomes of enrolled employees for purposes of determining continued eligibility of such employees under this subsection (11)(b). To minimize the burden and cost of complying with this reporting requirement, the plan shall accept documentation from the small business that provides such information as may be required by other state agencies. Should more than twenty-five percent of employees of an enrolled small business be found to have gross family incomes exceeding three times the federal poverty level, the plan shall notify the small business that those employees are no longer eligible for enrollment and shall dis-enroll these employees eighteen months after the notification. The remaining employees of such small businesses who have gross family incomes below three times the federal poverty level will continue to be eligible enrollees under (a) of this subsection.

(12) To accept applications from individuals residing in areas serviced by the plan, on behalf of themselves and their spouses and dependent children, under sixty-five years of age and not otherwise eligible for medicare, whose gross family income at the time of enrollment does not exceed three times the federal poverty level as adjusted for family size and determined by the federal department of

health and human services, who wish to enroll in the plan at no cost to the state and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. Any such nonsubsidized enrollees must pay the amount negotiated by the administrator with the participating managed health care system and the administrative cost of providing the plan to such nonsubsidized enrollees and shall not be eligible for any subsidy from the plan.

(13) 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. In determining the rate to be paid to a contractor, the administrator shall strive to assure that the rate does not result in adverse cost shifting to other private payers of health care.

((~~(11)~~)) (14) 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. 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)~~)) (15) 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)~~)) (16) 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)~~)) (17) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

((~~(15)~~)) (18) 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. 6. 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~~)) the average monthly 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, the administrator shall endeavor to secure participation contracts from managed health care systems in discrete geographic areas within at least five 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. 7. 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. 8.** SUNSET REPEALED. 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.

NEW SECTION. **Sec. 9.** A new section is added to chapter 74.09 RCW to read as follows:

FEDERAL WAIVER FOR STATE MEDICAID PROGRAM. (1) The department shall negotiate with the United States congress and the federal department of health and human services to obtain a waiver of provisions of the medicaid statute, Title XIX of the federal social security act to permit medicaid eligible individuals to:

(a) Enroll in the state basic health plan and receive the benefits offered to basic health plan enrollees; and

(b) Participate financially in purchasing health care benefits through such means as premium sharing, copayments, and deductibles provided that such contributions will be implemented in a manner to encourage the appropriate use of effective medical care services and do not serve as a barrier to receiving necessary medical care services.

(2) The department shall report to the appropriate policy and fiscal standing committees of the senate and house of representatives by October 31, 1992, on the progress of such negotiations.

Sec. 10. RCW 70.47.115 and 1991 c 315 s 22 are each amended to read as follows:

(1) The administrator, when specific funding is provided and where feasible, shall make the basic health plan available ((~~to dislocated forest products workers and their families~~)) in timber impact areas. The administrator shall prioritize making the plan available under this section to the timber impact areas meeting the following criteria, as determined by the employment security department: (a) A lumber and wood products employment location quotient at or above the state average; (b) a direct lumber and wood products job loss of one hundred positions or more; and (c) an annual unemployment rate twenty percent above the state average.

(2) ((~~Dislocated forest products workers~~)) Persons assisted under this section shall meet the requirements of enrollee as defined in RCW 70.47.020(4).

(3) For purposes of this section, ((~~(a) "dislocated forest products worker" means a forest products worker who: (i)(A) Has been terminated or received notice of termination from employment and is unlikely to return to employment in the individual's principal occupation or~~

~~previous industry because of a diminishing demand for his or her skills in that occupation or industry; or (B) is self-employed and has been displaced from his or her business because of the diminishing demand for the business's services or goods; and (ii) at the time of last separation from employment, resided in or was employed in a timber impact area; (b) "forest products worker" means a worker in the forest products industries affected by the reduction of forest fiber enhancement, transportation, or production. The workers included within this definition shall be determined by the employment security department, but shall include workers employed in the industries assigned the major group standard industrial classification codes "24" and "26" and the industries involved in the harvesting and management of logs, transportation of logs and wood products, processing of wood products, and the manufacturing and distribution of wood processing and logging equipment.~~

~~The commissioner may adopt rules further interpreting these definitions. For the purposes of this subsection, "standard industrial classification code" means the code identified in RCW 50.29.025(6)(c); and (c)~~)) "timber impact area" means a county having a population of less than five hundred thousand, or a city or town located within a county having a population of less than five hundred thousand, and meeting two of the following three criteria, as determined by the employment security department, for the most recent year such data is available: ((~~(i)~~)) (a) A lumber and wood products employment location quotient at or above the state average; ((~~(ii)~~)) (b) projected or actual direct lumber and wood products job losses of one hundred positions or more, except counties having a population greater than two hundred thousand but less than five hundred thousand must have direct lumber and wood products job losses of one thousand positions or more;

or ((~~(iii)~~)) (c) an annual unemployment rate twenty percent or more above the state average.

"PART III - USE OF ORGANIZED DELIVERY SYSTEMS BY STATE EMPLOYEES"

Sec. 11. 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 a combination thereof, that provides directly or by contract, an employee health benefits plan under this chapter to a defined group of employees, for a prepaid, capitated rate on or after July 1, 1992. Health care practitioners participating in an organized delivery system shall be financially at risk for health care services by the patients of such system, or the employer of such health care practitioners shall be financially at risk for such services.

NEW SECTION. **Sec. 12.** A new section is added to chapter 41.05 RCW to read as follows:

LEGISLATIVE INTENT. The legislature finds that:

(1) The rising costs of state purchased health care is an unsustainable burden to state government;

(2) State employee health benefits comprise a substantial portion of state health care expenditures;

(3) There are financial incentives that can be implemented to encourage prudent patient utilization of health care services; and

(4) Organized delivery system health care can be an effective way to efficiently and cost-effectively deliver appropriate health care services.

The legislature declares additional incentives should be developed to encourage state employees to enroll in organized delivery systems.

Sec. 13. RCW 41.05.065 and 1988 c 107 s 8 are each amended to read as follows:

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

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

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

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

(c) Wellness incentives that focus on proven strategies, such as smoking cessation, exercise, and automobile and motorcycle safety;

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

(e) Effective coordination of benefits.

(3) The board shall design benefits and determine the terms and conditions of employee participation and coverage, including establishment of eligibility criteria.

(4) The board shall utilize financial incentives to encourage employee enrollments in organized delivery systems. To encourage income equity, employee financial contributions may be structured on a sliding-scale basis based upon the income of the employee. These incentives shall result in a target of at least seventy-five percent enrollment of employees and retirees in organized delivery systems by July 1994.

The board may authorize premium contributions for an employee and the employee's dependents in a manner that encourages the use of cost-efficient organized delivery systems. ((~~Such authorization shall require a vote of five members of the board for approval.~~))

(5) Employees may choose participation in only one of the health care benefit plans developed by the board.

(6) The board shall review plans proposed by insurance carriers that desire to offer property insurance and/or accident and casualty insurance to state employees through payroll deduction. The board may

approve any such plan for payroll deduction by carriers holding a valid certificate of authority in the state of Washington and which the board determines to be in the best interests of employees and the state. The board shall promulgate rules setting forth criteria by which it shall evaluate the plans.

(7) The board shall report to the appropriate policy and fiscal committees of the legislature by December 1, 1994, on the following:

(a) The progress in meeting the organized delivery system target enrollment rate established in subsection (4) of this section and recommendations for increasing future participation above the target rate; and

(b) The impact on the growth of state employee benefit costs as the result of establishing organized delivery system target rates and required financial incentives to encourage enrollment in cost-efficient organized delivery systems.

"PART IV - HEALTH DATA COLLECTION"

Sec. 14. RCW 70.170.010 and 1989 1st ex.s. c 9 s 501 are each amended to read as follows:

(1) The legislature finds and declares that there is a need for health care information that helps the general public understand health care issues and how they can be better consumers and that is useful to purchasers, payers, and providers in making health care choices, determining and monitoring the quality of health care services, and ((~~negotiating payments~~)) making health care purchasing decisions. It is the purpose and intent of this chapter to establish a hospital data collection, storage, and retrieval system which supports these data needs and which also provides public officials and others engaged in

the development of state health policy the information necessary for the analysis of health care issues.

(2) The legislature finds that rising health care costs and access to health care services are of vital concern to the people of this state. It is, therefore, essential that strategies be explored that moderate health care costs and promote access to health care services.

(3) The legislature further finds that access to health care is among the state's goals and the provision of such care should be among the purposes of health care providers and facilities. Therefore, the legislature intends that charity care requirements and related enforcement provisions for hospitals be explicitly established.

(4) The lack of reliable statistical information about the delivery of charity care is a particular concern that should be addressed. It is the purpose and intent of this chapter to require hospitals to provide, and report to the state, charity care to persons with acute care needs, and to have a state agency both monitor and report on the relative commitment of hospitals to the delivery of charity care services, as well as the relative commitment of public and private purchasers or payers to charity care funding.

(5) The intent of the information collection activities authorized under this chapter is to insure that:

(a) A comprehensive data system that meets the objectives of this section be developed in the most efficient, accurate, and unbiased manner possible;

(b) All public and private providers and purchasers of health care services regularly supply the types of relevant data necessary to insure a complete, comprehensive, and accurate data system;

(c) The data system shall not by design or operation result in any provider or purchaser of health care being placed at a competitive advantage over any other provider or purchasing of health care;

(d) Providers, health care purchasers, consumers, public agencies, and others have equal access to the system's data; and

(e) Providers, health care purchasers, consumers, public agencies, and others have access to useful information developed from the system's data that enables them to make the comparative decisions necessary to fulfill the health care purchasing, provider selection, and quality assurance objectives set forth in this section.

Sec. 15. RCW 70.170.020 and 1989 1st ex.s. c 9 s 502 are each amended to read as follows:

As used in this chapter:

(1) "Council" means the health care access and cost control council created by this chapter.

(2) "Department" means department of health.

(3) "Hospital" means any health care institution which is required to qualify for a license under RCW 70.41.020(2); or as a psychiatric hospital under chapter 71.12 RCW.

(4) "Secretary" means secretary of health.

(5) "Charity care" means necessary hospital health care rendered to indigent persons, to the extent that the persons are unable to pay for the care or to pay deductibles or co-insurance amounts required by a third-party payer, as determined by the department.

(6) "Sliding fee schedule" means a hospital-determined, publicly available schedule of discounts to charges for persons deemed eligible for charity care; such schedules shall be established after consideration of guidelines developed by the department.

(7) "Special studies" means studies which have not been funded through the department's biennial or other legislative appropriations.

(8) "Health care" means all care, goods, technologies, or services provided to persons by providers of care intended to ascertain,

improve, or maintain the health of such persons. It specifically includes the care, goods, technologies, or services of health care practitioners, programs, facilities, or other health care entities regulated by Title 18 or 70 RCW.

(9) "Providers" means all health care practitioners, programs, facilities, or other health care entities regulated pursuant to Title 18 or 70 RCW.

(10) "Health care payors" includes all state health care payment programs; all disability insurers, health care service contractors, and health maintenance organizations subject to the jurisdiction of the insurance commissioner pursuant to Title 48 RCW; and all employers who provide health care benefits to employees through self-insurance.

(11) "Reporters" means providers and health care payors.

Sec. 16. RCW 70.170.030 and 1989 1st ex.s. c 9 s 503 are each amended to read as follows:

(1) There is created the health care access and cost control council within the department of health consisting of the following: The director of the department of labor and industries; the administrator of the health care authority; the secretary of social and health services; the administrator of the basic health plan; a person representing the governor on matters of health policy; the secretary of health; and ((~~one member from the public-at-large to be selected by the governor who shall represent individual consumers of health care. The public member shall not have any fiduciary obligation to any health care facility or any financial interest in the provision of health care services.~~)) nine public members. Public members shall be appointed by the governor with consent of the senate. In selecting public members, the governor shall assure that the council collectively has the technical expertise in health care data systems design, data

collection, and other technical areas relevant to the design and operation of a health care data system and also reflects the perspectives of the users and reporters of data. In its confirmation of gubernatorial nomination, the senate should verify the technical qualifications of appointments. Public members shall serve two-year terms and the governor shall designate four of the initial appointees to serve one-year terms in order to provide staggered terms; thereafter all public members shall serve two-year terms. All persons appointed to fill vacancies shall be appointed in the same manner as the persons they are replacing. Members employed by the state shall serve without pay and participation in the council's work shall be deemed performance of their employment. The public members shall be compensated in accordance with RCW 43.03.240 and shall be reimbursed for related travel expenses in accordance with RCW 43.03.050 and 43.03.060.

(2) A member of the council designated by the governor shall serve as chairman. The council shall elect a vice-chairman from its members biennially. Meetings of the council shall be held as frequently as its duties require. The council shall keep minutes of its meetings and adopt procedures for the governing of its meetings, minutes, and transactions.

(3) ((~~Four~~)) Eight members shall constitute a quorum, but ((~~a vacancy on the council shall not impair its power to act~~)) at least four of that number shall be public members. No action of the council shall be effective unless four members concur therein.

Sec. 17. RCW 70.170.040 and 1989 1st ex.s. c 9 s 504 are each amended to read as follows:

(1) In order to advise the department and the board of health in preparing executive request legislation and the state health report according to RCW 43.20.050, and, in order to represent the public

interest, the council shall monitor and evaluate hospital and related health care services consistent with RCW 70.170.010. In fulfilling its responsibilities, the council shall have complete access to all the department's data and information systems.

(2) The council shall advise the department on the ((~~hospital~~)) health care data collection system required by this chapter.

(3) The council, in addition to participation in the development of the state health report, shall, from time to time, report to the governor and the appropriate committees of the legislature with proposed changes in hospital and related health care services, consistent with the findings in RCW 70.170.010.

((~~(4) The department may undertake, with advice from the council and within available funds, the following studies:~~

~~(a) Recommendations regarding health care cost containment, and the assurance of access and maintenance of adequate standards of care;~~

~~(b) Analysis of the effects of various payment methods on health care access and costs;~~

~~(c) The utility of the certificate of need program and related health planning process;~~

~~(d) Methods of permitting the inclusion of advance medical technology on the health care system, while controlling inappropriate use;~~

~~(e) The appropriateness of allocation of health care services;~~

~~(f) Professional liabilities on health care access and costs, to include:~~

~~(i) Quantification of the financial effects of professional liability on health care reimbursement;~~

~~(ii) Determination of the effects, if any, of nonmonetary factors upon the availability of, and access to, appropriate and necessary~~

~~basic health services such as, but not limited to, prenatal and obstetrical care; and~~

~~(iii) Recommendation of proposals that would mitigate cost and access impacts associated with professional liability.~~

~~The department shall report its findings and recommendations to the governor and the appropriate committees of the legislature not later than July 1, 1991.~~))

Sec. 18. RCW 70.170.050 and 1989 1st ex.s. c 9 s 505 are each amended to read as follows:

The ((~~department~~)) council shall have the authority to respond to requests ((~~of others~~)) for data, special studies, or analysis. The ((~~department~~)) council may require ((~~such sponsors to pay~~)) payment of any or all of the reasonable costs associated with such requests that might be approved, but in no event may costs directly associated with any such special study be charged against the funds generated by the assessment authorized under ((~~RCW 70.170.080~~)) section 20 of this act.

Sec. 19. RCW 70.170.070 and 1989 1st ex.s. c 9 s 507 are each amended to read as follows:

(1) Every person who shall violate or knowingly aid and abet the violation of RCW 70.170.060 (5) or (6), ((~~70.170.080~~)) section 20 of this act, or 70.170.100, or any valid orders or rules adopted pursuant to these sections, or who fails to perform any act which it is herein made his or her duty to perform, shall be guilty of a misdemeanor. Following official notice to the accused by the department of the existence of an alleged violation, each day of noncompliance upon which a violation occurs shall constitute a separate violation. Any person violating the provisions of this chapter may be enjoined from continuing such violation. The department has authority to levy civil

penalties not exceeding one thousand dollars for violations of this chapter and determined pursuant to this section.

(2) Every person who shall violate or knowingly aid and abet the violation of RCW 70.170.060 (1) or (2), or any valid orders or rules adopted pursuant to such section, or who fails to perform any act which it is herein made his or her duty to perform, shall be subject to the following criminal and civil penalties:

(a) For any initial violations: The violating person shall be guilty of a misdemeanor, and the department may impose a civil penalty not to exceed one thousand dollars as determined pursuant to this section.

(b) For a subsequent violation of RCW 70.170.060 (1) or (2) within five years following a conviction: The violating person shall be guilty of a misdemeanor, and the department may impose a penalty not to exceed three thousand dollars as determined pursuant to this section.

(c) For a subsequent violation with intent to violate RCW 70.170.060 (1) or (2) within five years following a conviction: The criminal and civil penalties enumerated in (a) of this subsection; plus up to a three-year prohibition against the issuance of tax exempt bonds under the authority of the Washington health care facilities authority; and up to a three-year prohibition from applying for and receiving a certificate of need.

(d) For a violation of RCW 70.170.060 (1) or (2) within five years of a conviction under (c) of this subsection: The criminal and civil penalties and prohibition enumerated in (a) and (b) of this subsection; plus up to a one-year prohibition from participation in the state medical assistance or medical care services authorized under chapter 74.09 RCW.

(3) The provisions of chapter 34.05 RCW shall apply to all noncriminal actions undertaken by the department of health, the

department of social and health services, and the Washington health care facilities authority pursuant to chapter 9, Laws of 1989 1st ex. sess. (this act).

NEW SECTION. **Sec. 20.** A new section is added to chapter 70.170 RCW to read as follows:

The council shall fund the creation and maintenance of the data base and studies provided for in RCW 70.170.100 and 70.170.110 from a surcharge levied on the data acquired in whatever manner it deems to be efficient and fair by rule. No such assessment shall amount to more than four one-hundredths of one percent of the gross billed amount for the service that is the subject matter of the data. The council may accept gifts, donations, grants, and other funds received by the council. All moneys collected under this section shall be deposited by the state treasurer in the health care data collection account which is hereby created in the state treasury. This account is the successor to the hospital data collection account, the balance of which shall be placed in the health care data collection account. The council may also charge, receive, and dispense funds or authorize any contractor or outside sponsor to charge for and reimburse the costs associated with special studies as specified in RCW 70.170.050.

Any amounts raised by the collection of assessments provided for in this section that are not required to meet appropriations in the budget act for the current fiscal year shall be available to the council in succeeding years.

Sec. 21. RCW 70.170.100 and 1990 c 269 s 12 are each amended to read as follows:

(1) The ((~~department~~)) council is responsible for the development, implementation, and custody of a state-wide ((~~hospital~~)) health care

data system. As part of the design stage for development of the system, the ((~~department~~)) council shall undertake a needs assessment of the types of, and format for, ((~~hospital~~)) health care data needed by consumers, purchasers, ((~~payers, hospitals~~)) health care payors, providers, and state government as consistent with the intent of this chapter. The ((~~department~~)) council shall identify a set of ((~~hospital~~)) health care data elements and report specifications which satisfy these needs. The council shall ((~~review the design of the data system and may direct the department to~~)) contract with a private vendor ((~~for assistance in the design of the data system~~)) in the state of Washington for all work to be performed under this section. The data elements, specifications, and other ((~~design~~)) distinguishing features of this data system shall be made available for public review and comment and shall be published, with comments, as the ((~~department's first~~)) council's data plan by ((~~January 1, 1990~~)) July 1, 1993.

(2) ((~~Subsequent to the initial development of the data system as published as the department's first data plan, revisions to the data system shall be considered through the department's development of a biennial data plan, as proposed to, and funded by, the legislature through the biennial appropriations process. Costs of data activities outside of these data plans except for special studies shall be funded through legislative appropriations.~~

~~(3)~~)) In designing the state-wide ((~~hospital~~)) health care data system and any data plans, the ((~~department~~)) council shall identify ((~~hospital~~)) health care data elements relating to ((~~both hospital finances~~)) health care costs, the quality of health care services and ((~~the~~)) use of ((~~services by patients~~)) health care by consumers. Data elements ((~~relating to hospital finances~~)) shall be reported ((~~by hospitals~~)) as the council directs by reporters in conformance with a

uniform ((~~system of~~)) reporting ((~~as specified by the department and shall~~)) system established by the council, which shall be adopted by reporters. In the case of hospitals this includes data elements identifying each hospital's revenues, expenses, contractual allowances, charity care, bad debt, other income, total units of inpatient and outpatient services, and other financial information reasonably necessary to fulfill the purposes of this chapter, for hospital activities as a whole and, as feasible and appropriate, for specified classes of hospital purchasers and payers. Data elements relating to use of hospital services by patients shall, at least initially, be the same as those currently compiled by hospitals through inpatient discharge abstracts ((~~and reported to the Washington state hospital commission~~)). The council shall permit reporting by electronic transmission or hard copy as is practical and economical to reporters.

((~~(4)~~)) (3) The state-wide ((~~hospital~~)) health care data system shall be uniform in its identification of reporting requirements for ((~~hospitals~~)) reporters across the state to the extent that such uniformity is ((~~necessary~~)) useful to fulfill the purposes of this chapter. Data reporting requirements may reflect differences ((~~in hospital size; urban or rural location; scope, type, and method of providing service; financial structure; or other pertinent distinguishing factors~~)) that involve pertinent distinguishing features as determined by the council by rule. So far as ((~~possible~~)) is practical, the data system shall be coordinated with any requirements of the trauma care data registry as authorized in RCW 70.168.090, the federal department of health and human services in its administration of the medicare program, ((~~and~~)) the state in its role of gathering public health statistics, or any other payor program of consequence, so as to minimize any unduly burdensome reporting requirements imposed on ((~~hospitals~~)) reporters.

((~~(5)~~)) (4) In identifying financial reporting requirements under the state-wide ((~~hospital~~)) health care data system, the ((~~department~~)) council may require both annual reports and condensed quarterly reports from reporters, so as to achieve both accuracy and timeliness in reporting, but shall craft such requirements with due regard of the data reporting burdens of reporters.

((~~(6) In designing the initial state-wide hospital data system as published in the department's first data plan, the department shall review all existing systems of hospital financial and utilization reporting used in this state to determine their usefulness for the purposes of this chapter, including their potential usefulness as revised or simplified.~~

~~(7) Until such time as the state-wide hospital data system and first data plan are developed and implemented and hospitals are able to comply with reporting requirements, the department shall require hospitals to continue to submit the hospital financial and patient discharge information previously required to be submitted to the Washington state hospital commission. Upon publication of the first data plan, hospitals shall have a reasonable period of time to comply with any new reporting requirements and, even in the event that new reporting requirements differ greatly from past requirements, shall comply within two years of July 1, 1989.~~

~~(8)~~)) (5) The ((~~hospital~~)) health care data collected ((~~and~~)), maintained, and studied by the ((~~department~~)) council shall be available for retrieval in original or processed form to public and private requestors within a reasonable period of time after the date of request. The cost of retrieving data for state officials and agencies shall be funded through the state general appropriation. The cost of retrieving data for individuals and organizations engaged in research or private use of data or studies shall be funded by a fee schedule

developed by the ((~~department which~~)) council that reflects the direct cost of retrieving the data or study in the requested form.

(6) All persons subject to this chapter shall comply with council requirements established by rule in the acquisition of data. The council shall each December 1 of even-numbered years report to the senate and house of representatives policy committees on health care on the status of the data system, the level of participation by payor and provider groups and recommended statutory changes necessary to meet the objectives established in this chapter.

Sec. 22. RCW 70.170.110 and 1989 1st ex.s. c 9 s 511 are each amended to read as follows:

The ((~~department shall provide, or~~)) council may contract with a private ((~~entity to provide, hospital analyses and reports~~)) vendor in the state of Washington to provide any studies or reports it chooses to conduct consistent with the purposes of this chapter. ((~~Prior to release, the department shall provide affected hospitals with an opportunity to review and comment on reports which identify individual hospital data with respect to accuracy and completeness, and otherwise shall focus on aggregate reports of hospital performance. These reports shall~~)) The department may perform such studies or any other studies consistent with the purposes of this chapter. These reports may include:

(1) Consumer guides on purchasing ((~~hospital care services and~~)) or consuming health care and publications providing verifiable and useful comparative information to ((~~consumers on hospitals and hospital~~)) the public on health care services and the quality of health care providers;

(2) Reports for use by classes of purchasers, ((~~payers~~)) health care payors, and providers as specified for content and format in the state-wide data system and data plan; ((~~and~~))

(3) Reports on relevant ((~~hospital~~)) health care policy ((~~issues~~)) including the distribution of hospital charity care obligations among hospitals; absolute and relative rankings of Washington and other states, regions, and the nation with respect to expenses, net revenues, and other key indicators; ((~~hospital~~)) provider efficiencies; and the effect of medicare, medicaid, and other public health care programs on rates paid by other purchasers of ((~~hospital~~)) health care; and

(4) Any other reports the council deems useful to assist the public in understanding the prudent and cost-effective use of the health care delivery system.

NEW SECTION. **Sec. 23.** A new section is added to chapter 70.170 RCW to read as follows:

The council shall by rule adopt a uniform approach to health care claims processing, information requirements, definition of terms coding, and submission and payment mechanisms to be used by all providers and health care payors subject to this chapter.

NEW SECTION. **Sec. 24.** RCW 70.170.080 and 1991 sp.s. c 13 s 71 and 1989 1st ex.s. c 9 s 508 are each repealed.

"PART V - PRACTICE PARAMETERS AND RISK MANAGEMENT PROTOCOLS"

NEW SECTION. **Sec. 25.** LEGISLATIVE INTENT. The legislature finds that improving the quality of health services provided by health care professionals is an important public policy objective. It is in the public's interest to assure that health care professionals utilize

diagnostic procedures and treatments that are appropriate and efficacious.

The legislature further finds that the state of health care technology and knowledge is increasingly advancing to the point where it is possible to assess the effectiveness and appropriateness of specific treatments and measure the quality of health care services provided to individuals. Such advances will permit a more systematic monitoring and evaluation of services delivered by health care professionals towards the goals of assuring appropriate and effective utilization of such services.

The legislature finds and declares that practice guidelines or parameters and risk management protocols can be an effective means for assuring appropriate and efficacious treatments. Public policy should be established to encourage their development and use.

NEW SECTION. **Sec. 26.** DEPARTMENT ACTIVITIES. The department of health shall consult with health care providers, purchasers, health professional regulatory authorities under RCW 18.130.040, appropriate research and clinical experts, and consumers of health care services to identify specific practice areas where practice parameters and risk management protocols can reasonably be developed. The department shall make a report, including recommendations for legislation, to the governor and appropriate legislative committees in the senate and house of representatives by December 15, 1992, on the following:

(1) The health care services where practice parameters and risk management protocols can reasonably be developed given the current state of knowledge;

(2) The use of practice parameters and risk management protocols in quality assurance and as standards in malpractice litigation;

(3) Practical issues involved in developing practice parameters and risk management protocols, including needed data bases and monitoring capabilities;

(4) Appropriate roles for the public and private interests in the development and implementation of practice parameters and risk management protocols, including the role of health professional credentialing and disciplinary authorities, purchasers, consumers, health care research institutions, and others; and

(5) A strategy for the development of practice parameters and risk management protocols.

"PART VI - HEALTH CARE MALPRACTICE REFORM"

Sec. 27. RCW 7.70.070 and 1975-’76 2nd ex.s. c 56 s 12 are each amended to read as follows:

The court shall, in any action under this chapter, determine the reasonableness of each party’s fixed attorneys fees. The court shall take into consideration the following:

(1) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

(2) The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;

(3) The fee customarily charged in the locality for similar legal services;

(4) The amount involved and the results obtained;

(5) The time limitations imposed by the client or by the circumstances;

(6) The nature and length of the professional relationship with the client;

(7) The experience, reputation, and ability of the lawyer or lawyers performing the services((~~;~~

~~(8) Whether the fee is fixed or contingent~~)).

NEW SECTION. **Sec. 28.** CONTINGENT ATTORNEYS' FEES LIMITED. (1) As used in this section:

(a) "Contingency fee agreement" means an agreement that an attorney's fee is dependent or contingent, in whole or in part, upon successful prosecution or settlement of a claim or action, or upon the amount of recovery.

(b) "Properly chargeable disbursements" means reasonable expenses incurred and paid by an attorney on a client's behalf in prosecuting or settling a claim or action.

(c) "Recovery" means the amount to be paid to an attorney's client as a result of a settlement or money judgment.

(2) In a claim or action filed under this chapter for personal injury or wrongful death based upon the alleged conduct of another, if an attorney enters into a contingency fee agreement with his or her client and if a money judgment is awarded to the attorney's client or the claim or action is settled, the attorney's fee shall not exceed the amounts set forth in (a) and (b) of this subsection:

(a) Not more than forty percent of the first five thousand dollars recovered, then not more than thirty-five percent of the amount more than five thousand dollars but less than twenty-five thousand dollars, then not more than twenty-five percent of the amount of twenty-five thousand dollars or more but less than two hundred fifty thousand dollars, then not more than twenty percent of the amount of two hundred fifty thousand dollars or more but less than five hundred thousand

dollars, and not more than ten percent of the amount of five hundred thousand dollars or more.

(b) As an alternative to (a) of this subsection, not more than one-third of the first two hundred fifty thousand dollars recovered, not more than twenty percent of an amount more than two hundred fifty thousand dollars but less than five hundred thousand dollars, and not more than ten percent of an amount more than five hundred thousand dollars.

(3) The fees allowed in subsection (2) of this section are computed on the net sum of the recovery after deducting from the recovery the properly chargeable disbursements. In computing the fee, the costs as taxed by the court are part of the amount of the money judgment. In the case of a recovery payable in installments, the fee is computed using the present value of the future payments.

(4) A contingency fee agreement made by an attorney with a client must be in writing and must be executed at the time the client retains the attorney for the claim or action that is the basis for the contingency fee agreement. An attorney who fails to comply with this subsection is barred from recovering a fee in excess of the lowest fee available under subsection (2) of this section, but the other provisions of the contingency fee agreement remain enforceable.

(5) An attorney shall provide a copy of a contingency fee agreement to the client at the time the contingency fee agreement is executed. An attorney shall include his or her usual and customary hourly rate of compensation in a contingency fee agreement.

(6) An attorney who enters into a contingency fee agreement that violates subsection (2) of this section is barred from recovering a fee in excess of the attorney’s reasonable actual attorney fees based on his or her usual and customary hourly rate of compensation, up to the

lowest amount allowed under subsection (2) of this section, but the other provisions of the contingency fee agreement remain enforceable.

NEW SECTION. **Sec. 29.** LEGISLATIVE INTENT. The legislature finds that in *Sofie v. Fibreboard Corp., 112 Wn.2d 636 (1989),* the Washington state supreme court struck down the limit on noneconomic damages enacted by the legislature in 1986, because the court found that the statutory limitation on noneconomic damages interfered with the jury's province to determine damages, and thus violated a plaintiff's constitutionally protected right to trial by jury.

The legislature further finds that reforms in existing law for actions involving fault are necessary and proper to avoid catastrophic economic consequences for state and local governmental entities as well as private individuals and businesses.

Therefore, the legislature declares that to remedy the economic inequities which may arise from *Sofie*, defendants in actions involving fault should be held financially liable in closer proportion to their respective degree of fault. To treat them differently is unfair and inequitable.

It is further the intent of the legislature to partially eliminate causes of action based on joint and several liability as provided by this act for the purpose of reducing costs associated with the civil justice system.

NEW SECTION. **Sec. 30.** JOINT AND SEVERAL LIABILITY RESTRICTIONS. (1) For the purposes of this section, the term "economic damages" means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, cost of obtaining substitute domestic services, loss of employment, and loss of business or employment opportunities. "Economic damages" does not include subjective,

nonmonetary losses such as pain and suffering, mental anguish, emotional distress, disability and disfigurement, inconvenience, injury to reputation, humiliation, destruction of the parent-child relationship, the nature and extent of an injury, loss of consortium, society, companionship, support, love, affection, care, services, guidance, training, instruction, and protection.

(2) In all actions involving fault of more than one entity, the trier of fact shall determine the percentage of the total fault which is attributable to every entity which caused the claimant's injuries, including the claimant or person suffering personal injury, defendants, third-party defendants, entities released by the claimant, entities immune from liability to the claimant and entities with any other individual defense against the claimant. Judgment shall be entered against each defendant except those who have been released by the claimant or are immune from liability to the claimant or have prevailed on any other individual defense against the claimant in an amount which represents that party's proportionate share of the claimant's total damages. The liability of each defendant shall be several only and shall not be joint except:

(a) A party shall be responsible for the fault of another person or for payment of the proportionate share of another party where both were acting in concert or when a person was acting as an agent or servant of the party.

(b) If the trier of fact determines that the claimant or party suffering bodily injury was not at fault, the defendants against whom judgment is entered shall be jointly and severally liable for the sum of their proportionate shares of the claimant's economic damages.

(3) If a defendant is jointly and severally liable under one of the exceptions listed in subsection (2)(a) or (b) of this section, such defendant's rights to contribution against another jointly and

severally liable defendant, and the effect of settlement by either such defendant, shall be determined under RCW 4.22.040, 4.22.050, and 4.22.060.

NEW SECTION. **Sec. 31.** CERTIFICATE OF MERIT REQUIRED. (1) The claimant's attorney shall file the certificate specified in subsection (2) of this section within thirty days of filing or service, whichever occurs later, for any action for damages arising out of injuries resulting from health care by a person regulated by a disciplinary authority in the state of Washington to practice a health care profession under RCW 18.130.040 or by the state board of pharmacy under chapter 18.64 RCW.

(2) The certificate issued by the claimant's attorney shall declare:

(a) That the attorney has reviewed the facts of the case;

(b) That the attorney has consulted with at least one qualified expert who holds a license, certificate, or registration issued by this state or another state in the same profession as that of the defendant, who practices in the same specialty or subspecialty as the defendant, and who the attorney reasonably believes is knowledgeable in the relevant issues involved in the particular action;

(c) The identity of the expert and the expert's license, certification, or registration;

(d) That the expert is willing and available to testify to admissible facts or opinions; and

(e) That the attorney has concluded on the basis of such review and consultation that there is reasonable and meritorious cause for the filing of such action.

(3) Where a certificate is required under this section, and where there are multiple defendants, the certificate or certificates must

state the attorney's conclusion that on the basis of review and expert consultation, there is reasonable and meritorious cause for the filing of such action as to each defendant.

(4) The provisions of this section shall not be applicable to a plaintiff who is not represented by an attorney.

(5) Violation of this section shall be grounds for either dismissal of the case or sanctions against the attorney, or both, as the court deems appropriate.

NEW SECTION. **Sec. 32.** EFFECTIVE DATE. Section 31 of this act applies to all actions for damages arising out of injuries resulting from health care filed on or after July 1, 1992.

NEW SECTION. **Sec. 33.** LEGISLATIVE INTENT. There are a number of retired physicians who wish to provide, or are providing, health care services to low-income patients without compensation. However, the cost of obtaining malpractice insurance is a burden that is deterring them from donating their time and services in treating the health problems of the poor. The necessity of maintaining malpractice insurance for those in practice is a significant reality in today's litigious society.

A program to alleviate the onerous costs of malpractice insurance for retired physicians providing uncompensated health care services to low-income patients will encourage philanthropy and augment state resources in providing for the health care needs of those who have no access to basic health care services.

An estimated sixteen percent of the nonelderly population do not have health insurance and lack access to even basic health care services. This is especially problematic for low-income persons who are young and who are either unemployed or have entry-level jobs

without health care benefits. The majority of the uninsured, however, are working adults, and some twenty-nine percent are children.

The legislature declares that sections 34 and 35 of this act will increase the availability of primary care to low-income persons and is in the interest of the public health and safety.

NEW SECTION. **Sec. 34.** A new section is added to chapter 43.70 RCW to read as follows:

LIABILITY INSURANCE PURCHASE PROGRAM. (1) The department may establish a program to purchase and maintain liability malpractice insurance for retired physicians who provide primary health care services at community clinics. The following conditions shall apply to the program:

(a) Primary health care services shall be provided at community clinics that are public or private tax-exempt corporations;

(b) Primary health care services provided at such clinics shall be offered to low-income patients based on their ability to pay;

(c) Retired physicians providing health care services shall not receive compensation for their services; and

(d) The department shall contract only with a liability insurer authorized to offer liability malpractice insurance in the state.

(2) This section and section 35 of this act shall not be interpreted to require a liability insurer to provide coverage to a physician should the insurer determine that coverage should not be offered to a physician because of past claims experience or for other appropriate reasons.

(3) The state and its employees who operate the program shall be immune from any civil or criminal action involving claims against clinics or physicians that provided health care services under this

section or section 35 of this act. This protection of immunity shall not extend to any clinic or physician participating in the program.

(4) The department may monitor the claims experience of retired physicians covered by liability insurers contracting with the department.

(5) The department may provide liability insurance under this section and section 35 of this act only to the extent funds are provided for this purpose by the legislature.

NEW SECTION. **Sec. 35.** A new section is added to chapter 43.70 RCW to read as follows:

PROGRAM PARTICIPATION CONDITIONS. The department may establish by rule the conditions of participation in the liability insurance program by retired physicians at clinics utilizing retired physicians for the purposes of this section and section 34 of this act. These conditions shall include, but not be limited to, the following:

(1) The participating physician associated with the clinic shall hold a valid license to practice medicine and surgery in this state and otherwise be in conformity with current requirements for licensure as a retired physician, including continuing education requirements;

(2) The participating physician shall limit the scope of practice in the clinic to primary care. Primary care shall be limited to noninvasive procedures and shall not include obstetrical care, or any specialized care and treatment. Noninvasive procedures include injections, suturing of minor lacerations, and incisions of boils or superficial abscesses;

(3) The provision of liability insurance coverage shall not extend to acts outside the scope of rendering medical services pursuant to this section and section 34 of this act;

(4) The participating physician shall limit the provision of health care services to low-income persons provided that clinics may, but are not required to, provide means tests for eligibility as a condition for obtaining health care services;

(5) The participating physician shall not accept compensation for providing health care services from patients served pursuant to this section and section 34 of this act, nor from clinics serving these patients. "Compensation" shall mean any remuneration of value to the participating physician for services provided by the physician, but shall not be construed to include any nominal copayments charged by the clinic, nor reimbursement of related expenses of a participating physician authorized by the clinic in advance of being incurred; and

(6) The use of mediation or arbitration for resolving questions of potential liability may be used, however any mediation or arbitration agreement format shall be expressed in terms clear enough for a person with a sixth grade level of education to understand, and on a form no longer than one page in length.

"PART VII - HEALTH CARE PROVIDER CONFLICT OF FINANCIAL INTEREST"

NEW SECTION. **Sec. 36.** LEGISLATIVE INTENT. The legislature finds that there is a growing practice of health care professionals having financial interest in laboratory and other services. The legislature further finds that such practices may result in overutilization of health care services and excessive costs to individuals, third-party payers, and the health care system.

The legislature declares that the notification of patients and third-party payers about these referral practices can make them more aware of such practices and allow payers to track providers who through referrals overutilize services for financial reasons.

Sec. 37. RCW 19.68.010 and 1973 1st ex.s. c 26 s 1 are each amended to read as follows:

It shall be unlawful for any person, firm, corporation or association, whether organized as a cooperative, or for profit or nonprofit, to pay, or offer to pay or allow, directly or indirectly, to any person licensed by the state of Washington to engage in the practice of medicine and surgery, drugless treatment in any form, dentistry, or pharmacy and it shall be unlawful for such person to request, receive or allow, directly or indirectly, a rebate, refund, commission, unearned discount or profit by means of a credit or other valuable consideration in connection with the referral of patients to any person, firm, corporation or association, or in connection with the furnishings of medical, surgical or dental care, diagnosis, treatment or service, on the sale, rental, furnishing or supplying of clinical laboratory supplies or services of any kind, drugs, medication, or medical supplies, or any other goods, services or supplies prescribed for medical diagnosis, care or treatment: PROVIDED, That ownership of a financial interest in any firm, corporation or association which furnishes any kind of clinical laboratory or other services prescribed for medical, surgical, or dental diagnosis shall not be prohibited under this section where (1) the referring practitioner affirmatively discloses to the patient in writing, the fact that such practitioner has a financial interest in such firm, corporation, or association; and (2) the referring practitioner provides the patient with a list of effective alternative facilities, informs the patient that he or she has the option to use one of the alternative facilities, and assures the patient that he or she will not be treated differently by the referring practitioner if the patient chooses one of the alternative facilities.

Any person violating the provisions of this section is guilty of a misdemeanor.

NEW SECTION. **Sec. 38.** A new section is added to chapter 18.130 RCW to read as follows:

CONFLICT OF INTEREST STANDARDS. The secretary of health, in consultation with the health care disciplinary authorities under RCW 18.130.040(2)(b), shall establish standards prohibiting or restricting provider investments and referrals that present a conflict of interest resulting from inappropriate financial gain for the provider or his or her immediate family. These standards are not intended to inhibit the efficient operation of managed health care systems. The secretary shall report to the health policy committees of the senate and house of representatives by June 30, 1993, on the development of the standards and any recommended statutory changes necessary to implement the standards.

"PART VIII - STANDARDIZED HEALTH CARE INSURANCE CLAIM FORMS"

NEW SECTION. **Sec. 39.** A new section is added to chapter 48.20 RCW to read as follows:

APPLICATION TO DISABILITY INSURANCE POLICIES. (1) After January 1, 1994, all disability insurance policies that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 48 of this act shall be used by providers of health care and carriers under this chapter.

NEW SECTION. **Sec. 40.** A new section is added to chapter 48.21 RCW to read as follows:

APPLICATION TO GROUP DISABILITY INSURANCE POLICIES. (1) After January 1, 1994, all group disability insurance policies that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 48 of this act shall be used by providers of health care and carriers under this chapter.

NEW SECTION. **Sec. 41.** A new section is added to chapter 48.44 RCW to read as follows:

APPLICATION TO HEALTH CARE INSURANCE CONTRACTS. (1) After January 1, 1994, all health care insurance contracts that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 48 of this act shall be used by providers of health care and carriers under this chapter.

NEW SECTION. **Sec. 42.** A new section is added to chapter 48.46 RCW to read as follows:

APPLICATION TO HEALTH MAINTENANCE AGREEMENTS. (1) After January 1, 1994, all health maintenance agreements that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 48 of this act shall be used by providers of health care and carriers under this chapter.

NEW SECTION. **Sec. 43.** A new section is added to chapter 48.84 RCW to read as follows:

APPLICATION TO LONG-TERM CARE PROVIDERS. (1) After January 1, 1994, all providers of long-term care that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform bill (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 48 of this act shall be used by providers of health care and carriers under this chapter.

NEW SECTION. **Sec. 44.** A new section is added to chapter 41.05 RCW to read as follows:

APPLICATION TO STATE HEALTH CARE AUTHORITY. After July 1, 1994, the health care financing administration (HCFA) 1500 form, or its successor, and the uniform billing (UB) 82 form, or its successor, shall be used in either paper or electronic format for state-paid health care services provided through the health care authority. The forms developed under section 48 of this act shall be used for billing purposes for pharmacists, dentists, eyeglasses, transportation, or vocational services.

NEW SECTION. **Sec. 45.** A new section is added to chapter 74.09 RCW to read as follows:

APPLICATION TO THE MEDICAL ASSISTANCE PROGRAM. After July 1, 1994, the health care financing administration (HCFA) 1500 form, or its successor, and the uniform billing (UB) 82 form, or its successor, shall be used in either paper or electronic format for state-paid health care services provided by the department. The forms developed under section 48 of this act shall be used for billing purposes for pharmacists, dentists, eyeglasses, transportation, or vocational services.

NEW SECTION. **Sec. 46.** A new section is added to Title 51 RCW to read as follows:

APPLICATION TO LABOR AND INDUSTRIES. After July 1, 1994, the health care financing administration (HCFA) 1500 form, or its

successor, and the uniform billing (UB) 82 form, or its successor, shall be used in either paper or electronic format for state-paid health care services provided under this title. The forms developed under section 48 of this act shall be used for billing purposes for pharmacists, dentists, eyeglasses, transportation, or vocational services.

NEW SECTION. **Sec. 47.** APPLICATION TO BASIC HEALTH PLAN. After July 1, 1994, the health care financing administration (HCFA) 1500 form, or its successor, and the uniform billing (UB) 82 form, or its successor, shall be used in either paper or electronic format for state-paid health care services provided under the basic health plan. The forms developed under section 48 of this act shall be used for billing purposes for pharmacists, dentists, eyeglasses, transportation, or vocational services.

NEW SECTION. **Sec. 48.** A new section is added to chapter 70.170 RCW to read as follows:

JOINT AGENCY RULES. By January 1, 1993, the council shall develop and adopt by rule in paper and electronic format billing forms to be used by pharmacists, dentists, eyeglasses, transportation, and vocational services. These forms shall be made available to providers of health care coverage licensed under chapters 48.20, 48.21, 48.44, 48.46, and 48.84 RCW.

"PART IX - INCENTIVES TO PARTICIPATE AS A PROVIDER IN THE MEDICAID PROGRAM"

NEW SECTION. **Sec. 49.** LEGISLATIVE INTENT. The legislature finds that:

(1) The number of persons without access, or with increasingly limited access, to health care services continues to grow; and

(2) The state's medical assistance program continues to provide necessary services to low-income Washington residents.

The legislature finds and declares that incentives need to be developed for health care providers to accept and retain medical assistance patients.

Sec. 50. RCW 41.04.250 and 1981 c 256 s 2 are each amended to read as follows:

"Employee" as used in this section and RCW 41.04.260 includes all full-time, part-time and career seasonal employees of the state, a county, a municipality, or other political subdivision of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of the government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and of the superior and district courts; ((~~and~~)) members of the state legislature or of the legislative authority of any county, city, or town; and, for the sole purpose of participating in the deferred compensation program, an individual licensed health care providers who are independent contractors with the department of social and health services to provide care to medical assistance recipients under chapter 74.09 RCW.

The state, through the committee for deferred compensation created in RCW 41.04.260, and any county, municipality, or other political

subdivision of the state acting through its principal supervising official or governing body is authorized to contract with an employee to defer a portion of that employee's income, which deferred portion shall in no event exceed the amount allowable under 26 U.S.C. Sec. 457, and deposit or invest such deferred portion in a credit union, savings and loan association, bank, or mutual savings bank or purchase life insurance, shares of an investment company, or fixed and/or variable annuity contracts from any insurance company or any investment company licensed to contract business in this state. The committee can provide such plans as it deems are in the interests of state employees. In addition to the types of investments described in this section, the committee may invest the deferred portion of an employee's income, without limitation as to amount, in any of the class of investments described in RCW 43.84.150 as in effect on January 1, 1981. Any income deferred under such a plan shall continue to be included as regular compensation, for the purpose of computing the state or local retirement and pension benefits earned by any employee.

Coverage of an employee under a deferred compensation plan under this section shall not render such employee ineligible for simultaneous membership and participation in any pension system for public employees.

"PART X - HEALTH INSURANCE PREMIUMS TAX EXEMPTION"

Sec. 51. RCW 48.14.022 and 1987 c 431 s 23 are each amended to read as follows:

(1) The taxes imposed in RCW 48.14.020 do not apply to premiums collected or received for policies of insurance issued under RCW 48.41.010 through 48.41.210.

(2) Until July 1, 1994, the taxes imposed in RCW 48.14.020 do not apply to premiums collected or received for policies of insurance issued under RCW 48.21.045.

(3) In computing tax due under RCW 48.14.020, there may be deducted from taxable premiums the amount of any assessment against the taxpayer under RCW 48.41.010 through 48.41.210. Any portion of the deduction allowed in this section which cannot be deducted in a tax year without reducing taxable premiums below zero may be carried forward and deducted in successive years until the deduction is exhausted.

"PART XI - SMALL BUSINESS HEALTH CARE INSURANCE REFORM"

NEW SECTION. **Sec. 52.** SHORT TITLE. This chapter shall be known and may be cited as the small employer health care coverage availability act.

NEW SECTION. **Sec. 53.** PURPOSE. The purpose and intent of this chapter and RCW 48.14.040 is to promote the availability of health care coverage to small employers regardless of the health status or claims experience of their employees and their employees' dependents, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitation on the use of preexisting condition exclusions, to provide for development of basic and standard health benefit plans to be offered to all small employers, and to improve the overall fairness and efficiency of the small employer health care coverage market.

NEW SECTION. **Sec. 54.** DEFINITIONS. As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries, or other individual acceptable to the commissioner, that a small employer carrier is in compliance with the provisions of section 56 of this act, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Association" means an organization organized and maintained in good faith for purposes other than that of obtaining health care coverage. Associations shall have constitutions and bylaws or other analogous governing documents and shall have been in active existence for at least five years, unless they are based on participation in a certain industry, in which case they must have been in active existence for at least two years.

(4) "Base premium rate" means, as to a rating period, the lowest premium rate for either employees or enrollees, based on rates or formulas filed by the small employer carrier with the commissioner, that could be charged under the rating system by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Basic health benefit plan" means a health benefit plan developed under section 60 of this act.

(6) "Board" means the board of directors of the Washington state health insurance pool, as established by chapter 48.41 RCW and amended by chapter ..., Laws of 1992 (this act).

(7) "Carrier" means any entity that provides health benefits coverage in Washington state. For the purposes of this chapter, carrier includes an insurance company, health care service contractor, health maintenance organization, or any person or entity that lawfully writes, issues, or administers health benefit plans in Washington state and is subject to the jurisdiction of the state of Washington.

(8) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status, and duration of coverage shall not be case characteristics for the purposes of this chapter.

(9) "Commissioner" means the insurance commissioner as defined in RCW 48.02.010.

(10) "Committee" means the health benefit plan committee created under section 60 of this act.

(11) "Dependent" means the eligible employee’s lawful spouse, unmarried natural child, adopted child or child legally placed for adoption, stepchild, or legally designated minor ward; unmarried child who is a full-time student under the age of twenty-three years who is financially dependent upon an eligible employee; or unmarried child of any age who is medically certified and disabled and claimed as an exemption on the federal income tax form of the eligible employee.

(12) "Eligible employee" means an active employee, proprietor, partner, or corporate officer of the small employer’s group who is paid on a regular, periodic basis through the group’s payroll system and who regularly works on a full-time basis and has a normal work week of thirty or more hours, and who is expected to continue doing so. An eligible employee must have met any applicable requirement of the employer as to the period of employment before the employee is eligible

for health benefits coverage. The term does not include an employee, proprietor, partner, or corporate officer who works on a part-time, temporary, or substitute basis.

(13) "Established geographic service area" means a geographical area, if any, as approved by the commissioner and based on the carrier's certificate of authority to transact business in Washington state, within which the carrier is authorized to provide coverage.

(14) "Financially impaired" means a carrier that, after the effective date of this section, is not insolvent and is:

(a) Deemed by the commissioner to be potentially unable to fulfill its contractual obligations; or

(b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(15) "Health benefit plan" means any hospital or medical policy or certificate, health care service contract, health maintenance organization subscriber contract, or plan provided by any other benefit arrangement subject to this chapter. The term does not include accident only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

(16) "Index rate" means, as to a rating period for small employers with similar case characteristics for the same or similar coverage, the arithmetic average of the applicable base premium rate and corresponding highest premium rate for either employees or enrollees based on rates or formulas filed by the small employer carrier with the commissioner.

(17) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period in which the person was

initially eligible to enroll under the terms of the health benefit plan, provided that such initial enrollment period is a period of at least thirty days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual meets each of the following:

(i) The individual was covered under qualifying previous coverage at the time the individual was eligible to enroll;

(ii) The individual certified at the time of the initial enrollment that coverage under another health benefit plan was the reason for declining enrollment;

(iii) The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse, or divorce;

(iv) The individual requests enrollment within thirty days after termination of the qualifying previous coverage;

(b) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) A court has ordered coverage be provided for a dependent under a covered employee’s health benefit plan and request for enrollment is made within thirty days after issuance of the court order.

(18) "New business premium rate" means, as to a rating period, the lowest premium rate for either employees or enrollees based on rates or formulas filed by the small employer carrier with the commissioner and which could have been charged by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(19) "Plan of operation" means the plan of operation of the program established under section 59 of this act.

(20) "Premium" means all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(21) "Producer" means an agent, broker, or solicitor as defined in chapter 48.17 RCW.

(22) "Program" means the Washington small employer program established under section 59 of this act.

(23) "Qualifying previous coverage" and "qualifying existing coverage" means benefits or coverage provided under:

(a) Medicare, medicaid, or the basic health plan;

(b) An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under a basic or standard health benefit plan that is subject to regulations of Washington state provided that such coverage has been in effect for the individual in question for a period of at least six months; or

(c) An individual health insurance policy issued by a carrier that provides benefits similar to or exceeding benefits provided under a standard health benefit plan, provided that such policy has been in effect for a period of at least six months.

(24) "Rating period" means the twelve-month period for which premium rates established by a small employer carrier are presumed to be in effect.

(25) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into an arrangement with the carrier pursuant to chapter 48.44 or 48.46 RCW to provide health care services to covered individuals.

(26) "Similar coverage" means two or more health benefit plans whose differences in plan or benefit structure cause no major differences in the rate schedules associated with the benefit plans. Carriers may define two or more coverage plans as being dissimilar and separate coverage if the structure of the benefits, payment methods, or other aspect of the coverage plans results in actuarial rate differences of more than fifteen percent, as filed by the carrier with the commissioner. A fully insured association plan in existence on July 1, 1992, and meeting the requirements of this chapter as of July 1, 1993, may be considered dissimilar and separate coverage.

(27) "Small employer" means any person, firm, corporation, partnership, or association that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least three eligible employees unrelated by blood or marriage but no more than forty-nine eligible employees, the majority of whom were employed within Washington state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. Small employers who are members of multiple employer groups or associations are subject to this chapter. Multiple employer group members or association members that do not meet the definition of a small employer are not subject to this chapter.

(28) "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers in Washington state.

(29) "Standard benefit plan" means a health benefit plan developed under section 60 of this act.

NEW SECTION. **Sec. 55.** APPLICABILITY AND SCOPE. (1) This chapter shall apply to any health benefit plan that provides coverage to the employees of a small employer in Washington state if any of the following conditions are met:

(a) Any portion of the premium or benefits is paid by or on behalf of the small employer and the employer meets the minimum participation and employer contribution requirements set forth by the carrier;

(b) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

(c) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 162, 125, or 106 of the United States Internal Revenue Code.

(2) Each carrier holding a certificate of authority or a certificate of registration shall be treated as a separate carrier for the purposes of this chapter.

NEW SECTION. **Sec. 56.** RESTRICTIONS RELATING TO PREMIUM RATES. (1) Premium rates for health benefit plans subject to this chapter shall be subject to the following provisions:

(a) The premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system as filed with the commissioner, shall not vary from the index rate by more than twenty-five percent of the index rate.

(b) Subject to the limits established in (a) of this subsection, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) The percentage change applied to all small employers covered by the small employer carrier from the first day of the prior rating period to the first day of the new rating period to account for the cost experience of the prior rating period and the anticipated cost experience for the new rating period;

(ii) Any adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, and duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual; and

(iii) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual.

(c) For fully insured association plans in existence on July 1, 1992, and meeting the requirements of this chapter as of July 1, 1993, carriers may base the percentage increase in premium rates for small employers covered by an association plan using the procedure outlined in paragraph (b) of this subsection (1) applying only the experience of the small employers covered by the association plan.

(d) Adjustments in rates for claim experience, health status, and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) A small employer carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent.

(f) For health benefit plans issued prior to the effective date of this section, a premium rate for a rating period may exceed the ranges

set forth in (a) of this subsection for a period of three years following the effective date of this section. In such cases, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers; and

(ii) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier’s rate manual.

(g)(i) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers. Rating factors shall produce premiums for identical small employers that differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans. All small employer health benefit plans offered by a carrier shall be rated subject to the requirements of (a) of this subsection.

(ii) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(h) For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network,

provided that utilization of the restricted provider network results in substantial differences in claims costs.

(i) A small employer carrier shall not use case characteristics other than age, gender, industry and geographic area, without prior approval of the commissioner, based on the board's recommendation.

(j) The commissioner may establish rules, giving due consideration to the recommendations of the board, to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this chapter, including:

(i) Assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect actuarially acceptable differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans; and

(ii) Prescribing the manner in which case characteristics may be used by small employer carriers.

(k) Nothing in this section shall be construed as a prohibition against using family size and composition in setting rates.

(2) A small employer carrier shall not transfer a small employer involuntarily into a health benefit plan or out of a health benefit plan unless that benefit plan is discontinued by the carrier for all small employers. A small employer carrier shall not offer to transfer a small employer into or out of a health benefit plan unless such offer is made to transfer all small employers with the same health benefit plan without regard to case characteristics, claim experience, health status, or duration of coverage.

(3) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, at least once in writing to the small employer

or as part of its solicitation and sales materials, of all of the following:

(a) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(b) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and factors, other than claim experience, that affect changes in premium rates;

(c) The provision relating to renewability of policies and contracts; and

(d) The provisions relating to any preexisting condition.

(4)(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the commissioner annually on or before March 15 an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in (a) of this subsection available to the commissioner upon request. The information shall be considered proprietary and trade secret information and shall not be subject to

disclosure by the commissioner to any persons outside of the office except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

NEW SECTION. **Sec. 57.** RENEWABILITY OF COVERAGE. (1) A health benefit plan subject to this chapter shall be renewable with respect to all eligible employees and dependents, at the option of the small employer, except in any of the following cases:

(a) Nonpayment of the required premiums or cost-sharing requirements of the health benefit plan;

(b) Fraud or misrepresentation by the small employer or, with respect to coverage of individual insureds, the insureds or their representatives;

(c) Noncompliance with the carrier's minimum participation or eligibility requirements;

(d) Noncompliance with the carrier's employer contribution requirements;

(e) Repeated misuse of a provider network provision;

(f) The small employer carrier elects to not renew all of its health benefit plans issued to small employers in Washington state. In such a case the carrier shall:

(i) Provide advance notice of its decision under this subsection (1)(f)(i) to the board and to the commissioner; and

(ii) Provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected covered individual is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit plan by the carrier. Notice to the commissioner under this subsection (1)(f)(ii) shall be provided at least three working days prior to the notice to the affected small employers;

(g) The commissioner finds that the continuation of coverage for small employers would:

(i) Not be in the best interests of the policyholders or certificate holders; or

(ii) Impair the carrier's ability to meet its contractual obligations.

In such instance the commissioner shall assist affected small employers in finding replacement coverage.

(2) Nothing in this section will preclude a carrier from modifying its health benefit plans other than its basic or standard health benefit plans, unless changed by the board, so long as the modifications are offered to all of the small employers covered by the modified plans.

(3) A small employer carrier that elects not to renew a standard or basic health benefit plan under subsection (1)(f) of this section shall be prohibited from writing new business in the small employer market in Washington state for a period of five years from the date of notice to the commissioner.

(4) In the case of a small employer carrier that ceases doing business in one established geographic service area of the state, the rules set forth in this section shall apply only to the carrier's operations in such service area.

NEW SECTION. **Sec. 58.** GENERAL SMALL EMPLOYER CARRIER REQUIREMENTS. (1) Small employer carriers may offer a variety of benefit plans to small employers; however each small employer carrier must offer standard or basic health benefit plans developed by the health benefit plan committee pursuant to section 60 of this act to any eligible small employer. All health benefit plans, other than the basic health benefit plan, covering small employers shall include at

least a standard health benefit coverage established pursuant to this chapter and all health benefit plans offered to small employers shall also comply with the following provisions:

(a) A small employer carrier shall file with the commissioner, in a form and manner prescribed by the commissioner, the basic, standard, and other small employer health benefit plans to be used by the carrier. Any health benefit plan filed pursuant to this subsection (1)(a) may be used by a small employer carrier immediately after it is filed.

(b) A health benefit plan shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than six months following the effective date of the individual's coverage due to a preexisting condition. A small employer health benefit plan shall not define a preexisting condition more restrictively than:

(i) A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the six months immediately preceding the effective date of coverage;

(ii) A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage; or

(iii) A pregnancy existing on the effective date of coverage.

(c) A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage did not terminate more than thirty days prior to the effective date of the new coverage. This subsection (1)(c) does not preclude application of any eligibility waiting period imposed by the small employer subject to the federal Employee's Retirement Income Security Act (ERISA) and

applicable to all new employees and dependents under the health benefit plan. The eligibility waiting period imposed by the small employer shall not be counted as part of the time period used to determine qualifying previous coverage.

(d) A health benefit plan may exclude coverage for late enrollees for the greater of twelve months or for a twelve-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed twelve months from the date the individual enrolls for coverage under the health benefit plan.

(e)(i) Except as provided in (iv) of this subsection (1)(e), requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(ii) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(iii)(A) Except as provided in (iii)(B) of this subsection (1)(e), in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(B) With respect to a small employer with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by an employer in applying minimum participation requirements.

(iv) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(f)(i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of the small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in (e) of this subsection.

(ii) A small employer carrier shall not modify the basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the basic or standard health benefit plan.

(2)(a) Every small employer carrier shall, as a condition of transacting business in Washington state with small employers, actively offer to small employers at least a basic and a standard health benefit plan.

(b) A small employer carrier shall issue a basic or standard health benefit plan to any eligible small employer that applies for such a plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter.

(c) A small employer carrier shall issue at least the basic or standard health benefit plan to any eligible small employer that applies to such a plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit

plan not inconsistent with this chapter, until the carrier's target of high-risk individuals has been met under section 59 of this act.

(d) Coverage provided to a small employer through an association shall be subject to all of the requirements of this chapter, except the requirement to make health benefit plans available to small employers that do not belong to the association. For the purpose of providing coverage to the association, a carrier shall not be required to issue a health benefit plan to any small employer that is not a member of any such association through the association policy or contract.

(e)(i) No small employer carrier utilizing a restricted network provision shall be required to offer coverage or accept applications pursuant to (b) of this subsection in the case of the following:

(A) To a small employer, where the small employer is not physically located in the carrier's established geographic service area;

(B) To an employee, when the employee does not reside within the carrier's established geographic service area; or

(C) Within an established geographic service area where the carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner that it will not have the capacity within that area in its network of providers to deliver service adequately to the members of such groups because of its obligations to existing group contract holders and enrollees.

(ii) A carrier that cannot offer coverage pursuant to (e)(i)(C) of this subsection may not offer coverage in the applicable service area to any new employer groups until the later of ninety days following each such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups in that service area.

(f) A small employer carrier shall not be required to offer coverage or accept applications pursuant to (b) of this subsection

where the commissioner finds that the acceptance of an application or applications would place the small employer carrier in a financially impaired condition; provided, however, that a small employer carrier that has not offered coverage or accepted applications pursuant to this subsection (2)(f) may not offer health benefit plans to any group except pursuant to a marketing plan approved by the commissioner.

(g) For purposes of establishing continued small employer eligibility under this chapter, a small employer carrier may reassess the size of the covered employer on the anniversary date of the employer's policy. Coverage under this chapter may be discontinued if the small employer no longer meets the size requirements provided for in this chapter. However, if a small employer falls below the minimum size, coverage must be continued for a period of at least one year before the small employer carrier can discontinue coverage under this chapter, provided that the small employer continues to fall below the minimum group size requirements of this chapter.

(h) The provisions of this subsection shall be effective one hundred eighty days after the commissioner's approval of the basic and standard health benefit plans developed under section 60 of this act, provided that if the small employer program created under section 59 of this act is not yet in operation on such date, the provisions of this subsection shall be effective on the date that such program begins operation.

NEW SECTION. **Sec. 59.** SMALL EMPLOYER HEALTH BENEFITS COVERAGE PROGRAM. (1) All small employer carriers issuing health benefit plans in this state on and after July 1, 1993, shall be required to meet the requirements of this section as a condition of authority to transact business in Washington state. However, nothing in this chapter shall be construed to prohibit a small employer carrier from continuing to

offer coverage to small employer groups after meeting its target of high-risk individuals as defined by the board.

(2) There is created a nonprofit entity to be known as the Washington small employer health benefits coverage program. All small employer carriers issuing health benefit plans in Washington state on and after July 1, 1993, shall be participants in the program.

(3) The program shall operate subject to the supervision and control of the board of the Washington health insurance pool, as established by chapter 48.41 RCW and amended by chapter --, Laws of 1992 (this act).

(4) Within sixty days of the effective date of this section each small employer carrier shall make a filing with the commissioner containing the carrier's enrollment in health benefit plans issued to small employers in this state as of the effective date of this section.

(5) Within one hundred eighty days after the effective date of this section, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable, to assure the fair, reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, disapprove the plan of operation if the commissioner determines that it does not meet the requirements of chapter --, Laws of 1992 (this act). The plan of operation shall become effective unless disapproved in writing by the commissioner within thirty days of the date it was submitted by the board.

(6) If the board fails to submit a plan of operation within one hundred eighty days after the effective date of this section, the commissioner shall, after notice and hearing, adopt a temporary plan of operation, which shall be rescinded at the time a plan of operation is submitted by the board.

(7) The plan of operation shall:

(a) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the commissioner;

(b) Establish procedures for retaining independent consultants to assist the board in establishing and enforcing reasonable target amounts and risk distribution practices for small employer carriers;

(c) Establish procedures at least annually for assigning targets of high-risk individuals among small employer carriers in accordance with the provisions of this chapter;

(d) Establish targets of sufficient size and variability to assure that a substantial proportion of available carrier capacity remains open for new enrollment in a geographic area;

(e) Establish procedures so that carriers who have fulfilled their target of high-risk individuals from small employers in a geographic area may remain open selectively for new enrollment to small employers;

(f) Establish procedures for collecting assessments from all small employer carriers to provide for administrative expenses incurred or estimated to be incurred for the period for which the assessment is made; and

(g) Provide for any additional matters necessary for the implementation and administration of the program.

(8) The program board shall have the specific authority to:

(a) Establish rules, conditions, and procedures pertaining to its functions under this chapter, including the board’s authority to review and approve a carrier’s accounting for high-risk individuals from newly enrolled small employers;

(b) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this section, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common

functions or with persons or other organizations for the performance of administrative functions;

(c) Sue or be sued, including taking any legal actions necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any allocating carriers;

(d) Assess small employer carriers in accordance with the provisions of subsection (12) of this section, and to make interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

(e) Appoint appropriate legal, actuarial, audit, and other committees as necessary to provide technical assistance in the operation of the program, policy, and other contract design, and any other function within the authority of the program;

(f) Perform other functions necessary and proper to carry out its responsibilities under this chapter.

(9) The board shall establish procedures, as part of the plan of operation, for determining targets by geographic area of high-risk individuals in small employers with no more than twenty-five eligible employees among all small employer carriers. Such procedures shall be designed to assure a fair distribution of risks among small employer carriers. The procedures shall include the following:

(a) A method by which the board shall estimate each year the total number of expected new high-risk individuals across all small employer groups that will be identified and used for determining carrier targets under this subsection during the year. The board shall develop a uniform definition of a high-risk individual based on standardized criteria that are generally accepted, actuarially justified and similar to those that would be administered by carriers in determining on a

prospective basis an individual's likely risk category, for purposes of this section. The board shall not consider those high-risk individuals already in each small employer carrier's existing book of business subject to these targets, except as provided by (b) of this subsection.

(b) A method by which the board shall assign to each small employer carrier a target number of high-risk individuals. The target number for a small employer carrier shall bear the same proportional relationship to the total number of high-risk individuals estimated under (a) of this subsection as the small employer carrier's average annual enrollment of small employers bears to the average annual enrollment of all small employer carriers for coverage of small employers. However, for small employer carriers whose enrollees from small groups are at least sixty percent of their total covered enrollees from all sources in the geographic service area and which have fewer than ten thousand enrollees, no more than forty percent of their small group enrollees shall be deemed small group enrollees for purposes of establishing the carrier's target. In the case of an established small employer carrier with an established geographic services area, the board shall allow an initial adjustment to the target otherwise applicable to the small employer carrier where the carrier applies to the board for such an adjustment and demonstrates to the satisfaction of the board that such an adjustment is appropriate. The adjustment shall account for such factors as the carrier's increased or decreased exposure resulting from the demographics of the carrier's geographic service area, the existing mix of small groups, the existing risk base of the carrier, and other factors that the board deems appropriate and applies consistently.

(c) A procedure by which the board shall determine the number of high-risk eligible employees and dependents of each small employer that constitutes the carrier's target of high-risk individuals, not

including those high-risk individuals already in a small employer carrier's existing book of business subject to this chapter, except as provided in (b) of this subsection. A small employer carrier may not count an individual towards filling its target unless it receives the approval of the board. The board shall not approve an individual to be counted toward a small employer carrier's target unless the carrier submitted that individual to the board within sixty days following the commencement of coverage with the carrier. If a small employer carrier fails to submit an individual to the board within sixty days following the commencement of coverage, the carrier is permanently prohibited from submitting that individual to the board in the future for the purpose of meeting the carrier's target.

(d) A procedure by which a small employer carrier which has met its established target for new enrollment of high-risk individuals in small employer groups may cease enrolling small employers with high-risk individuals in the carrier's geographic service area.

(e) A procedure by which the board shall establish a target for a small employer carrier that wishes to enter a new geographic service area.

(f) Procedures for achieving an equitable, prospective distribution among small employer carriers of high-risk individuals; efficient administration of the program; and providing incentive for small employer carriers to manage the care of high-risk individuals enrolled under the program.

(10) The board shall periodically evaluate the program to assure equity in the distribution of high-risk individuals under small employers, including consideration of the comparative lengths of time that carriers have provided coverage to meet their target of high-risk individuals and of the utilization and cost data for small groups and high-risk individuals enrolled with the carrier after the effective

date of this section. The board, subject to the approval of the commissioner, shall have the authority to make adjustments to the procedures established pursuant to this subsection to further the goal of equitable distribution of high-risk individuals under small employers.

(11) Following the close of each fiscal year, the board shall determine the program expenses of the administration. The net expense for the year shall be recouped by assessment on the participating carriers.

(12) Small employer carriers shall accept application from all small employers until their targets for high-risk individuals are met, as determined by the board pursuant to subsection (9) of this section. A small employer carrier may also offer to small employers coverage that is more comprehensive than that required by this chapter.

(13) Each small employer carrier shall file with the commissioner, in a form and manner to be prescribed by the commissioner, an annual report. The report shall state the small employer carrier's enrollment of new small employer coverage written in the previous twelve-month period. The report also shall state the number and size of small employers with high-risk individuals and the number of high-risk individuals that meets the standard criteria for high-risk individuals, the names and number of the small employers that canceled or terminated coverage with it during the preceding calendar year, and the reasons for such cancellations or terminations, if known. The report shall be filed on or before March 1 for the preceding calendar year. A copy of the report shall be provided to the board.

(14) Neither the participation by members, the establishment of rates, forms, or procedures for coverages issued by the program, nor any other joint or collective action required by this chapter or the state of Washington shall be the basis of any legal action, criminal or

civil liability or penalty against the program or any small employer carrier either jointly or separately.

(15) The program board and operations are exempt from any and all taxes. This exemption shall not be construed to include carriers.

NEW SECTION. **Sec. 60.** HEALTH BENEFIT PLAN COMMITTEE. (1) The commissioner shall appoint a health benefit plan committee. The committee shall be composed of balanced representation from small employer carriers, including insurance companies, health care service contractors, health maintenance organizations, and other carriers, and from small employers, employees, and health care providers.

(2) The committee shall recommend the form and level of coverage to be made available by small employer carriers under sections 58 and 59 of this act.

(3)(a) The committee shall recommend benefit levels, cost sharing levels, exclusions, and limitations for the basic and standard health benefit plans. The committee shall also design at least two basic and two standard health benefit plans that contain benefit and cost sharing levels consistent with the basic method of operation and benefits of health maintenance organizations, at least one of which shall be consistent with restrictions and requirements imposed on health maintenance organizations by federal law, including the federal HMO act (42 U.S.C. Sec. 300e et seq.). The committee may also develop recommended underwriting standards for use voluntarily by carriers that employ such practices.

(b) With the approval of the board, the committee shall submit the health benefit plans described in (a) of this subsection to the commissioner for approval within one hundred eighty days after the appointment of the committee.

(c)(i) A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the health benefit plans to be used by the carrier. Any health benefit plan filed pursuant to this subsection (3)(c)(i) may be used by a small employer carrier immediately after it is filed.

(ii) The commissioner at any time may, after providing written notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this subsection.

NEW SECTION. **Sec. 61.** PERIODIC MARKET EVALUATION. (1) The board, in consultation with members of the committee, shall study and report at least every three years to the commissioner on the effectiveness of this chapter. The report shall analyze the effectiveness of this chapter in promoting rate stability, product availability, and percent of eligible employers providing coverage. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer health care coverage market place. The report shall address whether carriers and producers are fairly and actively marketing and issuing health benefit plans to small employers in fulfillment of the purposes of this chapter. The report may contain recommendations for market conduct or other regulatory standards or actions.

(2) The board shall commission an actuarial study, by an independent actuary approved by the commissioner, within the first three years of the operation of the program to evaluate and measure the relative risks being assumed by differing types of small employer carriers as a result of this chapter.

NEW SECTION. **Sec. 62.** WAIVER OF CERTAIN STATE LAWS. Nothing in this chapter shall be construed to require the basic and the standard health benefit plans of a small employer carrier to satisfy the applicable requirements of:

(1) RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240, 48.21.244, 48.21.250, 48.21.300, 48.21.310, or 48.21.320;

(2) RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460;

(3) RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530.

NEW SECTION. **Sec. 63.** ADMINISTRATIVE PROCEDURES. The commissioner may issue rules in accordance with this chapter, to be implemented on July 1, 1993, upon due consideration of recommendations of the board.

NEW SECTION. **Sec. 64.** STANDARDS TO ASSURE FAIR MARKETING. (1) If a small employer carrier chooses to offer only a basic or standard health benefit plan to a small employer, the carrier shall notify the small employer of the reason or reasons for this decision in a form and manner prescribed by the commissioner. If a small employer carrier that has met its target of high-risk individuals under section 59 of this act chooses not to offer a basic or standard health benefit plan to a small employer, the carrier shall notify the small employer in a form and manner prescribed by the commissioner of the availability of coverage through other small employer carriers in the geographic area.

(2) A small employer carrier may provide reasonable compensation, as provided under the plan of operation of the program, provided, no incentives or remuneration of any kind may be paid to or accepted by the producer to place or refer small groups with any carrier based on health status or claims history of potential enrollees.

(3) No small employer carrier shall terminate, fail to renew, or limit its contract or agreement of representation with a producer because the producer has placed small employers with the small employer carrier.

(4) No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee’s employment.

(5) If a small employer carrier declines to offer a health benefit plan to a small employer for a reason permitted under section 58 or 59 of this act, the small employer carrier shall notify the small employer of such decision in writing and shall state the reason or reasons for the decision.

(6) Upon due consideration of the recommendation of the board, the commissioner may adopt by rule additional standards to provide for the availability of health benefit plans to small employers through the program.

(7)(a) A violation of this section by a small employer insurer or producer shall be an unfair trade practice under chapter 48.30 RCW. A violation by a health care service contractor or a health maintenance organization is a prohibited practice under the applicable provisions of chapter 48.44 or 48.46 RCW.

(b) If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or the other services related to the

offering of health benefit plans to small employers in Washington state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

Sec. 65. RCW 48.41.040 and 1989 c 121 s 2 are each amended to read as follows:

(1) There is hereby created a nonprofit entity to be known as the Washington state health insurance pool. All members in this state on or after May 18, 1987, shall be members of the pool. When authorized by federal law, all self-insured employers shall also be members of the pool.

(2) Pursuant to chapter 34.05 RCW the commissioner shall, within ninety days after ((~~May 18, 1987~~)) the effective date of this section, give notice to all members of the time and place for the ((~~initial~~)) organizational meetings of the pool as restructured pursuant to chapter --, Laws of 1992 (this act). A board of directors shall be established, which shall be comprised of ((~~nine~~)) thirteen members. The commissioner shall select (a) three members of the board who shall represent ((~~(a)~~)) (i) the general public, ((~~(b)~~)) (ii) health care providers, and ((~~(c)~~)) (iii) health insurance agents and (b) two members of the board who shall represent small employers as defined by section 54 of this act. The remaining members of the board shall be selected by election from among the members of the pool. The elected members shall, to the extent possible, include at least ((~~one~~)) three representatives of health care service contractors, ((~~one~~)) three representatives of health maintenance organizations, and ((~~one~~)) two representatives of commercial insurers which provides disability insurance. When self-insured organizations become eligible for participation in the pool, the membership of the board shall be increased to ((~~eleven~~)) fifteen and at least one member of the board

shall represent the self-insurers. In electing and appointing members of the board, due regard shall be given to the need for geographic balance among members and for representation from diverse carrier perspectives. Members of the board representing small business shall not vote on matters involving the administration of the Washington state health insurance coverage access act established by this chapter. Members of the board representing providers and agents shall not vote on matters involving sections 52 through 64 and 66 of this act.

(3) The ((~~original~~)) additional members of the board of directors as provided by sections 52 through 64 and 66 of this act shall be appointed for intervals of one to three years. Thereafter, all board members shall serve a term of three years. Board members shall receive no compensation, but shall be reimbursed for all travel expenses as provided in RCW 43.03.050 and 43.03.060.

(4) The board shall submit to the commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the pool. The commissioner shall, after notice and hearing pursuant to chapter 34.05 RCW, approve the plan of operation if it is determined to assure the fair, reasonable, and equitable administration of the pool and provides for the sharing of pool losses on an equitable, proportionate basis among the members of the pool. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. If the board fails to submit a plan of operation within one hundred eighty days after the appointment of the board or any time thereafter fails to submit acceptable amendments to the plan, the commissioner shall, within ninety days after notice and hearing pursuant to chapters 34.05 and 48.04 RCW, adopt such rules as are necessary or advisable to effectuate this chapter. The rules shall

continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner.

NEW SECTION. **Sec. 66.** APPLICATION OF CHAPTER TO CHAPTERS 48.21, 48.44, AND 48.46 RCW. This chapter applies to carriers regulated under chapters 48.21, 48.44, and 48.46 RCW. After the effective date of this section, basic group disability insurance policies issued pursuant to RCW 48.21.045, basic health care service contracts issued pursuant to RCW 48.44.023, and basic health maintenance agreements issued pursuant to RCW 48.46.066 shall become subject to this chapter when they are renewed or reissued.

NEW SECTION. **Sec. 67.** A new section is added to chapter 82.02 RCW to read as follows:

The provisions of this title shall not apply to the Washington small employer benefits coverage program board and operations established under section 59 of this act. This exemption shall not be construed to include carriers.

NEW SECTION. **Sec. 68.** A new section is added to chapter 84.36 RCW to read as follows:

The real and personal property of the Washington small employer benefits coverage program board and operations established under section 59 of this act is exempt from taxation.

"PART XII - MISCELLANEOUS"

Sec. 69. RCW 18.130.040 and 1990 c 3 s 810 are each amended to read as follows:

(1) This chapter applies only to the secretary and the boards having jurisdiction in relation to the professions licensed under the chapters specified in this section. This chapter does not apply to any business or profession not licensed under the chapters specified in this section.

(2)(a) The secretary has authority under this chapter in relation to the following professions:

(i) Dispensing opticians licensed under chapter 18.34 RCW;

(ii) Naturopaths licensed under chapter 18.36A RCW;

(iii) Midwives licensed under chapter 18.50 RCW;

(iv) Ocularists licensed under chapter 18.55 RCW;

(v) Massage operators and businesses licensed under chapter 18.108 RCW;

(vi) Dental hygienists licensed under chapter 18.29 RCW;

(vii) Acupuncturists certified under chapter 18.06 RCW;

(viii) Radiologic technologists certified and x-ray technicians registered under chapter 18.84 RCW;

(ix) Respiratory care practitioners certified under chapter 18.89 RCW;

(x) Persons registered or certified under chapter 18.19 RCW;

(xi) Persons registered as nursing pool operators;

(xii) Nursing assistants registered or certified under chapter ((~~18.52B~~)) 18.88A RCW;

(xiii) Dietitians and nutritionists certified under chapter 18.138 RCW; and

(xiv) Sex offender treatment providers certified under chapter 18.155 RCW.

(b) The boards having authority under this chapter are as follows:

(i) The ((~~podiatry~~)) podiatric medical board as established in chapter 18.22 RCW;

(ii) The chiropractic disciplinary board as established in chapter 18.26 RCW governing licenses issued under chapter 18.25 RCW;

(iii) The dental disciplinary board as established in chapter 18.32 RCW;

(iv) The council on hearing aids as established in chapter 18.35 RCW;

(v) The board of funeral directors and embalmers as established in chapter 18.39 RCW;

(vi) The board of examiners for nursing home administrators as established in chapter 18.52 RCW;

(vii) The optometry board as established in chapter 18.54 RCW governing licenses issued under chapter 18.53 RCW;

(viii) The board of osteopathic medicine and surgery as established in chapter 18.57 RCW governing licenses issued under chapters 18.57 and 18.57A RCW;

(ix) The board of pharmacy as established in chapter 18.64 RCW governing licenses issued to pharmacists or pharmacy assistants under chapters 18.64 and 18.64A RCW;

(x) The medical disciplinary board as established in chapter 18.72 RCW governing licenses and registrations issued under chapters 18.71 and 18.71A RCW;

((~~(x)~~)) (xi) The board of physical therapy as established in chapter 18.74 RCW;

((~~(xi)~~)) (xii) The board of occupational therapy practice as established in chapter 18.59 RCW;

((~~(xii)~~)) (xiii) The board of practical nursing as established in chapter 18.78 RCW;

((~~(xiii)~~)) (xiv) The examining board of psychology and its disciplinary committee as established in chapter 18.83 RCW;

((~~(xiv)~~)) (xv) The board of nursing as established in chapter 18.88 RCW; and

((~~(xv)~~)) (xvi) The veterinary board of governors as established in chapter 18.92 RCW.

(3) In addition to the authority to discipline license holders, the disciplining authority has the authority to grant or deny licenses based on the conditions and criteria established in this chapter and the chapters specified in subsection (2) of this section. However, the board of chiropractic examiners has authority over issuance and denial of licenses provided for in chapter 18.25 RCW, the board of dental examiners has authority over issuance and denial of licenses provided for in RCW 18.32.040, and the board of medical examiners has authority over issuance and denial of licenses and registrations provided for in chapters 18.71 and 18.71A RCW. This chapter also governs any investigation, hearing, or proceeding relating to denial of licensure or issuance of a license conditioned on the applicant's compliance with an order entered pursuant to RCW 18.130.160 by the disciplining authority.

Sec. 70. RCW 18.130.175 and 1991 c 3 s 270 are each amended to read as follows:

(1) In lieu of disciplinary action under RCW 18.130.160 and if the disciplining authority determines that the unprofessional conduct may be the result of substance abuse, the disciplining authority may refer the license holder to a voluntary substance abuse monitoring program approved by the disciplining authority.

The cost of the treatment shall be the responsibility of the license holder, but the responsibility does not preclude payment by an employer, existing insurance coverage, or other sources. Primary alcoholism or drug treatment shall be provided by approved treatment facilities under RCW 70.96A.020((~~(2)~~)): PROVIDED, That nothing shall prohibit the disciplining authority from approving additional services and programs as an adjunct to primary alcoholism or drug treatment. The disciplining authority may also approve the use of out-of-state programs. Referral of the license holder to the program shall be done only with the consent of the license holder. Referral to the program may also include probationary conditions for a designated period of time. If the license holder does not consent to be referred to the program or does not successfully complete the program, the disciplining authority may take appropriate action under RCW 18.130.160.

(2) In addition to approving substance abuse monitoring programs that may receive referrals from the disciplining authority, the disciplining authority may establish by rule requirements for participation of license holders who are not being investigated or monitored by the disciplining authority for substance abuse. License holders voluntarily participating in the approved programs without being referred by the disciplining authority shall not be subject to disciplinary action under RCW 18.130.160 for their substance abuse, and shall not have their participation made known to the disciplining authority, if they meet the requirements of this section and the program in which they are participating.

(3) The license holder shall sign a waiver allowing the program to release information to the disciplining authority if the licensee does not comply with the requirements of this section or is unable to practice with reasonable skill or safety. The substance abuse program shall report to the disciplining authority any license holder who fails

to comply with the requirements of this section or the program or who, in the opinion of the program, is unable to practice with reasonable skill or safety. License holders shall report to the disciplining authority if they fail to comply with this section or do not complete the program's requirements. License holders may, upon the agreement of the program and disciplining authority, reenter the program if they have previously failed to comply with this section.

(4) The treatment and pretreatment records of license holders referred to or voluntarily participating in approved programs shall be confidential, shall be exempt from RCW 42.17.250 through 42.17.450, and shall not be subject to discovery by subpoena or admissible as evidence except for monitoring records reported to the disciplining authority for cause as defined in subsection (3) of this section. Monitoring records relating to license holders referred to the program by the disciplining authority or relating to license holders reported to the disciplining authority by the program for cause, shall be released to the disciplining authority at the request of the disciplining authority. Records held by the disciplining authority under this section shall be exempt from RCW 42.17.250 through 42.17.450 and shall not be subject to discovery by subpoena except by the license holder.

(5) "Substance abuse," as used in this section, means the impairment, as determined by the disciplining authority, of a license holder's professional services by an addiction to, a dependency on, or the use of alcohol, legend drugs, or controlled substances.

(6) This section does not affect an employer's right or ability to make employment-related decisions regarding a license holder. This section does not restrict the authority of the disciplining authority to take disciplinary action for any other unprofessional conduct.

(7) A person who, in good faith, reports information or takes action in connection with this section is immune from civil liability for reporting information or taking the action.

(a) The immunity from civil liability provided by this section shall be liberally construed to accomplish the purposes of this section and the persons entitled to immunity shall include:

(i) An approved monitoring treatment program;

(ii) The professional association operating the program;

(iii) Members, employees, or agents of the program or association;

(iv) Persons reporting a license holder as being impaired or providing information about the license holder's impairment; and

(v) Professionals supervising or monitoring the course of the impaired license holder's treatment or rehabilitation.

(b) The immunity provided in this section is in addition to any other immunity provided by law.

((~~(8) In addition to health care professionals governed by this chapter, this section also applies to pharmacists under chapter 18.64 RCW and pharmacy assistants under chapter 18.64A RCW. For that purpose, the board of pharmacy shall be deemed to be the disciplining authority and the substance abuse monitoring program shall be in lieu of disciplinary action under RCW 18.64.160 or 18.64A.050. The board of pharmacy shall adjust license fees to offset the costs of this program.~~))

Sec. 71. RCW 18.64.160 and 1985 c 7 s 60 are each amended to read as follows:

In addition to the grounds under RCW 18.130.170 and 18.130.180, the board of pharmacy ((~~shall have the power to refuse, suspend, or revoke~~)) may take disciplinary action against the license of any pharmacist or intern upon proof that:

(1) His or her license was procured through fraud, misrepresentation, or deceit;

(2) ((~~He or she has been convicted of a felony relating to his or her practice as a pharmacist;~~

~~(3) He or she has committed any act involving moral turpitude, dishonesty, or corruption, if the act committed directly relates to the pharmacist's fitness to practice pharmacy. Upon such conviction, however, the judgment and sentence shall be conclusive evidence at the ensuing disciplinary hearing of the guilt of the respondent pharmacist of the crime described in the indictment or information, and of his or her violation of the statute upon which it is based;~~

~~(4) He or she is unfit to practice pharmacy because of habitual intemperance in the use of alcoholic beverages, drugs, controlled substances, or any other substance which impairs the performance of professional duties;~~

~~(5)~~)) He or she exhibits behavior which may be due to physical or mental impairment, which creates an undue risk of causing harm to him or herself or to other persons when acting as a licensed pharmacist or intern;

((~~(6)~~)) (3) He or she has incompetently or negligently practiced pharmacy, creating an unreasonable risk of harm to any individual;

((~~(7) His or her legal authority to practice pharmacy, issued by any other properly constituted licensing authority of any other state, has been and is currently suspended or revoked;~~

~~(8)~~)) (4) In the event that a pharmacist is determined by a court of competent jurisdiction to be mentally incompetent, the pharmacist shall automatically have his or her license suspended by the board upon the entry of the judgment, regardless of the pendency of an appeal;

((~~(9)~~)) (5) He or she has knowingly violated or permitted the violation of any provision of any state or federal law, rule, or

regulation governing the possession, use, distribution, or dispensing of drugs, including, but not limited to, the violation of any provision of this chapter, Title 69 RCW, or rule or regulation of the board;

((~~(10)~~)) (6) He or she has knowingly allowed any unlicensed person to take charge of a pharmacy or engage in the practice of pharmacy, except a pharmacy intern or pharmacy assistant acting as authorized in this chapter or chapter 18.64A RCW in the presence of and under the immediate supervision of a licensed pharmacist;

((~~(11)~~)) (7) He or she has compounded, dispensed, or caused the compounding or dispensing of any drug or device which contains more or less than the equivalent quantity of ingredient or ingredients specified by the person who prescribed such drug or device: PROVIDED, HOWEVER, That nothing herein shall be construed to prevent the pharmacist from exercising professional judgment in the preparation or providing of such drugs or devices.

((~~In any case of the refusal, suspension, or revocation of a license by said board of pharmacy under the provisions of this chapter, said board shall proceed in accordance with chapter 34.05 RCW.~~))

NEW SECTION. **Sec. 72.** A new section is added to chapter 18.64 RCW to read as follows:

PHARMACISTS ARE SUBJECT TO THE UNIFORM DISCIPLINARY ACT. The uniform disciplinary act, chapter 18.130 RCW, governs unlicensed practice of pharmacy, the issuance and denial of licenses, and the discipline of licensed pharmacists under this chapter.

Sec. 73. RCW 18.64A.050 and 1989 1st ex.s. c 9 s 424 are each amended to read as follows:

In addition to the grounds under RCW 18.130.170 and 18.130.180, the board of pharmacy ((~~shall have the power to refuse, suspend, or~~

~~revoke~~)) may take disciplinary action against the certificate of any pharmacy assistant upon proof that:

(1) His or her certificate was procured through fraud, misrepresentation or deceit;

((~~(2) He or she has been found guilty of any offense in violation of the laws of this state relating to drugs, poisons, cosmetics or drug sundries by any court of competent jurisdiction. Nothing herein shall be construed to affect or alter the provisions of RCW 9.96A.020;~~

~~(3) He or she is unfit to perform his or her duties because of habitual intoxication or abuse of controlled substances;~~

~~(4) He or she has exhibited gross incompetency in the performance of his or her duties;~~

~~(5) He or she has willfully or repeatedly violated any of the rules and regulations of the board of pharmacy or of the department;~~

~~(6) He or she has willfully or repeatedly performed duties beyond the scope of his or her certificate in violation of the provisions of this chapter;~~)) or

((~~(7)~~)) (2) He or she has impersonated a licensed pharmacist.

((~~In any case of the refusal, suspension or revocation of a certificate by the board, a hearing shall be conducted in accordance with RCW 18.64.160, as now or hereafter amended, and appeal may be taken in accordance with the Administrative Procedure Act, chapter 34.05 RCW.~~))

NEW SECTION. **Sec. 74.** A new section is added to chapter 18.64A RCW to read as follows:

PHARMACY ASSISTANTS ARE SUBJECT TO THE UNIFORM DISCIPLINARY ACT. The uniform disciplinary act, chapter 18.130 RCW, governs the issuance and denial of certificates and the discipline of certificants under this chapter.

NEW SECTION. **Sec. 75.** RCW 18.64.260 and 1987 c 202 s 184, 1969 ex.s. c 199 s 17, 1909 c 213 s 9, & 1899 c 121 s 17 are each repealed.

Sec. 76. RCW 70.42.080 and 1989 c 386 s 9 are each amended to read as follows:

A test site shall have a designated test site supervisor who shall ((~~meet the~~)) hold an appropriate health care professional license granted by the state of Washington or certification granted by a nationally recognized clinical laboratory science certification organization. Test site supervisor qualifications shall be determined by the department in rule. The designated test site supervisor shall be responsible for the testing functions of the test site.

NEW SECTION. **Sec. 77.** EFFECTIVE DATE. (1) Sections 52 through 58, 61, 64, 66, and 69 of this act shall take effect July 1, 1993.

(2) Sections 59, 60, 62, 63, and 65 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect immediately.

NEW SECTION. **Sec. 78.** CODIFICATION INSTRUCTIONS. Sections 52 through 64 and 66 of this act shall constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec. 79.** CODIFICATION INSTRUCTIONS. Section 47 of this act is added to chapter 70.47 RCW.

NEW SECTION. **Sec. 80.** CODIFICATION INSTRUCTIONS. Sections 25 and 26 of this act shall constitute a new chapter in Title 18 RCW.

NEW SECTION. **Sec. 81.** CODIFICATION INSTRUCTIONS. Sections 28 through 31 of this act are each added to chapter 7.70 RCW.

NEW SECTION. **Sec. 82.** CAPTIONS NOT LAW. Captions, table of contents, and part headings, as used in this act constitute no part of the law.

NEW SECTION. **Sec. 83.** SEVERABILITY. 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.