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2 **E2SSB 5304** - H COMM AMD
3 By Committee on Revenue

4 ADOPTED AS AMENDED 4/8/93

5 Strike everything after the enacting clause and insert the
6 following:

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1 **PART I. FINDINGS, GOALS, AND INTENT**

2 NEW SECTION. **Sec. 101.** FINDINGS. The legislature finds that our
3 health and financial security are jeopardized by our ever increasing
4 demand for medical care and by current medical insurance and medical
5 system practices. Current medical system practices encourage public
6 demand for unneeded, ineffective, and sometimes dangerous medical
7 treatments. These practices often result in unaffordable cost
8 increases that far exceed ordinary inflation for essential care.
9 Current total medical and health care expenditure rates should be
10 sufficient to provide access to essential health and medical care
11 interventions to all within a reformed, efficient system.
12 The legislature finds that too many of our state's residents are
13 without medical insurance, that each year many individuals and families
14 are forced into poverty because of serious illness, and that many must
15 leave gainful employment to be eligible for publicly funded medical
16 services. Additionally, thousands of citizens are at risk of losing
17 adequate medical insurance, have had insurance canceled recently, or
18 cannot afford to renew existing coverage.
19 The legislature finds that businesses find it difficult to pay for
20 medical insurance and remain competitive in a global economy, and that
21 individuals, the poor, and small businesses bear an inequitable medical
22 insurance burden.
23 The legislature finds that persons of color have significantly
24 higher rates of mortality, poor health outcomes, and substantially
25 lower numbers and percentages of persons covered by health insurance
26 than general population. It is intended that chapter . . ., Laws of
27 1993 (this act) make provisions to address the special health care
28 needs of these racial and ethnic populations in order to improve their
29 health status.
30 The legislature finds that uncontrolled demand and expenditures for
31 medical care are eroding the ability of families, businesses,
32 communities, and governments to invest in other enterprises that
33 promote health, maintain independence, and ensure continued economic
34 welfare. Housing, nutrition, education, and the environment are all
35 diminished as we invest ever increasing shares of wealth in medical
36 treatments.

1 The legislature finds that while immediate steps must be taken, a
2 long-term plan of reform is also needed.

3 NEW SECTION. **Sec. 102.** LEGISLATIVE INTENT AND GOALS. (1) The
4 legislature intends that state government policy stabilize health
5 services costs, assure access to essential services for all residents,
6 actively address the health care needs of persons of color, improve the
7 public's health, and reduce unwarranted health services costs to
8 preserve the viability of nonmedical care businesses.
9 (2) The legislature intends that:
10 (a) Total health services costs be stabilized and kept within rates
11 of increase similar to the rates of general economic inflation within
12 a publicly regulated, private marketplace that preserves personal
13 choice;
14 (b) State residents be enrolled in the certified health plan of
15 their choice that meets state standards regarding affordability,
16 accessibility, cost-effectiveness, and clinically efficacious;
17 (c) State residents be able to choose health services from the full
18 range of health care providers, as defined in section 402(12) of this
19 act, in a manner consistent with good health service management,
20 quality assurance, and cost effectiveness;
21 (d) Individuals and businesses have the option to purchase any
22 health or medical services they may choose in addition to those
23 contained in the uniform benefits package;
24 (e) All state residents, businesses, employees, and government
25 participate in payment for health services, with total costs to
26 individuals on a sliding scale based on income to encourage efficient
27 and appropriate utilization of services and to protect individuals from
28 impoverishment because of health care costs;
29 (f) These goals be accomplished within a reformed system using
30 private service providers and facilities in a way that allows consumers
31 to choose among competing plans operating within budget limits and
32 other regulations that promote the public good; and
33 (g) That a policy of facilitating communication and networking in
34 the delivery, purchase, and provision of health services among the
35 federal, state, local, and tribal governments be encouraged and
36 accomplished by chapter . . ., Laws of 1993 (this act).

1 (3) Accordingly, the legislature intends that chapter . . ., Laws
2 of 1993 (this act) provide both early implementation measures and a
3 process for overall reform of the health services system.

4 **PART II. EARLY IMPLEMENTATION MEASURES**
5 **A. BASIC HEALTH PLAN EXPANSION**

6 NEW SECTION. **Sec. 201.** A new section is added to chapter 70.47
7 RCW to read as follows:
8 TRANSFER OF POWER AND DUTIES TO WASHINGTON STATE HEALTH CARE
9 AUTHORITY. The powers, duties, and functions of the Washington basic
10 health plan are hereby transferred to the Washington state health care
11 authority. All references to the administrator of the Washington basic
12 health plan in the Revised Code of Washington shall be construed to
13 mean the administrator of the Washington state health care authority.

14 NEW SECTION. **Sec. 202.** TRANSFER OF RECORDS, EQUIPMENT, FUNDS.
15 All reports, documents, surveys, books, records, files, papers, or
16 written material in the possession of the Washington basic health plan
17 shall be delivered to the custody of the Washington state health care
18 authority. All cabinets, furniture, office equipment, motor vehicles,
19 and other tangible property used by the Washington basic health plan
20 shall be made available to the Washington state health care authority.
21 All funds, credits, or other assets held by the Washington basic health
22 plan shall be assigned to the Washington state health care authority.
23 Any appropriations made to the Washington basic health plan shall,
24 on the effective date of this section, be transferred and credited to
25 the Washington state health care authority. At no time may those funds
26 in the basic health plan trust account, any funds appropriated for the
27 subsidy of any enrollees, or any premium payments or other sums made or
28 received on behalf of any enrollees in the basic health plan be
29 commingled with any appropriated funds designated or intended for the
30 purposes of providing health care coverage to any state or other public
31 employees.
32 Whenever any question arises as to the transfer of any personnel,
33 funds, books, documents, records, papers, files, equipment, or other
34 tangible property used or held in the exercise of the powers and the
35 performance of the duties and functions transferred, the director of

1 financial management shall make a determination as to the proper
2 allocation and certify the same to the state agencies concerned.

3 NEW SECTION. **Sec. 203.** TRANSFER OF EMPLOYEES. All employees of
4 the Washington basic health plan are transferred to the jurisdiction of
5 the Washington state health care authority. All employees classified
6 under chapter 41.06 RCW, the state civil service law, are assigned to
7 the Washington state health care authority to perform their usual
8 duties upon the same terms as formerly, without any loss of rights,
9 subject to any action that may be appropriate thereafter in accordance
10 with the laws and rules governing state civil service.

11 NEW SECTION. **Sec. 204.** RULES AND BUSINESS. All rules and all
12 pending business before the Washington basic health plan shall be
13 continued and acted upon by the Washington state health care authority.
14 All existing contracts and obligations shall remain in full force and
15 shall be performed by the Washington state health care authority.

16 NEW SECTION. **Sec. 205.** VALIDITY OF PRIOR ACTS. The transfer of
17 the powers, duties, functions, and personnel of the Washington basic
18 health plan shall not affect the validity of any act performed prior to
19 the effective date of this section.

20 NEW SECTION. **Sec. 206.** APPORTIONMENT OF BUDGETED FUNDS. If
21 apportionments of budgeted funds are required because of the transfers
22 directed by sections 201 through 205 of this act, the director of
23 financial management shall certify the apportionments to the agencies
24 affected, the state auditor, and the state treasurer. Each of these
25 shall make the appropriate transfer and adjustments in funds and
26 appropriation accounts and equipment records in accordance with the
27 certification.

28 NEW SECTION. **Sec. 207.** COLLECTIVE BARGAINING. Nothing contained
29 in sections 201 through 206 of this act may be construed to alter any
30 existing collective bargaining unit or the provisions of any existing
31 collective bargaining agreement until the agreement has expired or
32 until the bargaining unit has been modified by action of the personnel
33 board as provided by law.

Sec. 208. RCW 70.47.010 and 1987 1st ex.s. c 5 s 3 are each amended to read as follows:

BASIC HEALTH PLAN--FINDINGS. (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 at-risk children and adolescents who need greater access to managed health care.

(2) The purpose of this chapter is to provide or make more readily available necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization of necessary health care services. To that end, this chapter establishes a program to be made available to those residents ((~~under sixty-five years of age~~)) not ((~~otherwise~~)) eligible for medicare ((~~with gross family income at or below two hundred percent of the federal poverty guidelines~~)) or medical assistance 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. However, the legislature recognizes that cost-effective and affordable health plans may not always be available to small business employers. 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 a managed care system.

(b) As a consequence, the legislature intends to extend an option to enroll to certain citizens above two hundred percent of the federal poverty guidelines within the state 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 basic health plan if the purchase 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 to purchase health care through the program. It is also the intent of the legislature to condition access to this plan for nonsubsidized enrollees upon the prior placement of subsidized enrollees, to the extent funding is available.

(c) The legislature directs that the basic health plan administrator identify enrollees who are likely to be eligible for medical assistance and assist these individuals in applying for and receiving medical assistance. The administrator and the department of social and health services shall implement a seamless system to coordinate eligibility determinations and benefit coverage for enrollees of the basic health plan and medical assistance recipients.

Sec. 209. RCW 70.47.020 and 1987 1st ex.s. c 5 s 4 are each amended to read as follows:

BASIC HEALTH PLAN--DEFINITIONS. 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, who also holds the position of administrator of the Washington state health care authority.

(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. On and after July 1, 1995, "managed health care system" means a certified health plan, as defined in section 402 of this act.

(4) "Subsidized enrollee" means an individual, or an individual plus the individual's spouse ((~~and/or~~)) or dependent children, ((~~all under the age of sixty-five and~~)) not ((~~otherwise~~)) eligible for medicare or medical assistance, 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.

(5) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children, not eligible for medicare, who resides in an area of the state served by a managed health care system participating in the plan, who chooses to obtain basic health care coverage from a particular managed health care system and who pays or on whose behalf is paid the full costs for participation in the plan, without 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~~)) a subsidized enrollee plus the administrative cost to the plan of providing the plan to that subsidized enrollee, and the amount determined to be the subsidized 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~~)) individual, their employer or another financial sponsor

makes to the plan as consideration for enrollment in the plan as a subsidized enrollee or a nonsubsidized enrollee.

((~~(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 subsidized and nonsubsidized enrollees in the plan and in that system.

Sec. 210. RCW 70.47.030 and 1992 c 232 s 907 are each amended to read as follows:

ACCOUNTS. (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, 1993, 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 from or on behalf of nonsubsidized enrollees 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 nonsubsidized enrollees in the plan and payment of costs of administering the plan. The account is subject to allotment procedures under chapter 43.88 RCW, but no appropriation is required for expenditures.

(3) The administrator shall take every precaution to see that none of the 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. 211. RCW 70.47.040 and 1987 1st ex.s. c 5 s 6 are each amended to read as follows:

BASIC HEALTH PLAN--PROGRAM WITHIN STATE HEALTH CARE AUTHORITY. (1) The Washington basic health plan is created as ((~~an independent agency of the state~~)) a program within the Washington state health care authority. The administrative head and appointing authority of the plan shall be the administrator ((~~who shall be appointed by the governor, with the consent of the senate, and shall serve at the pleasure of the governor. The salary for this office shall be set by the governor pursuant to RCW 43.03.040~~)) of the Washington state health care authority. The administrator shall appoint a medical director. The ((~~administrator,~~)) medical director((~~,~~)) and up to five other employees of the plan shall be exempt from the civil service law, chapter 41.06 RCW.

(2) The administrator shall employ such other staff as are necessary to fulfill the responsibilities and duties of the administrator, such staff to be subject to the civil service law, chapter 41.06 RCW. In addition, the administrator may contract with third parties for services necessary to carry out its activities where this will promote economy, avoid duplication of effort, and make best use of available expertise. Any such contractor or consultant shall be prohibited from releasing, publishing, or otherwise using any information made available to it under its contractual responsibility without specific permission of the plan. The administrator may call upon other agencies of the state to provide available information as necessary to assist the administrator in meeting its responsibilities under this chapter, which information shall be supplied as promptly as circumstances permit.

(3) The administrator may appoint such technical or advisory committees as he or she deems necessary. The administrator shall appoint a standing technical advisory committee that is representative of health care professionals, health care providers, and those directly involved in the purchase, provision, or delivery of health care services, as well as consumers and those knowledgeable of the ethical issues involved with health care public policy. Individuals appointed to any technical or other advisory committee shall serve without compensation for their services as members, but may be reimbursed for their travel expenses pursuant to RCW 43.03.050 and 43.03.060.

(4) The administrator may apply for, receive, and accept grants, gifts, and other payments, including property and service, from any governmental or other public or private entity or person, and may make

arrangements as to the use of these receipts, including the undertaking of special studies and other projects relating to health care costs and access to health care.

(5) ((~~In the design, organization, and administration of the plan under this chapter, the administrator shall consider the report of the Washington health care project commission established under chapter 303, Laws of 1986. Nothing in this chapter requires the administrator to follow any specific recommendation contained in that report except as it may also be included in this chapter or other law~~)) Whenever feasible, the administrator shall reduce the administrative cost of operating the program by adopting joint policies or procedures applicable to both the basic health plan and employee health plans.

Sec. 212. RCW 70.47.060 and 1992 c 232 s 908 are each amended to read as follows:

ADMINISTRATOR'S POWERS AND DUTIES. 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, prescription drugs and medications, and other services that may be necessary for basic health care, which subsidized and nonsubsidized 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 and shall include all services necessary for prenatal, postnatal, and well-child care. However, ((~~for the period ending June 30, 1993,~~)) with respect to coverage for groups of subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for ((~~prenatal or postnatal~~)) such services ((~~that are provided under the medical assistance program under chapter 74.09 RCW~~)) except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider((~~, or except to provide any such services associated with pregnancies diagnosed by the managed care provider before July 1, 1992~~)). The schedule of services shall also include a separate schedule of basic health care services for children, eighteen years of age and younger, for those

subsidized or nonsubsidized enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.42.080, and such other factors as the administrator deems appropriate. On and after July 1, 1995, the uniform benefits package adopted and from time to time revised by the Washington health services commission pursuant to section 448 of this act shall be implemented by the administrator as the schedule of covered basic health care services. However, with respect to coverage for subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that the services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider.

(2)(a) To design and implement a structure of periodic premiums due the administrator from subsidized enrollees that is based upon gross family income, giving appropriate consideration to family size ((~~as well as~~)) and 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. The structure of periodic premiums shall be applied to subsidized enrollees entering the plan as individuals pursuant to subsection (9) of this section and to the share of the cost of the plan due from subsidized enrollees entering the plan as employees pursuant to subsection (10) of this section.

(b) To determine the periodic premiums due the administrator from nonsubsidized enrollees. Premiums due from nonsubsidized 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 and the appropriate premium tax as provided by law.

(c) An employer or other financial sponsor may, with the prior approval of the administrator, pay the premium, rate, or any other amount on behalf of a subsidized or nonsubsidized 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 ninety-five percent of the total premiums due from the enrollee.

(3) To design and implement a structure of ((~~nominal~~)) copayments due a managed health care system from subsidized and nonsubsidized 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. On and after July 1, 1995, the administrator shall comply with schedules of enrollee point of service cost-sharing adopted by the Washington health services commission.

(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.

(5) To limit the payment of subsidies to subsidized enrollees, as defined in RCW 70.47.020.

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

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

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

(7) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state. Contracts with participating managed health care systems shall ensure that basic health plan enrollees who become eligible for medical assistance may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

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

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

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan as subsidized or nonsubsidized enrollees, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and at least ((~~annually~~)) semiannually thereafter, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. ((~~An enrollee who remains current in payment of the sliding-scale premium, as determined under subsection (2) of this section, and whose gross family income has risen above twice the federal poverty level, may continue enrollment unless and until the enrollee's gross family income has remained above twice the poverty level for six consecutive months, by making payment at the unsubsidized rate required for the managed health care system in which he or she may be enrolled.~~)) 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, as a result of an eligibility review, the administrator determines that a subsidized enrollee's income exceeds twice the federal poverty level and that the enrollee knowingly failed to inform the plan of such increase in income, the administrator may bill the enrollee for the subsidy paid on the enrollee's behalf during the period of time that the enrollee's income exceeded twice the federal poverty level. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to re-enroll in the plan.

(10) To accept applications from small business owners on behalf of themselves and their employees, spouses, and dependent children, as subsidized or nonsubsidized enrollees, 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. The administrator shall require that a small business owner pay at least fifty percent but not more than ninety-five percent of the

nonsubsidized premium cost of the plan on behalf of each employee enrolled in the plan. For the purposes of this subsection, an employee means an individual who regularly works for the small business for at least twenty hours per week. The businesses may have no more than one hundred employees at the time of initial enrollment and enrollment is limited to those not eligible for medicare or medical assistance, who wish to enroll in the plan 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.

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

((~~(11)~~)) (12) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed health care systems and to the ((~~administrator~~)) plan. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

((~~(12) 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) 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) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

(15) ((~~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~~)) To endeavor to expand enrollment as much as possible to correspond to the proportion of persons of color in the community served using the best available data that estimates representation of persons of color and describe these efforts in its annual report.

Sec. 213. RCW 70.47.080 and 1987 1st ex.s. c 5 s 10 are each amended to read as follows:

ENROLLMENT. 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 ((~~enrollment shall not exceed the number established 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)~~)) 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. To the extent that new funding is appropriated for expansion, the administrator shall endeavor to secure participation contracts from managed health care systems in geographic areas of the state that are unserved by the plan at the time at which the new funding is appropriated. In the selection of any such areas 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.

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).

B. EXPANDED MANAGED CARE FOR STATE EMPLOYEES

Sec. 214. RCW 41.05.011 and 1990 c 222 s 2 are each amended to read as follows:

DEFINITIONS. 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~~)) insurer as defined in chapter 48.01 RCW, a health care service contractor as defined in chapter 48.44 RCW, or a health maintenance organization as defined in chapter 48.46 RCW. On

and after July 1, 1995, "insuring entity" means a certified health plan, as defined in section 402 of this act.

(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; upon a determination by the administrator as provided in RCW 41.05.021(2), all employees of school districts; 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~~)) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, upon the determination provided for in RCW 41.05.021(2) by the administrator, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization.

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

Sec. 215. RCW 41.05.021 and 1990 c 222 s 3 are each amended to read as follows:

HEALTH CARE AUTHORITY DUTIES. (1) The Washington state health care authority is created within the executive branch. The authority shall

1 have an administrator appointed by the governor, with the consent of
2 the senate. The administrator shall serve at the pleasure of the
3 governor. The administrator may employ up to seven staff members, who
4 shall be exempt from chapter 41.06 RCW, and any additional staff
5 members as are necessary to administer this chapter. The primary
6 duties of the authority shall be to administer state employees'
7 insurance benefits ((~~and to~~)), study state-purchased health care
8 programs in order to maximize cost containment in these programs while
9 ensuring access to quality health care, and implement state
10 initiatives, joint purchasing strategies, and techniques for efficient
11 administration that have potential application to all state-purchased
12 health services. The authority's duties include, but are not limited
13 to, the following:
14 ((~~(1)~~)) (a) To administer a health care benefit program for
15 employees as specifically authorized in RCW 41.05.065 and in accordance
16 with the methods described in RCW 41.05.075, 41.05.140, and other
17 provisions of this chapter;
18 ((~~(2)~~)) (b) To analyze state-purchased health care programs and to
19 explore options for cost containment and delivery alternatives for
20 those programs that are consistent with the purposes of those programs,
21 including, but not limited to:
22 ((~~(a)~~)) (i) Creation of economic incentives for the persons for
23 whom the state purchases health care to appropriately utilize and
24 purchase health care services, including the development of flexible
25 benefit plans to offset increases in individual financial
26 responsibility;
27 ((~~(b)~~)) (ii) Utilization of provider arrangements that encourage
28 cost containment and ensure access to quality care, including but not
29 limited to prepaid delivery systems, utilization review, and
30 prospective payment methods;
31 ((~~(c)~~)) (iii) Coordination of state agency efforts to purchase
32 drugs effectively as provided in RCW 70.14.050;
33 ((~~(d)~~)) (iv) Development of recommendations and methods for
34 purchasing medical equipment and supporting services on a volume
35 discount basis; and
36 ((~~(e)~~)) (v) Development of data systems to obtain utilization data
37 from state-purchased health care programs in order to identify cost
38 centers, utilization patterns, provider and hospital practice patterns,

and procedure costs, utilizing the information obtained pursuant to RCW 41.05.031;

((~~(3)~~)) (c) To analyze areas of public and private health care interaction;

((~~(4)~~)) (d) To provide information and technical and administrative assistance to the board;

((~~(5)~~)) (e) To review and approve or deny applications from counties, municipalities, and other political subdivisions of the state((~~, and school districts~~)) to provide state-sponsored insurance or self-insurance programs to their employees in accordance with the provisions of RCW 41.04.205 ((~~and 28A.400.350~~)), setting the premium contribution for approved groups as outlined in RCW 41.05.050;

((~~(6)~~)) (f) To appoint a health care policy technical advisory committee as required by RCW 41.05.150; and

((~~(7)~~)) (g) To promulgate and adopt rules consistent with this chapter as described in RCW 41.05.160.

(2) The administrator shall determine the year in which the public employees' benefits board will undertake design and approval of insurance benefits plans for school district employees. Upon making that determination the administrator shall:

(a) Provide written notification to the fiscal committees of the senate and the house of representatives. Such notification shall be given by January 1 of the year prior to which the administrator will begin purchasing insurance benefits on behalf of school district employees; and

(b) Develop procedures necessary to ensure that the transition to insurance benefits purchasing by the administrator does not disrupt existing insurance contracts between school district employees and insurers.

(3) The public employees' benefits board shall implement strategies to promote managed competition among employee health benefit plans by January 1, 1995, including but not limited to:

(a) Standardizing the benefit package;

(b) Soliciting competitive bids for the benefit package;

(c) Limiting the state's contribution to a percent of the lowest priced sealed bid of a qualified plan within a geographical area. If the state's contribution is less than one hundred percent of the lowest priced sealed bid, employee financial contributions shall be structured on a sliding-scale basis related to household income;

(d) Ensuring access to quality health services, including assuring reasonable access to local providers, especially for enrollees residing in rural areas;

(e) Monitoring the impact of the approach under this subsection with regards to: Efficiencies in health service delivery, cost shifts to subscribers, access to and choice of managed care plans state-wide, and quality of health services. The health care authority shall also advise on the value of administering a benchmark employer-managed plan to promote competition among managed care plans. The health care authority shall report its findings and recommendations to the legislature by January 1, 1997.

Sec. 216. RCW 41.05.050 and 1988 c 107 s 18 are each amended to read as follows:

FERRY EMPLOYEES. (1) Every department, division, or separate agency of state government, and such county, municipal, or other political subdivisions as are covered by this chapter, shall provide contributions to insurance and health care plans for its employees and their dependents, the content of such plans to be determined by the authority. Contributions, paid by the county, the municipality, or other political subdivision for their employees, shall include an amount determined by the authority to pay such administrative expenses of the authority as are necessary to administer the plans for employees of those groups. All such contributions will be paid into the ((~~state~~)) public employees' health insurance account.

(2) The contributions of any department, division, or separate agency of the state government, and such county, municipal, or other political subdivisions as are covered by this chapter, shall be set by the authority, subject to the approval of the governor for availability of funds as specifically appropriated by the legislature for that purpose. ((~~However,~~)) Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270 until December 31, 1996. On and after January 1, 1997, ferry employees shall enroll with certified health plans under chapter . . ., Laws of 1993 (this act).

(3) The administrator with the assistance of the ((~~state~~)) public employees' benefits board shall survey private industry and public employers in the state of Washington to determine the average employer contribution for group insurance programs under the jurisdiction of the authority. Such survey shall be conducted during each even-numbered

1 year but may be conducted more frequently. The survey shall be
2 reported to the authority for its use in setting the amount of the
3 recommended employer contribution to the employee insurance benefit
4 program covered by this chapter. The authority shall transmit a
5 recommendation for the amount of the employer contribution to the
6 governor and the director of financial management for inclusion in the
7 proposed budgets submitted to the legislature.

8 **Sec. 217.** RCW 41.05.055 and 1989 c 324 s 1 are each amended to
9 read as follows:
10 PUBLIC EMPLOYEES' BENEFITS BOARD--SCHOOL DISTRICT EMPLOYEES. (1)
11 The ((~~state~~)) public employees' benefits board is created within the
12 authority. The function of the board is to design and approve
13 insurance benefit plans for state employees and upon a determination by
14 the administrator as provided in RCW 41.05.021(2), school district
15 employees.
16 (2) Beginning in the year in which the administrator determines
17 that the public employees' benefits board will undertake design and
18 approval of insurance benefits plans for school district employees, as
19 provided in RCW 41.05.021(2), the board shall be composed of ((~~seven~~))
20 nine members appointed by the governor as follows:
21 (a) ((~~Three~~)) Two representatives of state employees, ((~~one of whom~~
22 ~~shall represent an employee association certified as exclusive~~
23 ~~representative of at least one bargaining unit of classified~~
24 ~~employees,~~)) one of whom shall represent an employee union certified as
25 exclusive representative of at least one bargaining unit of classified
26 employees, and one of whom is retired, is covered by a program under
27 the jurisdiction of the board, and represents an organized group of
28 retired public employees;
29 (b) Two representatives of school district employees, one of whom
30 shall represent an association of school employees and one of whom is
31 retired, and represents an organized group of retired school employees;
32 ((~~Three~~)) (c) Four members with experience in health benefit
33 management and cost containment; and
34 ((~~(c)~~)) (d) The administrator.
35 Prior to that year, the composition of the public employees
36 benefits board shall reflect its composition on January 1, 1993.
37 (3) The governor shall appoint the initial members of the board to
38 staggered terms not to exceed four years. Members appointed thereafter

shall serve two-year terms. Members of the board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060. The board shall prescribe rules for the conduct of its business. The administrator shall serve as chair of the board. Meetings of the board shall be at the call of the chair.

Sec. 218. RCW 41.05.065 and 1988 c 107 s 8 are each amended to read as follows:

EMPLOYEE BENEFIT PLANS--STANDARDS. (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~~)), however liability insurance shall not be made available to dependents.

(2) The ((~~state~~)) public 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, blood cholesterol reduction, and nutrition education;

(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;

(f) Minimum standards for insuring entities; and

(g) Minimum scope and content of standard benefit plans to be offered to enrollees participating in the employee health benefit plans. On and after July 1, 1995, the uniform benefits package shall

constitute the minimum level of health benefits offered to employees. To maintain the comprehensive nature of employee health care benefits, the benefits provided to employees shall be substantially equivalent to the state employees' health benefits plan in effect on January 1, 1993.

(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 attempt to achieve enrollment of all employees and retirees in managed health care 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 managed health care systems. ((~~Such authorization shall require a vote of five members of the board for approval.~~))

(5) Employees ((~~may~~)) shall choose participation in ((~~only~~)) one of the health care benefit plans developed by the board, but employees may choose to obtain employee only coverage or employee and dependent coverage.

(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.

Sec. 219. RCW 41.05.120 and 1991 sp.s. c 13 s 100 are each amended to read as follows:

PUBLIC EMPLOYEES' INSURANCE ACCOUNT. (1) The ((~~state~~)) public employees' insurance account is hereby established in the custody of the state treasurer, to be used by the administrator for the deposit of contributions, reserves, dividends, and refunds, and for payment of premiums for employee insurance benefit contracts. Moneys from the account shall be disbursed by the state treasurer by warrants on vouchers duly authorized by the administrator.

(2) The state treasurer and the state investment board may invest moneys in the ((~~state~~)) public employees' insurance account. All such investments shall be in accordance with RCW 43.84.080 or 43.84.150, whichever is applicable. The administrator shall determine whether the

state treasurer or the state investment board or both shall invest moneys in the ((~~state~~)) public employees' insurance account.

Sec. 220. RCW 41.05.140 and 1988 c 107 s 12 are each amended to read as follows:

PUBLIC EMPLOYEES' INSURANCE RESERVE FUND. (1) The authority may self-fund or self-insure for public employees' benefits plans, but shall also enter into other methods of providing insurance coverage for insurance programs under its jurisdiction except property and casualty insurance. The authority shall contract for payment of claims or other administrative services for programs under its jurisdiction. If a program does not require the prepayment of reserves, the authority shall establish such reserves within a reasonable period of time for the payment of claims as are normally required for that type of insurance under an insured program. Reserves established by the authority shall be held in a separate trust fund by the state treasurer and shall be known as the ((~~state~~)) public employees' insurance reserve fund. The state investment board shall act as the investor for the funds and, except as provided in RCW 43.33A.160, one hundred percent of all earnings from these investments shall accrue directly to the ((~~state~~)) public employees' insurance reserve fund.

(2) Any savings realized as a result of a program created under this section shall not be used to increase benefits unless such use is authorized by statute.

(3) Any program created under this section shall be subject to the examination requirements of chapter 48.03 RCW as if the program were a domestic insurer. In conducting an examination, the commissioner shall determine the adequacy of the reserves established for the program.

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

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

1 NEW SECTION. **Sec. 221.** A new section is added to chapter 41.05
2 RCW to read as follows:
3 MEDICARE SUPPLEMENTAL BENEFITS. (1) Notwithstanding any other
4 provisions of this chapter, if a waiver of the medicare statute, as
5 provided in section 468 of this act, is not obtained prior to June 30,
6 1995, the administrator shall develop at least two medical plans for
7 retirees eligible for medicare. One of the packages shall include
8 coverage for prescription drugs. The packages shall be offered
9 beginning July 1, 1996, and until a medicare waiver is obtained, to any
10 public employee eligible for medicare benefits.
11 (2) The administrator may:
12 (a) Offer a self-funded medical plan for retired state employees
13 eligible for medicare that includes all services available in the
14 uniform benefits package to the extent they are not covered by
15 medicare; and
16 (b) Offer medical plans for all other retired public employees
17 eligible for medicare that conform to the requirements of chapter 48.66
18 RCW.
19 (3) The medical plans for retirees eligible for medicare shall be
20 administered and shall have rates calculated as a distinct experience
21 pool.
22 (4) To the extent that funding is made available specifically for
23 this purpose, the administrator shall establish subsidies for low-
24 income retired public employees' premium and cost-sharing payments.

25 **Sec. 222.** RCW 47.64.270 and 1988 c 107 s 21 are each amended to
26 read as follows:
27 FERRY EMPLOYEES--ENROLLMENT IN CERTIFIED HEALTH PLANS. Until
28 December 31, 1996, absent a collective bargaining agreement to the
29 contrary, the department of transportation shall provide contributions
30 to insurance and health care plans for ferry system employees and
31 dependents, as determined by the state health care authority, under
32 chapter 41.05 RCW((.)); and the ferry system management and employee
33 organizations may collectively bargain for other insurance and health
34 care plans, and employer contributions may exceed that of other state
35 agencies as provided in RCW 41.05.050, subject to RCW 47.64.180. On
36 January 1, 1997, ferry employees shall enroll in certified health plans
37 under the provisions of chapter . . ., Laws of 1993 (this act). To the
38 extent that ferry employees by bargaining unit have absorbed the

required offset of wage increases by the amount that the employer's contribution for employees' and dependents' insurance and health care plans exceeds that of other state general government employees in the 1985-87 fiscal biennium, employees shall not be required to absorb a further offset except to the extent the differential between employer contributions for those employees and all other state general government employees increases during any subsequent fiscal biennium. If such differential increases in the 1987-89 fiscal biennium or the 1985-87 offset by bargaining unit is insufficient to meet the required deduction, the amount available for compensation shall be reduced by bargaining unit by the amount of such increase or the 1985-87 shortage in the required offset. Compensation shall include all wages and employee benefits.

Sec. 223. RCW 28A.400.200 and 1990 1st ex.s. c 11 s 2 and 1990 c 33 s 381 are each reenacted and amended to read as follows:

SCHOOL DISTRICT EMPLOYEES--EMPLOYER CONTRIBUTIONS. (1) Every school district board of directors shall fix, alter, allow, and order paid salaries and compensation for all district employees in conformance with this section.

(2)(a) Salaries for certificated instructional staff shall not be less than the salary provided in the appropriations act in the state-wide salary allocation schedule for an employee with a baccalaureate degree and zero years of service; and

(b) Salaries for certificated instructional staff with a masters degree shall not be less than the salary provided in the appropriations act in the state-wide salary allocation schedule for an employee with a masters degree and zero years of service;

(3)(a) The actual average salary paid to basic education certificated instructional staff shall not exceed the district's average basic education certificated instructional staff salary used for the state basic education allocations for that school year as determined pursuant to RCW 28A.150.410.

(b) Fringe benefit contributions for basic education certificated instructional staff shall be included as salary under (a) of this subsection only to the extent that the district's actual average benefit contribution exceeds the ((~~greater of: (i) The formula amount for insurance benefits~~)) amount of the insurance benefits allocation provided per certificated instructional staff unit in the state

operating appropriations act in effect at the time the compensation is payable((~~; or (ii) the actual average amount provided by the school district in the 1986-87 school year~~)). For purposes of this section, fringe benefits shall not include payment for unused leave for illness or injury under RCW 28A.400.210((~~, or~~)); employer contributions for old age survivors insurance, workers' compensation, unemployment compensation, and retirement benefits under the Washington state retirement system; or employer contributions for health benefits in excess of the insurance benefits allocation provided per certificated instructional staff unit in the state operating appropriations act in effect at the time the compensation is payable. A school district may not use state funds to provide employer contributions for such excess health benefits.

(c) Salary and benefits for certificated instructional staff in programs other than basic education shall be consistent with the salary and benefits paid to certificated instructional staff in the basic education program.

(4) Salaries and benefits for certificated instructional staff may exceed the limitations in subsection (3) of this section only by separate contract for additional time, additional responsibilities, or incentives. Supplemental contracts shall not cause the state to incur any present or future funding obligation. Supplemental contracts shall be subject to the collective bargaining provisions of chapter 41.59 RCW and the provisions of RCW 28A.405.240, shall not exceed one year, and if not renewed shall not constitute adverse change in accordance with RCW 28A.405.300 through 28A.405.380. No district may enter into a supplemental contract under this subsection for the provision of services which are a part of the basic education program required by Article IX, section 3 of the state Constitution.

(5) Employee benefit plans offered by any district shall comply with RCW 28A.400.350 and 28A.400.275 and 28A.400.280.

Sec. 224. RCW 28A.400.350 and 1990 1st ex.s. c 11 s 3 and 1990 c 74 s 1 are each reenacted and amended to read as follows:

SCHOOL DISTRICTS--HEALTH CARE COVERAGE ONLY BY CONTRACTS WITH THE STATE HEALTH CARE AUTHORITY. (1) The board of directors of any of the state's school districts may make available liability, life, health, health care, accident, disability and salary protection or insurance or any one of, or a combination of the enumerated types of insurance, or

any other type of insurance or protection, for the members of the boards of directors, the students, and employees of the school district, and their dependents. Such coverage may be provided by contracts with private carriers, with the state health care authority after July 1, 1990, pursuant to the approval of the authority administrator, or through self-insurance or self-funding pursuant to chapter 48.62 RCW, or in any other manner authorized by law. Except for health benefits purchased with nonstate funds as provided in RCW 28A.400.200, upon the making of a determination provided for in RCW 41.05.021(2) by the administrator of the state health care authority, health care coverage, life insurance, liability insurance, accidental death and dismemberment insurance, and disability income insurance shall be provided only by contracts with the state health care authority.

(2) Whenever funds are available for these purposes the board of directors of the school district may contribute all or a part of the cost of such protection or insurance for the employees of their respective school districts and their dependents. The premiums on such liability insurance shall be borne by the school district.

After October 1, 1990, school districts may not contribute to any employee protection or insurance other than liability insurance unless the district's employee benefit plan conforms to RCW 28A.400.275 and 28A.400.280.

(3) For school board members and students, the premiums due on such protection or insurance shall be borne by the assenting school board member or student((~~: PROVIDED, That~~)). The school district may contribute all or part of the costs, including the premiums, of life, health, health care, accident or disability insurance which shall be offered to all students participating in interschool activities on the behalf of or as representative of their school or school district. The school district board of directors may require any student participating in extracurricular interschool activities to, as a condition of participation, document evidence of insurance or purchase insurance that will provide adequate coverage, as determined by the school district board of directors, for medical expenses incurred as a result of injury sustained while participating in the extracurricular activity. In establishing such a requirement, the district shall adopt regulations for waiving or reducing the premiums of such coverage as may be offered through the school district to students participating in

1 extracurricular activities, for those students whose families, by
2 reason of their low income, would have difficulty paying the entire
3 amount of such insurance premiums. The district board shall adopt
4 regulations for waiving or reducing the insurance coverage requirements
5 for low-income students in order to assure such students are not
6 prohibited from participating in extracurricular interschool
7 activities.
8 (4) All contracts for insurance or protection written to take
9 advantage of the provisions of this section shall provide that the
10 beneficiaries of such contracts may utilize on an equal participation
11 basis the services of those practitioners licensed pursuant to chapters
12 18.22, 18.25, 18.53, 18.57, and 18.71 RCW.

13 **C. CONSOLIDATED STATE HEALTH CARE PURCHASING AGENT**

14 NEW SECTION. **Sec. 225.** A new section is added to Title 43 RCW to
15 read as follows:
16 STATE HEALTH SERVICES AGENT. (1) The health care authority is
17 hereby designated as the single state agent for purchasing health
18 services.
19 (2) On and after July 1, 1995, at least the following state-
20 purchased health services programs shall be merged into a single,
21 community-rated risk pool: The basic health plan; health benefits for
22 active employees of school districts, to the extent that the
23 administrator has made a determination under RCW 41.05.021(2); and
24 health benefits for active state employees. Until that date, in
25 purchasing health services, the health care authority shall maintain
26 separate experience pools for each of the programs in this subsection.
27 The administrator may develop mechanisms to ensure that the cost of
28 comparable benefits packages does not vary widely across the experience
29 pools. At the earliest opportunity the governor shall seek necessary
30 federal waivers and state legislation to place the medical and acute
31 care components of the medical assistance program, the limited casualty
32 program, and the medical care services program of the department of
33 social and health services in this single risk pool. Long-term care
34 services that are provided under the medical assistance program shall
35 not be placed in the single risk pool until such services have been
36 added to the uniform benefits package. On or before January 1, 1997,
37 the governor shall submit necessary legislation to place the purchasing

of health benefits for persons incarcerated in institutions administered by the department of corrections into the single community-rated risk pool effective on and after July 1, 1997.

(3) At a minimum, and regardless of other legislative enactments, the state health services purchasing agent shall:

(a) Require that a public agency that provides subsidies for a substantial portion of services now covered under the basic health plan or a uniform benefits package as adopted by the Washington health services commission as provided in section 448 of this act, use uniform eligibility processes, insofar as may be possible, and ensure that multiple eligibility determinations are not required;

(b) Require that a health care provider or a health care facility that receives funds from a public program provide care to state residents receiving a state subsidy who may wish to receive care from them, and that a health maintenance organization, health care service contractor, insurer, or certified health plan that receives funds from a public program accept enrollment from state residents receiving a state subsidy who may wish to enroll with them;

(c) Strive to integrate purchasing for all publicly sponsored health services in order to maximize the cost control potential and promote the most efficient methods of financing and coordinating services;

(d) Annually suggest changes in state and federal law and rules to bring all publicly funded health programs in compliance with the goals and intent of chapter . . ., Laws of 1993 (this act);

(e) Consult regularly with the governor, the legislature, and state agency directors whose operations are affected by the implementation of this section;

(f) Ensure that procedures and due process guarantees no less beneficial than those available under federal and state law to participants in the medical assistance, limited casualty, and medical care services programs are provided to all persons who, but for the federal waivers and state legislation procured under subsection (1) of this section, would be eligible for those programs.

NEW SECTION. **Sec. 226.** A new section is added to chapter 41.05 RCW to read as follows:

WASHINGTON STATE GROUP PURCHASING ASSOCIATION. (1) The Washington state group purchasing association is established for the purpose of

1 coordinating and enhancing the health care purchasing power of the
2 groups identified in subsection (2) of this section. The purchasing
3 association shall be administered by the administrator.
4 (2) The following organizations or entities may seek the approval
5 of the administrator for membership in the purchasing association:
6 (a) Private nonprofit human services provider organizations under
7 contract with state agencies, on behalf of their employees and their
8 employees' spouses and dependent children;
9 (b) Individuals providing in-home long-term care services to
10 persons whose care is financed in whole or in part through the medical
11 assistance personal care or community options program entry system
12 program as provided in chapter 74.09 RCW, or the chore services
13 program, as provided in chapter 74.08 RCW, on behalf of themselves and
14 their spouses and dependent children;
15 (c) Owners and operators of child day care centers and family child
16 care homes licensed under chapter 74.15 RCW and of preschool or other
17 child care programs exempted from licensing under chapter 74.15 RCW on
18 behalf of themselves and their employees and employees' spouses and
19 dependent children; and
20 (d) Foster parents contracting with the department of social and
21 health services under chapter 74.13 RCW and licensed under chapter
22 74.15 RCW on behalf of themselves and their spouses and dependent
23 children.
24 (3) In administering the purchasing association, the administrator
25 shall:
26 (a) Negotiate and enter into contracts on behalf of the purchasing
27 association's members in conjunction with its contracting and
28 purchasing activities for employee benefit plans under RCW 41.05.075.
29 In negotiating and contracting with insuring entities on behalf of
30 employees and purchasing association members, distinct experience pools
31 shall be maintained.
32 (b) Review and approve or deny applications from entities seeking
33 membership in the purchasing association:
34 (i) The administrator may require all or the substantial majority
35 of the employees of the organizations or entities listed in subsection
36 (2) of this section to enroll in the purchasing association.
37 (ii) The administrator shall require, that as a condition of
38 membership in the purchasing association, an entity or organization
39 listed in subsection (2) of this section that employs individuals pay

1 at least fifty percent of the cost of the insurance coverage for each
2 employee enrolled in the purchasing association.
3 (iii) In offering and administering the purchasing association, the
4 administrator may not discriminate against individuals or groups based
5 on age, gender, geographic area, industry, or medical history.
6 (4) On and after July 1, 1995, the uniform benefits package and
7 schedule of premiums and point of service cost-sharing adopted and from
8 time to time revised by the health services commission pursuant to
9 chapter . . ., Laws of 1993 (this act) shall be applicable to the
10 association.
11 (5) The administrator shall adopt preexisting condition coverage
12 provisions for the association as provided in sections 279 through 282
13 of this act.
14 (6) Except to the extent that funds are appropriated specifically
15 for this purpose, include its reasonable administrative and marketing
16 costs in premiums charged to members of the purchasing association.
17 (7)(a) The Washington state group purchasing association account is
18 established in the custody of the state treasurer, to be used by the
19 administrator for the deposit of premium payments from individuals and
20 entities described in subsection (2) of this section, and for payment
21 of premiums for benefit contracts entered into on behalf of the
22 purchasing association's participants and operating expenses incurred
23 by the authority in the administration of benefit contracts under this
24 section. Moneys from the account shall be disbursed by the state
25 treasurer by warrants on vouchers duly authorized by the administrator.
26 (b) Disbursements from the account are not subject to
27 appropriations, but shall be subject to the allotment procedure
28 provided under chapter 43.88 RCW.

29 NEW SECTION. **Sec. 227.** A new section is added to chapter 41.05
30 RCW to read as follows:
31 MARKETING PLAN. The administrator shall develop a marketing plan
32 for the basic health plan and the Washington state group purchasing
33 association. The plan shall be targeted to individuals and entities
34 eligible to enroll in the two programs and provide clear and
35 understandable explanations of the programs and enrollment procedures.
36 The plan also shall incorporate special efforts to reach communities
37 and people of color.

1 NEW SECTION. **Sec. 228.** WASHINGTON STATE GROUP PURCHASING
2 ASSOCIATION--REPEAL. The following acts or parts of acts, as now
3 existing or hereafter amended, are each repealed, effective June 30,
4 1998:
5 (1) RCW 41.05.___ and 1993 c ___ s 226 (section 226 of this act);
6 and
7 (2) RCW 41.05.___ and 1993 c ___ s 227 (section 227 of this act).

8 NEW SECTION. **Sec. 229.** TRANSFER OF AUTHORITY TO PURCHASE SERVICES
9 FROM COMMUNITY HEALTH CENTERS. (1) State general funds appropriated to
10 the department of health for the purposes of funding community health
11 centers to provide primary medical and dental care services, migrant
12 health services, and maternity health care services shall be
13 transferred to the state health care authority. Any related
14 administrative funds expended by the department of health for this
15 purpose shall also be transferred to the health care authority. The
16 health care authority shall exclusively expend these funds through
17 contracts with community health centers to provide primary medical and
18 dental care services, migrant health services, and maternity health
19 care services. The administrator of the health care authority shall
20 establish requirements necessary to assure community health centers
21 provide quality health care services that are appropriate and effective
22 and are delivered in a cost-efficient manner. The administrator shall
23 further assure that community health centers have appropriate referral
24 arrangements for acute care and medical specialty services not provided
25 by the community health centers.
26 (2) To further the intent of chapter . . ., Laws of 1993 (this
27 act), the health care authority, in consultation with the department of
28 health, shall evaluate the organization and operation of the federal
29 and state-funded community health centers and other not-for-profit
30 health care organizations and propose recommendations to the health
31 services commission and the health policy committees of the legislature
32 by November 30, 1994, that identify changes to permit community health
33 centers and other not-for-profit health care organizations to form
34 certified health plans or other innovative health care delivery
35 arrangements that help ensure access to primary health care services
36 consistent with the purposes of chapter . . ., Laws of 1993 (this act).

37 **D. HEALTH CARE PROVIDER CONFLICT OF INTEREST STANDARDS**

Sec. 230. RCW 19.68.010 and 1973 1st ex.s. c 26 s 1 are each amended to read as follows:

FINANCIAL INTEREST IN HEALTH CARE FACILITIES--LIST OF ALTERNATIVE FACILITIES TO BE PROVIDED. 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.

E. PUBLIC HEALTH FINANCING AND GOVERNANCE

Sec. 231. RCW 70.05.010 and 1967 ex.s. c 51 s 1 are each amended to read as follows:

DEFINITIONS--DEPARTMENT OF HEALTH. For the purposes of chapters 70.05 and 70.46 RCW ((~~and RCW 70.46.020 through 70.46.090~~)) and unless the context thereof clearly indicates to the contrary:

(1) "Local health departments" means the ((~~city, town,~~)) county or district which provides public health services to persons within the area;

(2) "Local health officer" means the legally qualified physician who has been appointed as the health officer for the ((~~city, town,~~)) county or district public health department;

(3) "Local board of health" means the ((~~city, town,~~)) county or district board of health.

(4) "Health district" means ((~~all territory encompassed within a single county and all cities and towns therein except cities with a population of over one hundred thousand, or~~)) all the territory consisting of one or more counties ((~~and all the cities and towns in all of the combined counties except cities of over one hundred thousand population which have been combined and~~)) organized pursuant to the provisions of chapters 70.05 and 70.46 RCW ((~~and RCW 70.46.020 through 70.46.090: PROVIDED, That cities with a population of over one hundred thousand may be included in a health district as provided in RCW 70.46.040~~)).

(5) "Department" means the department of health.

Sec. 232. RCW 70.05.030 and 1967 ex.s. c 51 s 3 are each amended to read as follows:

LOCAL BOARD OF HEALTH--COUNTIES WITHOUT HOME RULE CHARTER--JURISDICTION. In counties without a home rule charter, the board of county commissioners ((~~of each and every county in this state, except where such county is a part of a health district or is purchasing services under a contract as authorized by chapter 70.05 RCW and RCW 70.46.020 through 70.46.090,~~)) shall constitute the local board of health ((~~for such county, and said local board of health's jurisdiction~~)), unless the county is part of a health district pursuant to chapter 70.46 RCW. The jurisdiction of the local board of health shall be coextensive with the boundaries of said county((~~, except that nothing herein contained shall give said board jurisdiction in cities of over one hundred thousand population or in such other cities and towns as are providing health services which meet health standards pursuant to RCW 70.46.090~~)).

Sec. 233. RCW 70.05.040 and 1984 c 25 s 1 are each amended to read as follows:

LOCAL BOARD OF HEALTH--VACANCIES. The local board of health shall elect a ((~~chairman~~)) chair and may appoint an administrative officer. A local health officer shall be appointed pursuant to RCW 70.05.050. Vacancies on the local board of health shall be filled by appointment within thirty days and made in the same manner as was the original appointment. At the first meeting of the local board of health, the members shall elect a ((~~chairman~~)) chair to serve for a period of one year. ((~~In home rule charter counties that have a local board of health established under RCW 70.05.050, the administrative officer may be appointed by the official designated under the county's charter.~~))

NEW SECTION. **Sec. 234.** A new section is added to chapter 70.05 RCW to read as follows:

HOME RULE CHARTER--LOCAL BOARD OF HEALTH. In counties with a home rule charter, the county legislative authority shall establish a local board of health and may prescribe the membership and selection process for the board. The jurisdiction of the local board of health shall be coextensive with the boundaries of the county. The local health officer, as described in RCW 70.05.050, shall be appointed by the official designated under the provisions of the county charter. The same official designated under the provisions of the county charter may appoint an administrative officer, as described in RCW 70.05.045.

Sec. 235. RCW 70.05.050 and 1984 c 25 s 5 are each amended to read as follows:

LOCAL HEALTH OFFICER. ((~~Each local board of health, other than boards which are established under RCW 70.05.030 and which are located in counties having home rule charters, shall appoint a local health officer. In home rule charter counties which have a local board of health established under RCW 70.05.030, the local health officer shall be appointed by the official designated under the provisions of the county's charter.~~))

The local health officer shall be an experienced physician licensed to practice medicine and surgery or osteopathy and surgery in this state and who is qualified or provisionally qualified in accordance with the standards prescribed in RCW 70.05.051 through 70.05.055 to hold the office of local health officer. No term of office shall be

established for the local health officer but ((~~he~~)) the local health officer shall not be removed until after notice is given ((~~him~~)), and an opportunity for a hearing before the board or official responsible for his or her appointment under this section as to the reason for his or her removal. ((~~He~~)) The local health officer shall act as executive secretary to, and administrative officer for the local board of health and shall also be empowered to employ such technical and other personnel as approved by the local board of health except where the local board of health has appointed an administrative officer under RCW 70.05.040. The local health officer shall be paid such salary and allowed such expenses as shall be determined by the local board of health.

Sec. 236. RCW 70.05.070 and 1991 c 3 s 309 are each amended to read as follows:

LOCAL HEALTH OFFICER DUTIES. The local health officer, acting under the direction of the local board of health or under direction of the administrative officer appointed under RCW 70.05.040 or section 234 of this act, if any, shall:

(1) Enforce the public health statutes of the state, rules of the state board of health and the secretary of health, and all local health rules, regulations and ordinances within his or her jurisdiction including imposition of penalties authorized under RCW 70.119A.030 and filing of actions authorized by RCW 43.70.190;

(2) Take such action as is necessary to maintain health and sanitation supervision over the territory within his or her jurisdiction;

(3) Control and prevent the spread of any dangerous, contagious or infectious diseases that may occur within his or her jurisdiction;

(4) Inform the public as to the causes, nature, and prevention of disease and disability and the preservation, promotion and improvement of health within his or her jurisdiction;

(5) Prevent, control or abate nuisances which are detrimental to the public health;

(6) Attend all conferences called by the secretary of health or his or her authorized representative;

(7) Collect such fees as are established by the state board of health or the local board of health for the issuance or renewal of

licenses or permits or such other fees as may be authorized by law or by the rules of the state board of health;

(8) Inspect, as necessary, expansion or modification of existing public water systems, and the construction of new public water systems, to assure that the expansion, modification, or construction conforms to system design and plans;

(9) Take such measures as he or she deems necessary in order to promote the public health, to participate in the establishment of health educational or training activities, and to authorize the attendance of employees of the local health department or individuals engaged in community health programs related to or part of the programs of the local health department.

Sec. 237. RCW 70.05.080 and 1991 c 3 s 310 are each amended to read as follows:

LOCAL HEALTH OFFICER--APPOINTMENT BY SECRETARY OF HEALTH IF LOCAL BOARD FAILS TO ACT. If the local board of health or other official responsible for appointing a local health officer under RCW 70.05.050 refuses or neglects to appoint a local health officer after a vacancy exists, the secretary of health may appoint a local health officer and fix the compensation. The local health officer so appointed shall have the same duties, powers and authority as though appointed under RCW 70.05.050. Such local health officer shall serve until a qualified individual is appointed according to the procedures set forth in RCW 70.05.050. The board or official responsible for appointing the local health officer under RCW 70.05.050 shall also be authorized to appoint an acting health officer to serve whenever the health officer is absent or incapacitated and unable to fulfill his or her responsibilities under the provisions of chapter<u>s</u> 70.05 <u>and 70.46</u> RCW ((~~and RCW 70.46.020 through 70.46.090~~)).

Sec. 238. RCW 70.05.120 and 1984 c 25 s 8 are each amended to read as follows:

REMOVAL OF LOCAL HEALTH OFFICER. Any local health officer or administrative officer appointed under RCW 70.05.040, if any, who shall refuse or neglect to obey or enforce the provisions of chapter<u>s</u> 70.05 <u>and 70.46</u> RCW ((~~and RCW 70.46.020 through 70.46.090~~)) or the rules, regulations or orders of the state board of health or who shall refuse or neglect to make prompt and accurate reports to the state board of

health, may be removed as local health officer or administrative officer by the state board of health and shall not again be reappointed except with the consent of the state board of health. Any person may complain to the state board of health concerning the failure of the local health officer or administrative officer to carry out the laws or the rules and regulations concerning public health, and the state board of health shall, if a preliminary investigation so warrants, call a hearing to determine whether the local health officer or administrative officer is guilty of the alleged acts. Such hearings shall be held pursuant to the provisions of chapter 34.05 RCW, and the rules and regulations of the state board of health adopted thereunder.

Any member of a local board of health who shall violate any of the provisions of chapter<u>s</u> 70.05 <u>and 70.46</u> RCW ((~~and RCW 70.46.020 through 70.46.090~~)) or refuse or neglect to obey or enforce any of the rules, regulations or orders of the state board of health made for the prevention, suppression or control of any dangerous contagious or infectious disease or for the protection of the health of the people of this state, shall be guilty of a misdemeanor, and upon conviction shall be fined not less than ten dollars nor more than two hundred dollars. Any physician who shall refuse or neglect to report to the proper health officer or administrative officer within twelve hours after first attending any case of contagious or infectious disease or any diseases required by the state board of health to be reported or any case suspicious of being one of such diseases, shall be guilty of a misdemeanor, and upon conviction shall be fined not less than ten dollars nor more than two hundred dollars for each case that is not reported.

Any person violating any of the provisions of chapter<u>s</u> 70.05 <u>and 70.46</u> RCW ((~~and RCW 70.46.020 through 70.46.090~~)) or violating or refusing or neglecting to obey any of the rules, regulations or orders made for the prevention, suppression and control of dangerous contagious and infectious diseases by the local board of health or local health officer or administrative officer or state board of health, or who shall leave any isolation hospital or quarantined house or place without the consent of the proper health officer or who evades or breaks quarantine or conceals a case of contagious or infectious disease or assists in evading or breaking any quarantine or concealing any case of contagious or infectious disease, shall be guilty of a misdemeanor, and upon conviction thereof shall be subject to a fine of

not less than twenty-five dollars nor more than one hundred dollars or to imprisonment in the county jail not to exceed ninety days or to both fine and imprisonment.

Sec. 239. RCW 70.05.130 and 1991 c 3 s 313 are each amended to read as follows:

EXPENSES OF CARRYING OUT PUBLIC HEALTH LAW. All expenses incurred by the state, health district, or county in carrying out the provisions of chapters 70.05 and 70.46 RCW ((~~and RCW 70.46.020 through 70.46.090~~)) or any other public health law, or the rules of the ((~~state~~)) department of health enacted under such laws, shall be paid by the county ((~~or city by which or in behalf of which such expenses shall have been incurred~~)) and such expenses shall constitute a claim against the general fund as provided ((~~herein~~)) in this section.

Sec. 240. RCW 70.05.150 and 1967 ex.s. c 51 s 22 are each amended to read as follows:

AUTHORITY TO CONTRACT. In addition to powers already granted them, any ((~~city, town,~~)) county, district, or local health department may contract for either the sale or purchase of any or all health services from any local health department((~~: PROVIDED, That~~)). Such contract shall require the approval of the state board of health.

Sec. 241. RCW 70.08.010 and 1985 c 124 s 1 are each amended to read as follows:

APPOINTMENT OF LOCAL HEALTH OFFICER BY COMBINED CITY AND COUNTY HEALTH DEPARTMENT. Any city with one hundred thousand or more population and the county in which it is located, are authorized, as shall be agreed upon between the respective governing bodies of such city and said county, to establish and operate a combined city and county health department, and to appoint ((~~the director of public health~~)) a local health officer for the county served. Class AA counties may appoint a director of public health as specified in this chapter.

Sec. 242. RCW 70.12.030 and 1945 c 46 s 1 are each amended to read as follows:

MONEY MANAGEMENT. Any county, ((~~first class city~~)) combined city-county health department, or health district is hereby authorized and

empowered to create a "public health pooling fund", hereafter called the "fund", for the efficient management and control of all moneys coming to such county, ((~~first class city~~)) combined department, or district for public health purposes.

((~~"Health district" as used herein may mean all territory consisting of one or more counties and all cities with a population of one hundred thousand or less, and towns therein.~~))

Sec. 243. RCW 70.12.050 and 1945 c 46 s 3 are each amended to read as follows:

EXPENDITURES. All expenditures in connection with salaries, wages and operations incurred in carrying on the health department of the county, ((~~first class city~~)) combined city-county health department, or health district shall be paid out of such fund.

Sec. 244. RCW 70.46.020 and 1967 ex.s. c 51 s 6 are each amended to read as follows:

MULTICOUNTY HEALTH DISTRICTS. Health districts consisting of two or more counties may be created whenever two or more boards of county commissioners shall by resolution establish a district for such purpose. Such a district shall consist of all the area of the combined counties ((~~including all cities and towns except cities of over one hundred thousand population~~)). The district board of health of such a district shall consist of not less than five members for districts of two counties and seven members for districts of more than two counties, including two representatives from each county who are members of the board of county commissioners and who are appointed by the board of county commissioners of each county within the district, and shall have a jurisdiction coextensive with the combined boundaries. ((~~The remaining members shall be representatives of the cities and towns in the district selected by mutual agreement of the legislative bodies of the cities and towns concerned from their membership, taking into consideration the financial contribution of such cities and towns and representation from the several classifications of cities and towns.~~))

At the first meeting of a district board of health the members shall elect a ((~~chairman~~)) chair to serve for a period of one year.

Sec. 245. RCW 70.46.060 and 1967 ex.s. c 51 s 11 are each amended to read as follows:

DISTRICT BOARD OF HEALTH POWERS AND DUTIES. The district board of health shall constitute the local board of health for all the territory included in the health district, and shall supersede and exercise all the powers and perform all the duties by law vested in the county ((~~or city or town~~)) board of health of any county((~~, city or town~~)) included in the health district((~~, except as otherwise in chapter 70.05 RCW and RCW 70.46.020 through 70.46.090 provided~~)).

Sec. 246. RCW 70.46.080 and 1971 ex.s. c 85 s 10 are each amended to read as follows:

DISTRICT HEALTH FUND. Each health district shall establish a fund to be designated as the "district health fund", in which shall be placed all sums received by the district from any source, and out of which shall be expended all sums disbursed by the district. ((~~The county treasurer of the county in the district embracing only one county; or,~~)) In a district composed of more than one county the county treasurer of the county having the largest population shall be the custodian of the fund, and the county auditor of said county shall keep the record of the receipts and disbursements, and shall draw and the county treasurer shall honor and pay all warrants, which shall be approved before issuance and payment as directed by the board((~~: PROVIDED, That in local health departments wherein a city of over one hundred thousand population is a part of said department, the local board of health may pool the funds available for public health purposes in the office of the city treasurer in a special pooling fund to be established and which shall be expended as set forth above~~)).

Each county((~~, city or town~~)) which is included in the district shall contribute such sums towards the expense for maintaining and operating the district as shall be agreed upon between it and the local board of health in accordance with guidelines established by the state board of health ((~~after consultation with the Washington state association of counties and the association of Washington cities. In the event that no agreement can be reached between the district board of health and the county, city or town, the matter shall be resolved by a board of arbitrators to consist of a representative of the district board of health, a representative from the county, city or town involved, and a third representative to be appointed by the two representatives, but if they are unable to agree, a representative shall be appointed by a judge in the county in which the city or town~~)

~~is located. The determination of the proportionate share to be paid by a county, city or town shall be binding on all parties. Payments into the fund of the district may be made by the county or city or town members during the first year of membership in said district from any funds of the respective county, city or town as would otherwise be available for expenditures for health facilities and services, and thereafter the members shall include items in their respective budgets for payments to finance the health district~~)).

Sec. 247. RCW 70.46.085 and 1967 ex.s. c 51 s 20 are each amended to read as follows:

COUNTY TO BEAR EXPENSES. The expense of providing public health services shall be borne by each county((~~, city or town~~)) within the health district((~~, and the local health officer shall certify the amount agreed upon or as determined pursuant to RCW 70.46.080, and remaining unpaid by each county, city or town to the fiscal or warrant issuing officer of such county, city or town.~~

~~If the expense as certified is not paid by any county, city or town within thirty days after the end of the fiscal year, the local health officer shall certify the amount due to the auditor of the county in which the governmental unit is situated who shall promptly issue his warrant on the county treasurer payable out of the current expense fund of the county, which fund shall be reimbursed by the county auditor out of the money due said governmental unit at the next monthly settlement or settlements of the collection of taxes and shall be transferred to the current expense fund~~)).

Sec. 248. RCW 70.46.090 and 1967 ex.s. c 51 s 21 are each amended to read as follows:

WITHDRAWAL FROM MEMBERSHIP. Any county ((~~or any city or town~~)) may withdraw from membership in said health district any time after it has been within the district for a period of two years, but no withdrawal shall be effective except at the end of the calendar year in which the county((~~, city or town~~)) gives at least six months' notice of its intention to withdraw at the end of the calendar year. No withdrawal shall entitle any member to a refund of any moneys paid to the district nor relieve it of any obligations to pay to the district all sums for which it obligated itself due and owing by it to the district for the year at the end of which the withdrawal is to be effective((~~:~~

1 ~~PROVIDED, That~~)). Any county((~~, city or town~~)) which withdraws from
2 membership in said health district shall immediately establish a health
3 department or provide health services which shall meet the standards
4 for health services promulgated by the state board of health((~~:~~
5 ~~PROVIDED FURTHER, That~~)). No local health department ((~~shall~~)) may be
6 deemed to provide adequate public health services unless there is at
7 least one full time professionally trained and qualified physician as
8 set forth in RCW 70.05.050.

9 **Sec. 249.** RCW 70.46.120 and 1963 c 121 s 1 are each amended to
10 read as follows:
11 FEES MAY BE CHARGED. In addition to all other powers and duties,
12 health districts shall have the power to charge fees in connection with
13 the issuance or renewal of a license or permit required by law:
14 PROVIDED, That the fees charged shall not exceed the actual cost
15 involved in issuing or renewing the license or permit((~~: PROVIDED~~
16 ~~FURTHER, That no fees shall be charged pursuant to this section within~~
17 ~~the corporate limits of any city or town which prior to the enactment~~
18 ~~of this section charged fees in connection with the issuance or renewal~~
19 ~~of a license or permit pursuant to city or town ordinance and where~~
20 ~~said city or town makes a direct contribution to said health district,~~
21 ~~unless such city or town expressly consents thereto~~)).

22 **Sec. 250.** RCW 82.44.110 and 1991 c 199 s 221 are each amended to
23 read as follows:
24 DISPOSITION OF MOTOR VEHICLE EXCISE TAX REVENUE--PUBLIC HEALTH.
25 The county auditor shall regularly, when remitting license fee
26 receipts, pay over and account to the director of licensing for the
27 excise taxes collected under the provisions of this chapter. The
28 director shall forthwith transmit the excise taxes to the state
29 treasurer.
30 (1) The state treasurer shall deposit the excise taxes collected
31 under RCW 82.44.020(1) as follows:
32 (a) 1.60 percent into the motor vehicle fund to defray
33 administrative and other expenses incurred by the department in the
34 collection of the excise tax.
35 (b) 8.15 percent into the Puget Sound capital construction account
36 in the motor vehicle fund.

1 (c) 4.07 percent into the Puget Sound ferry operations account in
2 the motor vehicle fund.
3 (d) ((~~8.83~~)) <u>5.88</u> percent into the general fund to be distributed
4 under RCW 82.44.155.
5 (e) 4.75 percent into the municipal sales and use tax equalization
6 account in the general fund created in RCW 82.14.210.
7 (f) 1.60 percent into the county sales and use tax equalization
8 account in the general fund created in RCW 82.14.200.
9 (g) 62.6440 percent into the general fund through June 30, 1993,
10 57.6440 percent into the general fund beginning July 1, 1993, and 66
11 percent into the general fund beginning January 1, 1994.
12 (h) 5 percent into the transportation fund created in RCW 82.44.180
13 beginning July 1, 1993.
14 (i) 5.9686 percent into the county criminal justice assistance
15 account created in RCW 82.14.310 through December 31, 1993.
16 (j) 1.1937 percent into the municipal criminal justice assistance
17 account for distribution under RCW 82.14.320 through December 31, 1993.
18 (k) 1.1937 percent into the municipal criminal justice assistance
19 account for distribution under RCW 82.14.330 through December 31, 1993.
20 <u>(l) 2.95 percent into the general fund to be distributed by the</u>
21 <u>state treasurer to county health departments to be used exclusively for</u>
22 <u>public health. The state treasurer shall distribute these funds</u>
23 <u>proportionately among the counties based on population as determined by</u>
24 <u>the most recent United States census.</u>
25 (2) The state treasurer shall deposit the excise taxes collected
26 under RCW 82.44.020(2) into the transportation fund.
27 (3) The state treasurer shall deposit the excise tax imposed by RCW
28 82.44.020(3) into the air pollution control account created by RCW
29 70.94.015.

30 **Sec. 251.** RCW 82.44.155 and 1991 c 199 s 223 are each amended to
31 read as follows:
32 MOTOR VEHICLE EXCISE TAX DISTRIBUTION TO CITIES AND TOWNS. When
33 distributions are made under RCW 82.44.150, the state treasurer shall
34 apportion and distribute the motor vehicle excise taxes deposited into
35 the general fund under RCW 82.44.110((~~(4)~~))<u>(1)(d)</u> to the cities and
36 towns ratably on the basis of population as last determined by the
37 office of financial management. When so apportioned, the amount
38 payable to each such city and town shall be transmitted to the city

treasurer thereof, and shall be used by the city or town for the purposes of police and fire protection ((~~and the preservation of the public health~~)) in the city or town, and not otherwise. If it is adjudged that revenue derived from the excise taxes imposed by RCW 82.44.020 (1) and (2) cannot lawfully be apportioned or distributed to cities or towns, all moneys directed by this section to be apportioned and distributed to cities and towns shall be credited and transferred to the state general fund.

Sec. 252. RCW 43.20.030 and 1984 c 287 s 75 are each amended to read as follows:

COMPOSITION OF STATE BOARD OF HEALTH--CITY MEMBER ELIMINATED. The state board of health shall be composed of ten members. These shall be the secretary or the secretary's designee and nine other persons to be appointed by the governor, including four persons experienced in matters of health and sanitation, ((~~an elected city official who is a member of a local health board, an~~)) two elected county officials who ((~~is a~~)) are members of a local health board, a local health officer, and two persons representing the consumers of health care. ((~~Before appointing the city official, the governor shall consider any recommendations submitted by the association of Washington cities.~~)) Before appointing the county official, the governor shall consider any recommendations submitted by the Washington state association of counties. Before appointing the local health officer, the governor shall consider any recommendations submitted by the Washington state association of local public health officials. Before appointing one of the two consumer representatives, the governor shall consider any recommendations submitted by the state council on aging. The chairman shall be selected by the governor from among the nine appointed members. The department ((~~of social and health services~~)) shall provide necessary technical staff support to the board. The board may employ an executive director and a confidential secretary, each of whom shall be exempt from the provisions of the state civil service law, chapter 41.06 RCW.

Members of the board shall be compensated in accordance with RCW 43.03.240 and shall be reimbursed for their travel expenses in accordance with RCW 43.03.050 and 43.03.060.

NEW SECTION. **Sec. 253.** RECODIFICATION--CITY/COUNTY HEALTH DEPARTMENT. RCW 70.08.010, as amended by this act, shall be recodified in chapter 70.05 RCW.

NEW SECTION. **Sec. 254.** REPEALERS--CITIES AND TOWNS. The following acts or parts of acts are each repealed:

(1) RCW 70.05.005 and 1989 1st ex.s. c 9 s 243;

(2) RCW 70.05.020 and 1967 ex.s. c 51 s 2;

(3) RCW 70.05.132 and 1984 c 25 s 9 & 1983 1st ex.s. c 39 s 6;

(4) RCW 70.05.145 and 1983 1st ex.s. c 39 s 5;

(5) RCW 70.12.005 and 1989 1st ex.s. c 9 s 245;

(6) RCW 70.46.030 and 1991 c 363 s 141, 1969 ex.s. c 70 s 1, 1967 ex.s. c 51 s 5, & 1945 c 183 s 3;

(7) RCW 70.46.040 and 1967 ex.s. c 51 s 7 & 1945 c 183 s 4; and

(8) RCW 70.46.050 and 1967 ex.s. c 51 s 8, 1957 c 100 s 1, & 1945 c 183 s 5.

NEW SECTION. **Sec. 255.** STUDY LOCAL GOVERNMENT HEALTH SERVICE DELIVERY. It is hereby requested that the governing authorities of the association of Washington cities, the Washington state association of counties, and the Washington association of county officials jointly initiate a study and develop consensus recommendations regarding implementation of the provisions of sections 231 through 254 of this act. The study and recommendations should at a minimum include consideration of the fiscal impact of these sections on counties, the desirability of maintaining a process whereby city officials can effectively communicate concerns regarding the delivery of public health services to both the counties and the state, the need for larger cities to be able to continue to provide supplemental health care services when needed, and other matters as the three associations agree are of substance in the implementation of sections 231 through 254 of this act. The agreed upon recommendations shall be presented to the senate health and human services and house of representatives health care committees prior to December 31, 1993.

F. DATA COLLECTION

Sec. 256. RCW 70.170.100 and 1990 c 269 s 12 are each amended to read as follows:

1 STATE-WIDE DATA SYSTEM--HEALTH SERVICES COMMISSION. (1) To promote
2 the public interest consistent with the purposes of chapter . . ., Laws
3 of 1993 (this act), the department is responsible for the development,
4 implementation, and custody of a state-wide ((~~hospital~~)) health care
5 data system, with policy direction and oversight to be provided by the
6 Washington health services commission. As part of the design stage for
7 development of the system, the department shall undertake a needs
8 assessment of the types of, and format for, ((~~hospital~~)) health care
9 data needed by consumers, purchasers, health care payers, ((~~hospitals~~))
10 providers, and state government as consistent with the intent of
11 chapter . . ., Laws of 1993 (this act) ((~~chapter~~)). The department
12 shall identify a set of ((~~hospital~~)) health care data elements and
13 report specifications which satisfy these needs. The ((~~council~~))
14 Washington health services commission, created by section 403 of this
15 act, shall review the design of the data system and may ((~~direct the~~
16 ~~department to~~)) establish a technical advisory committee on health data
17 and shall, if deemed cost-effective and efficient, recommend that the
18 department contract with a private vendor for assistance in the design
19 of the data system or for any part of the work to be performed under
20 this section. The data elements, specifications, and other ((~~design~~))
21 distinguishing features of this data system shall be made available for
22 public review and comment and shall be published, with comments, as the
23 department's first data plan by ((~~January 1, 1990~~)) July 1, 1994.

24 (2) Subsequent to the initial development of the data system as
25 published as the department's first data plan, revisions to the data
26 system shall be considered ((~~through the department's development of a~~
27 ~~biennial data plan, as proposed to,~~)) with the oversight and policy
28 guidance of the Washington health services commission or its technical
29 advisory committee and funded by((~~,~~)) the legislature through the
30 biennial appropriations process with funds appropriated to the health
31 services account. ((~~Costs of data activities outside of these data~~
32 ~~plans except for special studies shall be funded through legislative~~
33 ~~appropriations.~~

34 ~~(3)~~)) In designing the state-wide ((~~hospital~~)) health care data
35 system and any data plans, the department shall identify ((~~hospital~~))
36 health care data elements relating to ((~~both hospital finances~~)) health
37 care costs, the quality of health care services, the outcomes of health
38 care services, and ((~~the~~)) use of ((~~services by patients~~)) health care
39 by consumers. Data elements ((~~relating to hospital finances~~)) shall be

reported ((~~by hospitals~~)) as the Washington health services commission directs by reporters in conformance with a uniform ((~~system of~~)) reporting ((~~as specified by the department and shall~~)) system established by the department, which shall be adopted by reporters. "Reporter" means an individual, hospital, or business entity, required to be registered with the department of revenue for payment of taxes imposed under chapter 82.04 RCW or Title 48 RCW, that is primarily engaged in furnishing or insuring for medical, surgical, and other health services to persons. 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 chapter . . ., Laws of 1993 (this ((~~chapter~~)) act), 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 commission and the department shall encourage and 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 chapter . . ., Laws of 1993 (this ((~~chapter~~)) act). 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 Washington health services commission 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 payer 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 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 or the Washington health services commission shall only be available for retrieval in original or processed form to public and private requestors and shall be available 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 reflects the direct cost of retrieving the data or study in the requested form.

(6) All persons subject to chapter . . ., Laws of 1993 (this act) shall comply with departmental or commission requirements established by rule in the acquisition of data.

Sec. 257. RCW 70.170.110 and 1989 1st ex.s. c 9 s 511 are each amended to read as follows:

HEALTH CARE DATA--STUDIES, ANALYSES, OR REPORTS. The department shall provide, or may contract with a private entity to provide, ((~~hospital~~)) analyses and reports or any studies it chooses to conduct consistent with the purposes of chapter . . ., Laws of 1993 (this ((~~chapter~~)) act). Subject to the availability of funds and any policy direction that may be given by the Washington health services commission. ((~~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 studies, analyses, or reports shall include:

(1) Consumer guides on purchasing ((~~hospital care services and~~)) or consuming health care and publications providing verifiable and useful aggregate comparative information to ((~~consumers on hospitals and hospital services~~)) the public on health care services, their cost, and the quality of health care providers who participate in certified health plans;

(2) Reports for use by classes of purchasers, who purchase from certified health plans, health care payers, 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 commission or department deems useful to assist the public or purchasers of certified health plans in understanding the prudent and cost-effective use of certified health plan services.

NEW SECTION. **Sec. 258.** A new section is added to chapter 70.170 RCW to read as follows:

CONFIDENTIALITY OF DATA. Notwithstanding the provisions of chapter 42.17 RCW, any material contained within the state-wide health care data system or in the files of either the department or the Washington

health services commission shall be subject to the following limitations: (1) Records obtained, reviewed by, or on file that contain information concerning medical treatment of individuals shall be exempt from public inspection and copying; and (2) any actuarial formulas, statistics, and assumptions submitted by a certified health plan to the commission or department upon request shall be exempt from public inspection and copying in order to preserve trade secrets or prevent unfair competition.

All persons and any public or private agencies or entities whatsoever subject to this chapter shall comply with any requirements established by rule relating to the acquisition or use of health services data and maintain the confidentiality of any information which may, in any manner, identify individual persons.

NEW SECTION. **Sec. 259.** A new section is added to chapter 70.170 RCW to read as follows:

HEALTH SERVICES COMMISSION ACCESS TO DATA. The Washington health services commission shall have access to all health data presently available to the secretary of health. To the extent possible, the commission shall use existing data systems and coordinate among existing agencies. The department of health shall be the designated depository agency for all health data collected pursuant to chapter . . ., Laws of 1993 (this act). The following data sources shall be developed or made available:

(1) The commission shall coordinate with the secretary of health to utilize data collected by the state center for health statistics, including hospital charity care and related data, rural health data, epidemiological data, ethnicity data, social and economic status data, and other data relevant to the commission's responsibilities.

(2) The commission, in coordination with the department of health and the health science programs of the state universities shall develop procedures to analyze clinical and other health services outcome data, and conduct other research necessary for the specific purpose of assisting in the design of the uniform benefit package under chapter . . ., Laws of 1993 (this act).

(3) The commission shall establish cost data sources and shall require each certified health plan to provide the commission and the department of health with enrollee care and cost information, to include, but not be limited to: (a) Enrollee identifier, including

1 date of birth, sex, and ethnicity; (b) provider identifier; (c)
2 diagnosis; (d) health care services or procedures provided; (e)
3 provider charges, if any; and (f) amount paid. The department shall
4 establish by rule confidentiality standards to safeguard the
5 information from inappropriate use or release.

6 (4) The commission shall coordinate with the area Indian health
7 service, reservation Indian health service units, tribal clinics, and
8 any urban Indian health service organizations the design, development,
9 implementation, and maintenance of an American Indian-specific health
10 data, statistics information system. The commission rules regarding
11 the confidentiality to safeguard the information from inappropriate use
12 or release shall apply.

13 NEW SECTION. **Sec. 260.** A new section is added to chapter 70.170
14 RCW to read as follows:

15 PERSONAL HEALTH SERVICES DATA AND INFORMATION SYSTEM. (1) The
16 department is responsible for the implementation and custody of a
17 state-wide personal health services data and information system. The
18 data elements, specifications, and other design features of this data
19 system shall be consistent with criteria adopted by the Washington
20 health services commission. The department shall provide the
21 commission with reasonable assistance in the development of these
22 criteria, and shall provide the commission with periodic progress
23 reports related to the implementation of the system or systems related
24 to those criteria.

25 (2) The department shall coordinate the development and
26 implementation of the personal health services data and information
27 system with related private activities and with the implementation
28 activities of the data sources identified by the commission. Data
29 shall include: (a) Enrollee identifier, including date of birth, sex,
30 and ethnicity; (b) provider identifier; (c) diagnosis; (d) health
31 services or procedures provided; (e) provider charges, if any; and (f)
32 amount paid. The commission shall establish by rule, confidentiality
33 standards to safeguard the information from inappropriate use or
34 release. The department shall assist the commission in establishing
35 reasonable time frames for the completion of the system development and
36 system implementation.

NEW SECTION. **Sec. 261.** HEALTH CARE ENTITY REPORTING REQUIREMENTS. The commission shall determine, by January 1, 1995, the necessity, if any, of reporting requirements by the following health care entities: Health care providers, health care facilities, insuring entities, and certified health plans. The reporting requirements, if any, shall be for the purposes of determining whether the health care system is operating as efficiently as possible. Information reported pursuant to this section shall be made available to interested parties upon request. The commission shall report its findings to the legislature by January 1, 1995.

G. DISCLOSURE OF HOSPITAL, NURSING HOME, AND PHARMACY CHARGES

NEW SECTION. **Sec. 262.** A new section is added to chapter 70.41 RCW to read as follows:

SPIRALING COSTS--HOSPITALS. (1) The legislature finds that the spiraling costs of health care continue to surmount efforts to contain them, increasing at approximately twice the inflationary rate. The causes of this phenomenon are complex. By making physicians and other health care providers with hospital admitting privileges more aware of the cost consequences of health care services for consumers, these providers may be inclined to exercise more restraint in providing only the most relevant and cost-beneficial hospital services, with a potential for reducing the utilization of those services. The requirement of the hospital to inform physicians and other health care providers of the charges of the health care services that they order may have a positive effect on containing health costs. Further, the option of the physician or other health care provider to inform the patient of these charges may strengthen the necessary dialogue in the provider-patient relationship that tends to be diminished by intervening third-party payers.

(2) The chief executive officer of a hospital licensed under this chapter and the superintendent of a state hospital shall establish and maintain a procedure for disclosing to physicians and other health care providers with admitting privileges the charges of all health care services ordered for their patients. Copies of hospital charges shall be made available to any physician and/or other health care provider ordering care in hospital inpatient/outpatient services. The physician and/or other health care provider may inform the patient of these

1 charges and may specifically review them. Hospitals are also directed
2 to study methods for making daily charges available to prescribing
3 physicians through the use of interactive software and/or computerized
4 information thereby allowing physicians and other health care providers
5 to review not only the costs of present and past services but also
6 future contemplated costs for additional diagnostic studies and
7 therapeutic medications.

8 NEW SECTION. **Sec. 263.** A new section is added to chapter 18.68
9 RCW to read as follows:
10 SPIRALING COSTS--PRESCRIPTION MEDICATIONS. The legislature finds
11 that the spiraling costs of health care continue to surmount efforts to
12 contain them, increasing at approximately twice the inflationary rate.
13 One of the fastest growing segments of the health care expenditure
14 involves prescription medications. By making physicians and other
15 health care providers with prescriptive authority more aware of the
16 cost consequences of health care treatments for consumers, these
17 providers may be inclined to exercise more restraint in providing only
18 the most relevant and cost-beneficial drug and medication treatments.
19 The requirement of the pharmacy to inform physicians and other health
20 care providers of the charges of prescription drugs and medications
21 that they order may have a positive effect on containing health costs.
22 Further, the option of the physician or other health care provider to
23 inform the patient of these charges may strengthen the necessary
24 dialogue in the provider-patient relationship that tends to be
25 diminished by intervening third-party payers.

26 NEW SECTION. **Sec. 264.** A new section is added to chapter 18.68
27 RCW to read as follows:
28 COST OF PRESCRIPTIVE MEDICATIONS. The registered or licensed
29 pharmacist of this chapter shall establish and maintain a procedure for
30 disclosing to physicians and other health care providers with
31 prescriptive authority information detailed by prescriber, of the cost
32 and dispensation of all prescriptive medications prescribed by him or
33 her for his or her patients on request. These charges should be made
34 available on at least a quarterly basis for all requested patients and
35 should include medication, dosage, number dispensed, and the cost of
36 the prescription. Pharmacies may provide this information in a summary
37 form for each prescribing physician for all patients rather than as

1 individually itemized reports. All efforts should be made to utilize
2 the existing computerized records and software to provide this
3 information in the least costly format.

4 NEW SECTION. **Sec. 265.** A new section is added to chapter 18.51
5 RCW to read as follows:
6 SPIRALING COSTS--NURSING HOMES. (1) The legislature finds that the
7 spiraling costs of nursing home care continue to surmount efforts to
8 contain them, increasing at approximately twice the inflationary rate.
9 The causes of this phenomenon are complex. By making nursing home
10 facilities and care providers more aware of the cost consequences of
11 care services for consumers, these providers may be inclined to
12 exercise more restraint in providing only the most relevant and cost-
13 beneficial services and care, with a potential for reducing the
14 utilization of those services. The requirement of the nursing home to
15 inform physicians, consumers, and other care providers of the charges
16 of the services that they order may have a positive effect on
17 containing health costs.
18 (2) All nursing home administrators in facilities licensed under
19 this chapter shall be required to develop and maintain a written
20 procedure for disclosing patient charges to attending physicians with
21 admitting privileges. The nursing home administrator shall have the
22 capability to provide an itemized list of the charges for all health
23 care services that may be ordered by a physician. The information
24 shall be made available on request of consumers, or the physicians or
25 other appropriate health care providers responsible for prescribing
26 care.

27 NEW SECTION. **Sec. 266.** DEPARTMENT OF HEALTH--REPORT ON EFFORTS TO
28 CONTAIN COSTS. The department of health shall report to the
29 legislature by December 31, 1994, with recommendations on any necessary
30 revisions to sections 262 through 265 of this act, including their
31 continued necessity and the appropriateness of their repeal.

32 **H. HEALTH PROFESSIONAL SHORTAGES**

33 NEW SECTION. **Sec. 267.** LEGISLATIVE INTENT. The legislature finds
34 that the successful implementation of health care reform will depend on
35 a sufficient supply of primary health care providers throughout the

state. Many rural and medically underserved urban areas lack primary health care providers and because of this, basic health care services are limited or unavailable to populations living in these areas. The legislature has in recent years initiated new programs to address these provider shortages but funding has been insufficient and additional specific provider shortages remain.

Sec. 268. RCW 28B.125.010 and 1991 c 332 s 5 are each amended to read as follows:

STATE-WIDE HEALTH PERSONNEL RESOURCE PLAN--PERSONS OF COLOR--INDIAN HEALTH. (1) The higher education coordinating board, the state board for community ((~~college education~~)) and technical colleges, the superintendent of public instruction, the state department of health, the Washington health services commission, and the state department of social and health services, to be known for the purposes of this section as the committee, shall establish a state-wide health personnel resource plan. The governor shall appoint a lead agency from one of the agencies on the committee.

In preparing the state-wide plan the committee shall consult with the training and education institutions affected by this chapter, health care providers, employers of health care providers, insurers, consumers of health care, and other appropriate entities.

Should a successor agency or agencies be authorized or created by the legislature with planning, coordination, or administrative authority over vocational-technical schools, community colleges, or four-year higher education institutions, the governor shall grant membership on the committee to such agency or agencies and remove the member or members it replaces.

The committee shall appoint subcommittees for the purpose of assisting in the development of the institutional plans required under this chapter. Such subcommittees shall at least include those committee members that have statutory responsibility for planning, coordination, or administration of the training and education institutions for which the institutional plans are being developed. In preparing the institutional plans for four-year institutes of higher education, the subcommittee shall be composed of at least the higher education coordinating board and the state's four-year higher education institutions. The appointment of subcommittees to develop portions of the state-wide plan shall not relinquish the committee's responsibility

for assuring overall coordination, integration, and consistency of the state-wide plan.

In establishing and implementing the state-wide health personnel resource plan the committee shall, to the extent possible, utilize existing data and information, personnel, equipment, and facilities and shall minimize travel and take such other steps necessary to reduce the administrative costs associated with the preparation and implementation of the plan.

(2) The state-wide health resource plan shall include at least the following:

(a)(i) Identification of the type, number, and location of the health care professional work force necessary to meet health care needs of the state.

(ii) A description and analysis of the composition and numbers of the potential work force available for meeting health care service needs of the population to be used for recruitment purposes. This should include a description of the data, methodology, and process used to make such determinations.

(b) A centralized inventory of the numbers of student applications to higher education and vocational-technical training and education programs, yearly enrollments, yearly degrees awarded, and numbers on waiting lists for all the state's publicly funded health care training and education programs. The committee shall request similar information for incorporation into the inventory from private higher education and vocational-technical training and education programs.

(c) A description of state-wide and local specialized provider training needs to meet the health care needs of target populations and a plan to meet such needs in a cost-effective and accessible manner.

(d) A description of how innovative, cost-effective technologies such as telecommunications can and will be used to provide higher education, vocational-technical, continued competency, and skill maintenance and enhancement education and training to placebound students who need flexible programs and who are unable to attend institutions for training.

(e) A strategy for assuring higher education and vocational-technical educational and training programming is sensitive to the changing work force such as reentry workers, women, minorities, and the disabled.

(f) Strategies for promoting an increase in the use of persons of color in the health professions including adequate resources to train and utilize persons of color in the full spectrum of health professions, to include physicians, licensed physicians who are foreign medical graduates, nurses, administrators, planners, education, technicians, outreach workers, and dentists.

(g) A strategy that includes the incorporation of federal assistance programs for health career development with an emphasis on the national Indian health service programs targeting the American Indian population and other federal and state education and training assistance programs for the economically disadvantaged, physically challenged, and persons of color in all health professions.

((~~(f)~~)) (g) A strategy and coordinated state-wide policy developed by the subcommittees authorized in subsection (1) of this section for increasing the number of graduates intending to serve in shortage areas after graduation, including such strategies as the establishment of preferential admissions and designated enrollment slots.

((~~(g)~~)) (h) Guidelines and policies developed by the subcommittees authorized in subsection (1) of this section for allowing academic credit for on-the-job experience such as internships, volunteer experience, apprenticeships, and community service programs.

((~~(h)~~)) (i) A strategy developed by the subcommittees authorized in subsection (1) of this section for making required internships and residency programs available that are geographically accessible and sufficiently diverse to meet both general and specialized training needs as identified in the plan when such programs are required.

((~~(i)~~)) (j) A description of the need for multiskilled health care professionals and an implementation plan to restructure educational and training programming to meet these needs.

((~~(j)~~)) (k) An analysis of the types and estimated numbers of health care personnel that will need to be recruited from out-of-state to meet the health professional needs not met by in-state trained personnel.

((~~(k)~~)) (l) An analysis of the need for educational articulation within the various health care disciplines and a plan for addressing the need.

((~~(l)~~)) (m) An analysis of the training needs of those members of the long-term care profession that are not regulated and that have no formal training requirements. Programs to meet these needs should be

developed in a cost-effective and a state-wide accessible manner that provide for the basic training needs of these individuals.

((~~(m)~~)) (n) A designation of the professions and geographic locations in which loan repayment and scholarships should be available based upon objective data-based forecasts of health professional shortages. A description of the criteria used to select professions and geographic locations shall be included. Designations of professions and geographic locations may be amended by the department of health when circumstances warrant as provided for in RCW 28B.115.070.

((~~(n)~~)) (o) A description of needed changes in regulatory laws governing the credentialing of health professionals.

((~~(o)~~)) (p) A description of linguistic and cultural training needs of foreign-trained health care professionals to assure safe and effective practice of their health care profession.

((~~(p)~~)) (q) A plan to implement the recommendations of the state-wide nursing plan authorized by RCW 74.39.040.

((~~(q)~~)) (r) A description of criteria and standards that institutional plans provided for in this section must address in order to meet the requirements of the state-wide health personnel resource plan, including funding requirements to implement the plans. The committee shall also when practical identify specific outcome measures to measure progress in meeting the requirements of this plan. The criteria and standards shall be established in a manner as to provide flexibility to the institutions in meeting state-wide plan requirements. The committee shall establish required submission dates for the institutional plans that permit inclusion of funding requests into the institutions budget requests to the state.

((~~(r)~~)) (s) A description of how the higher education coordinating board, state board for community ((~~college education~~)) and technical colleges, superintendent of public instruction, department of health, and department of social and health services coordinated in the creation and implementation of the state plan including the areas of responsibility each agency shall assume. The plan should also include a description of the steps taken to assure participation by the groups that are to be consulted with.

((~~(s)~~)) (t) A description of the estimated fiscal requirements for implementation of the state-wide health resource plan that include a description of cost saving activities that reduce potential costs by

avoiding administrative duplication, coordinating programming activities, and other such actions to control costs.

(3) The committee may call upon other agencies of the state to provide available information to assist the committee in meeting the responsibilities under this chapter. This information shall be supplied as promptly as circumstances permit.

(4) State agencies involved in the development and implementation of the plan shall to the extent possible utilize existing personnel and financial resources in the development and implementation of the state-wide health personnel resource plan.

(5) The state-wide health personnel resource plan shall be submitted to the governor by July 1, 1992, and updated by July 1 of each even-numbered year. The governor, no later than December 1 of that year, shall approve, approve with modifications, or disapprove the state-wide health resource plan.

(6) The approved state-wide health resource plan shall be submitted to the senate and house of representatives committees on health care, higher education, and ways and means or appropriations by December 1 of each even-numbered year.

(7) Implementation of the state-wide plan shall begin by July 1, 1993.

(8) Notwithstanding subsections (5) and (7) of this section, the committee shall prepare and submit to the higher education coordinating board by June 1, 1992, the analysis necessary for the initial implementation of the health professional loan repayment and scholarship program created in chapter 28B.115 RCW.

(9) Each publicly funded two-year and four-year institute of higher education authorized under Title 28B RCW and vocational-technical institution authorized under Title 28A RCW that offers health training and education programs shall biennially prepare and submit an institutional plan to the committee. The institutional plan shall identify specific programming and activities of the institution that meet the requirements of the state-wide health professional resource plan.

The committee shall review and assess whether the institutional plans meet the requirements of the state-wide health personnel resource plan and shall prepare a report with its determination. The report shall become part of the institutional plan and shall be submitted to the governor and the legislature.

The institutional plan shall be included with the institution's biennial budget submission. The institution's budget shall identify proposed spending to meet the requirements of the institutional plan. Each vocational-technical institution, college, or university shall be responsible for implementing its institutional plan.

Sec. 269. RCW 28B.115.080 and 1991 c 332 s 21 are each amended to read as follows:

ANNUAL AWARD AMOUNT. After June 1, 1992, the board, in consultation with the department and the department of social and health services, shall:

(1) Establish the annual award amount for each credentialed health care profession which shall be based upon an assessment of reasonable annual eligible expenses involved in training and education for each credentialed health care profession. The annual award amount may be established at a level less than annual eligible expenses. The annual award amount shall ((~~not be more than fifteen thousand dollars per year~~)) be established by the board for each eligible health profession. The awards shall not be paid for more than a maximum of five years per individual;

(2) Determine any scholarship awards for prospective physicians in such a manner to require the recipients declare an interest in serving in rural areas of the state of Washington. Preference for scholarships shall be given to students who reside in a rural physician shortage area or a nonshortage rural area of the state prior to admission to the eligible education and training program in medicine. Highest preference shall be given to students seeking admission who are recommended by sponsoring communities and who declare the intent of serving as a physician in a rural area. The board may require the sponsoring community located in a nonshortage rural area to financially contribute to the eligible expenses of a medical student if the student will serve in the nonshortage rural area;

(3) Establish the required service obligation for each credentialed health care profession, which shall be no less than three years or no more than five years. The required service obligation may be based upon the amount of the scholarship or loan repayment award such that higher awards involve longer service obligations on behalf of the participant;

(4) Determine eligible education and training programs for purposes of the scholarship portion of the program;

(5) Honor loan repayment and scholarship contract terms negotiated between the board and participants prior to May 21, 1991, concerning loan repayment and scholarship award amounts and service obligations authorized under chapter ((~~18.150~~)) 28B.115, 28B.104, or 70.180 RCW.

NEW SECTION. **Sec. 270.** A new section is added to chapter 43.70 RCW to read as follows:

MULTICULTURAL HEALTH CARE TECHNICAL ASSISTANCE PROGRAM. (1) Consistent with funds appropriated specifically for this purpose, the department shall provide matching grants to support a community-based multicultural health care technical assistance program. Its purpose shall be to promote technical assistance to community and migrant health clinics and other appropriate health care providers who serve principally the underserved and persons of color.

The technical assistance provided shall include, but is not limited to: (a) Collaborative research and data analysis on health care outcomes that disproportionately affect persons of color; (b) design and development of model health education and promotion strategies aimed at modifying unhealthy health behaviors or enhancing the use of the health care delivery system by persons of color; (c) provision of technical information and assistance on program planning and financial management; (d) administration, public policy development, and analysis in health care issues affecting people of color; and (e) enhancement and promotion of health care career opportunities for persons of color.

(2) Consistent with appropriated funds, the programs shall be available on a state-wide basis.

Sec. 271. RCW 70.185.030 and 1991 c 332 s 9 are each amended to read as follows:

COMMUNITY-BASED RECRUITMENT AND RETENTION--UNDERSERVED URBAN AREAS. (1) The department ((~~shall~~)) may, subject to funding, establish ((~~up to three~~)) community-based recruitment and retention project sites to provide financial and technical assistance to participating communities. The goal of the project is to help assure the availability of health care providers in rural and underserved urban areas of Washington state.

(2) Administrative costs necessary to implement this project shall be kept at a minimum to insure the maximum availability of funds for participants.

(3) The secretary may contract with third parties for services necessary to carry out activities to implement this chapter where this will promote economy, avoid duplication of effort, and make the best use of available expertise.

(4) The secretary may apply for, receive, and accept gifts and other payments, including property and service, from any governmental or other public or private entity or person, and may make arrangements as to the use of these receipts, including the undertaking of special studies and other projects related to the delivery of health care in rural areas.

(5) In designing and implementing the project the secretary shall coordinate the project with the Washington rural health system project as authorized under chapter 70.175 RCW to consolidate administrative duties and reduce costs.

Sec. 272. RCW 43.70.460 and 1992 c 113 s 2 are each amended to read as follows:

RETIRED PRIMARY CARE PROVIDERS--MALPRACTICE INSURANCE. (1) The department may establish a program to purchase and maintain liability malpractice insurance for retired ((~~physicians~~)) primary care providers who provide primary health care services at community clinics. The following conditions 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 the clinics shall be offered to low-income patients based on their ability to pay;

(c) Retired ((~~physicians~~)) primary care providers 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 RCW 43.70.470 shall not be interpreted to require a liability insurer to provide coverage to a ((~~physician~~)) primary care provider 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 and RCW 43.70.470. This protection of immunity shall not extend to any clinic or ((~~physician~~)) primary care provider 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 chapter 113, Laws of 1992 only to the extent funds are provided for this purpose by the legislature.

Sec. 273. RCW 43.70.470 and 1992 c 113 s 3 are each amended to read as follows:

RETIRED PRIMARY CARE PROVIDERS--CONDITIONS. The department may establish by rule the conditions of participation in the liability insurance program by retired ((~~physicians~~)) primary care providers at clinics utilizing retired physicians for the purposes of this section and RCW 43.70.460. These conditions shall include, but not be limited to, the following:

(1) The participating ((~~physician~~)) primary care provider associated with the clinic shall hold a valid license to practice ((~~medicine and surgery in this state and otherwise~~)) as a physician under chapter 18.71 or 18.57 RCW, a naturopath under chapter 18.36A RCW, a physician assistant under chapter 18.71A or 18.57A RCW, an advanced registered nurse practitioner under chapter 18.88 RCW, a dentist under chapter 18.32 RCW, or other health professionals as may be deemed in short supply in the health personnel resource plan under chapter 28B.125 RCW. All primary care providers must be in conformity with current requirements for licensure as a retired ((~~physician~~)) primary care health care provider, including continuing education requirements;

(2) The participating ((~~physician~~)) primary care health care provider 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.

Primary dental care shall be limited to diagnosis, oral hygiene, restoration, and extractions and shall not include orthodontia, or other specialized care and treatment;

(3) The provision of liability insurance coverage shall not extend to acts outside the scope of rendering medical services pursuant to this section and RCW 43.70.460;

(4) The participating ((~~physician~~)) primary care health care provider shall limit the provision of health care services to primarily 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~~)) primary care health care provider shall not accept compensation for providing health care services from patients served pursuant to this section and RCW 43.70.460, nor from clinics serving these patients. "Compensation" shall mean any remuneration of value to the participating ((~~physician~~)) primary care health care provider for services provided by the ((~~physician~~)) primary care health care provider, but shall not be construed to include any nominal copayments charged by the clinic, nor reimbursement of related expenses of a participating ((~~physician~~)) primary care health care provider 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.

NEW SECTION. **Sec. 274.** MEDICAL SCHOOL GRADUATES SERVING IN RURAL AND MEDICALLY UNDERSERVED AREAS OF THE STATE--LEGISLATIVE INTENT. The legislature finds that the shortage of primary care physicians practicing in rural and medically underserved areas of the state has created a severe public health and safety problem. If unaddressed, this problem is expected to worsen with health care reform since an increased demand for primary care services will only contribute further to these shortages.

The legislature further finds that the medical training program at the University of Washington is an important and well respected resource to the people of this state in the training of primary care

1 physicians. Currently, only a small proportion of medical school
2 graduates are Washington residents who serve as primary care
3 practitioners in certain parts of this state.

4 NEW SECTION. **Sec. 275.** MEDICAL SCHOOL PRIMARY CARE PHYSICIAN
5 SHORTAGE PLAN DEVELOPMENT. (1) The University of Washington shall
6 prepare a primary care shortage plan that accomplishes the following:
7 (a) Identifies specific activities that the school of medicine
8 shall pursue to increase the number of Washington residents serving as
9 primary care physicians in rural and medically underserved areas of the
10 state, including establishing a goal that assures that no less than
11 forty-five percent of medical school graduates who are Washington state
12 residents at the time of matriculation will enter into primary care
13 residencies in Washington state by the year 2000;
14 (b) Assures that the school of medicine shall establish among its
15 highest training priorities the distribution of its primary care
16 physician graduates from the school and associated postgraduate
17 residency programs into rural and medically underserved areas;
18 (c) Establishes the goal of assuring that the annual number of
19 graduates from the family practice residency network entering rural or
20 medically underserved practice shall be increased by forty percent over
21 a baseline period from 1985 through 1990 by 1995;
22 (d) Establishes a further goal to make operational at least two
23 additional family practice residency programs within Washington state
24 in geographic areas identified by the plan as underserved in family
25 practice by 1997. The geographic areas identified by the plan as being
26 underserved by family practice physicians shall be consistent with any
27 such similar designations as may be made in the health personnel
28 research plan as authorized under chapter 28B.125 RCW;
29 (e) Establishes, with the cooperation of existing community and
30 migrant health clinics in rural or medically underserved areas of the
31 state, three family practice residency training tracks. Furthermore,
32 the primary care shortage plan shall provide that one of these training
33 tracks shall be a joint American osteopathic association and American
34 medical association approved training site coordinated with an
35 accredited college of osteopathic medicine with extensive experience in
36 training primary care physicians for the western United States. Such
37 a proposed joint accredited training track will have at least fifty
38 percent of its residency positions in osteopathic medicine; and

(f) Implements the plan, with the exception of the expansion of the family practice residency network, within current biennial appropriations for the University of Washington school of medicine.

(2) The plan shall be submitted to the appropriate committees of the legislature no later than December 1, 1993.

I. SHORT-TERM HEALTH INSURANCE REFORM

NEW SECTION. **Sec. 276.** INTENT--INCREASE ACCESS TO COVERAGE. The legislature intends that, during the transition to a fully reformed health services system, certain health insurance practices be modified to increase access to health insurance coverage for some individuals and groups. The legislature recognizes that health insurance reform will not remedy the significant lack of access to coverage in Washington state without the implementation of strong cost control measures. The authority granted to the commissioner in chapter . . ., Laws of 1993 (this act) is in addition to any authority the commissioner currently has under Title 48 RCW to regulate insurers, health care service contractors, and health maintenance organizations.

NEW SECTION. **Sec. 277.** A new section is added to chapter 48.18 RCW to read as follows:

CANCELLATIONS, DENIALS--WRITTEN COMMUNICATION. Every insurer upon canceling, denying, or refusing to renew any disability policy, shall, upon written request, directly notify in writing the applicant or insured, as the case may be, of the reasons for the action by the insurer and to any person covered under a group contract. Any benefits, terms, rates, or conditions of such a contract that are restricted, excluded, modified, increased, or reduced shall, upon written request, be set forth in writing and supplied to the insured and to any person covered under a group contract. The written communications required by this section shall be phrased in simple language that is readily understandable to a person of average intelligence, education, and reading ability.

Sec. 278. RCW 48.21.200 and 1983 c 202 s 16 and 1983 c 106 s 24 are each reenacted and amended to read as follows:

REDUCTIONS OR REFUSAL OF BENEFITS. (1) No individual or group disability insurance policy, health care service contract, or health

1 maintenance agreement which provides benefits for hospital, medical, or
2 surgical expenses shall be delivered or issued for delivery in this
3 state ((after September 8, 1975)) which contains any provision whereby
4 the insurer, contractor, or health maintenance organization may reduce
5 or refuse to pay such benefits otherwise payable thereunder solely on
6 account of the existence of similar benefits provided under any
7 ((individual)) disability insurance policy, ((or under any individual))
8 health care service contract, or health maintenance agreement.
9 (2) No individual or group disability insurance policy, health care
10 service contract, or health maintenance agreement providing hospital,
11 medical or surgical expense benefits and which contains a provision for
12 the reduction of benefits otherwise payable or available thereunder on
13 the basis of other existing coverages, shall provide that such
14 reduction will operate to reduce total benefits payable below an amount
15 equal to one hundred percent of total allowable expenses exclusive of
16 copayments, deductibles, and other similar cost-sharing arrangements.
17 (3) The commissioner shall by rule establish guidelines for the
18 application of this section, including:
19 (a) The procedures by which persons ((insured)) covered under such
20 policies, contracts, and agreements are to be made aware of the
21 existence of such a provision;
22 (b) The benefits which may be subject to such a provision;
23 (c) The effect of such a provision on the benefits provided;
24 (d) Establishment of the order of benefit determination; ((and))
25 (e) Exceptions necessary to maintain the integrity of policies,
26 contracts, and agreements that may require the use of particular health
27 care facilities or providers; and
28 (f) Reasonable claim administration procedures to expedite claim
29 payments and prevent duplication of payments or benefits under such a
30 provision((: PROVIDED, HOWEVER, That any group disability insurance
31 policy which is issued as part of an employee insurance benefit program
32 authorized by RCW 41.05.025(3) may exclude all or part of any
33 deductible amounts from the definition of total allowable expenses for
34 purposes of coordination of benefits within the plan and between such
35 plan and other applicable group coverages: AND PROVIDED FURTHER, That
36 any group disability insurance policy providing coverage for persons in
37 this state may exclude all or part of any deductible amounts required
38 by a group disability insurance policy from the definition of total
39 allowable expenses for purposes of coordination of benefits between

~~such policy and a group disability insurance policy issued as part of an employee insurance benefit program authorized by RCW 41.05.025(3).~~

~~(3) The provisions of this section shall apply to health care service contractor contracts and health maintenance organization agreements~~)).

NEW SECTION. **Sec. 279.** A new section is added to chapter 48.20 RCW to read as follows:

DISABILITY INSURER--PREEXISTING CONDITIONS EXCLUSIONS AND LIMITATIONS. (1) After January 1, 1994, every disability insurer issuing coverage against loss arising from medical, surgical, hospital, or emergency care coverage shall waive any preexisting condition exclusion or limitation for persons who had similar coverage under a different policy, health care service contract, or health maintenance agreement in the three-month period immediately preceding the effective date of coverage under the new policy to the extent that such person has satisfied a waiting period under such preceding policy, contract, or agreement; however, if the person satisfied a twelve-month waiting period under such preceding policy, contract, or agreement, the insurer shall waive any preexisting condition exclusion or limitation. The insurer need not waive a preexisting condition exclusion or limitation under the new policy for coverage not provided under such preceding policy, contract, or agreement.

(2) The commissioner may adopt rules establishing guidelines for determining when coverage is similar under new and preceding policies, contracts, and agreements and for determining when a preexisting condition waiting period has been satisfied.

(3) The commissioner in consultation with insurers, health care service contractors, and health maintenance organizations shall study the effect of preexisting condition exclusions and limitations on the cost and availability of health care coverage and shall adopt rules restricting the use of such conditions and limitations by January 1, 1994. No insurer, health care service contractor, or health maintenance organization may deny, exclude, or limit coverage for preexisting conditions for a period longer than that provided for in such rules after July 1, 1994.

NEW SECTION. **Sec. 280.** A new section is added to chapter 48.21 RCW to read as follows:

1 GROUP DISABILITY INSURERS--PREEXISTING CONDITIONS EXCLUSIONS AND
2 LIMITATIONS. (1) After January 1, 1994, every disability insurer
3 issuing coverage against loss arising from medical, surgical, hospital,
4 or emergency care coverage shall waive any preexisting condition
5 exclusion or limitation for persons who had similar coverage under a
6 different policy, health care service contract, or health maintenance
7 agreement in the three-month period immediately preceding the effective
8 date of coverage under the new policy to the extent that such person
9 has satisfied a waiting period under such preceding policy, contract,
10 or agreement; however, if the person satisfied a twelve-month waiting
11 period under such preceding policy, contract, or agreement, the insurer
12 shall waive any preexisting condition exclusion or limitation. The
13 insurer need not waive a preexisting condition exclusion or limitation
14 under the new policy for coverage not provided under such preceding
15 policy, contract, or agreement.
16 (2) The commissioner may adopt rules establishing guidelines for
17 determining when coverage is similar under new and preceding policies,
18 contracts, and agreements and for determining when a preexisting
19 condition waiting period has been satisfied.
20 (3) The commissioner in consultation with insurers, health care
21 service contractors, and health maintenance organizations shall study
22 the effect of preexisting condition exclusions and limitations on the
23 cost and availability of health care coverage and shall adopt rules
24 restricting the use of such conditions and limitations by January 1,
25 1994. No insurer, health care service contractor, or health
26 maintenance organization may deny, exclude, or limit coverage for
27 preexisting conditions for a period longer than that provided for in
28 such rules after July 1, 1994.

29 NEW SECTION. **Sec. 281.** A new section is added to chapter 48.44
30 RCW to read as follows:
31 HEALTH CARE SERVICE CONTRACTORS--PREEXISTING CONDITIONS EXCLUSIONS
32 AND LIMITATIONS. (1) After January 1, 1994, every health care service
33 contractor, except limited health care service contractors as defined
34 under RCW 48.44.035, shall waive any preexisting condition exclusion or
35 limitation for persons who had similar coverage under a different
36 policy, health care service contract, or health maintenance agreement
37 in the three-month period immediately preceding the effective date of
38 coverage under the new contract to the extent that such person has

1 satisfied a waiting period under such preceding policy, contract, or
2 agreement; however, if the person satisfied a twelve-month waiting
3 period under such preceding policy, contract, or agreement, the insurer
4 shall waive any preexisting condition exclusion or limitation. The
5 insurer need not waive a preexisting condition exclusion or limitation
6 under the new policy for coverage not provided under such preceding
7 policy, contract, or agreement.
8 (2) The commissioner may adopt rules establishing guidelines for
9 determining when coverage is similar under new and preceding policies,
10 contracts, and agreements and for determining when a preexisting
11 condition waiting period has been satisfied.
12 (3) The commissioner in consultation with insurers, health care
13 service contractors, and health maintenance organizations shall study
14 the effect of preexisting condition exclusions and limitations on the
15 cost and availability of health care coverage and shall adopt rules
16 restricting the use of such conditions and limitations by January 1,
17 1994. No insurer, health care service contractor, or health
18 maintenance organization may deny, exclude, or limit coverage for
19 preexisting conditions for a period longer than that provided for in
20 such rules after July 1, 1994.

21 NEW SECTION. **Sec. 282.** A new section is added to chapter 48.46
22 RCW to read as follows:
23 HEALTH MAINTENANCE ORGANIZATIONS--PREEXISTING CONDITIONS EXCLUSIONS
24 AND LIMITATIONS. (1) After January 1, 1994, every health maintenance
25 organization shall waive any preexisting condition exclusion or
26 limitation for persons who had similar coverage under a different
27 policy, health care service contract, or health maintenance agreement
28 in the three-month period immediately preceding the effective date of
29 coverage under the new agreement to the extent that such person has
30 satisfied a waiting period under such preceding policy, contract, or
31 agreement; however, if the person satisfied a twelve-month waiting
32 period under such preceding policy, contract, or agreement, the insurer
33 shall waive any preexisting condition exclusion or limitation. The
34 insurer need not waive a preexisting condition exclusion or limitation
35 under the new policy for coverage not provided under such preceding
36 policy, contract, or agreement.
37 (2) The commissioner may adopt rules establishing guidelines for
38 determining when coverage is similar under new and preceding policies,

contracts, and agreements and for determining when a preexisting condition waiting period has been satisfied.

(3) The commissioner in consultation with insurers, health care service contractors, and health maintenance organizations shall study the effect of preexisting condition exclusions and limitations on the cost and availability of health care coverage and shall adopt rules restricting the use of such conditions and limitations by January 1, 1994. No insurer, health care service contractor, or health maintenance organization may deny, exclude, or limit coverage for preexisting conditions for a period longer than that provided for in such rules after July 1, 1994.

Sec. 283. RCW 48.30.300 and 1975-'76 2nd ex.s. c 119 s 7 are each amended to read as follows:

UNFAIR PRACTICES. <u>Notwithstanding any provision contained in Title 48 RCW to the contrary:</u>

<u>(1)</u> No person or entity engaged in the business of insurance in this state shall refuse to issue any contract of insurance or cancel or decline to renew such contract because of the sex or marital status, or the presence of any sensory, mental, or physical handicap of the insured or prospective insured. The amount of benefits payable, or any term, rate, condition, or type of coverage shall not be restricted, modified, excluded, increased or reduced on the basis of the sex or marital status, or be restricted, modified, excluded or reduced on the basis of the presence of any sensory, mental, or physical handicap of the insured or prospective insured. <u>Subject to the provisions of subsection (2) of this section t</u>hese provisions shall not prohibit fair discrimination on the basis of sex, or marital status, or the presence of any sensory, mental, or physical handicap when bona fide statistical differences in risk or exposure have been substantiated.

<u>(2) With respect to disability policies issued or renewed on and after July 1, 1994, that provide coverage against loss arising from medical, surgical, hospital, or emergency care services:</u>

<u>(a) Policies shall guarantee continuity of coverage. Such provision, which shall be included in every policy, shall provide that:</u>

<u>(i) The policy may be canceled or nonrenewed without the prior written approval of the commissioner only for nonpayment of premium or as permitted under RCW 48.18.090; and</u>

(ii) The policy may be canceled or nonrenewed because of a change in the physical or mental condition or health of a covered person only with the prior written approval of the commissioner. Such approval shall be granted only when the insurer has discharged its obligation to continue coverage for such person by obtaining coverage with another insurer, health care service contractor, or health maintenance organization, which coverage is comparable in terms of premiums and benefits as defined by rule of the commissioner.

(b) It is an unfair practice for a disability insurer to modify the coverage provided or rates applying to an in-force disability insurance policy and to fail to make such modification in all such issued and outstanding policies.

(c) Subject to rules adopted by the commissioner, it is an unfair practice for a disability insurer to:

(i) Cease the sale of a policy form unless it has received prior written authorization from the commissioner and has offered all policyholders covered under such discontinued policy the opportunity to purchase comparable coverage without health screening; or

(ii) Engage in a practice that subjects policyholders to rate increases on discontinued policy forms unless such policyholders are offered the opportunity to purchase comparable coverage without health screening.

The insurer may limit an offer of comparable coverage without health screening to a period not less than thirty days from the date the offer is first made.

NEW SECTION. **Sec. 284.** A new section is added to chapter 48.44 RCW to read as follows:

HEALTH CARE SERVICE CONTRACTS--UNFAIR PRACTICES. (1) With respect to all health care service contracts issued or renewed on and after July 1, 1994, except limited health care service contracts as defined in RCW 48.44.035:

(a) Contracts shall guarantee continuity of coverage. Such provision, which shall be included in every contract, shall provide that:

(i) The contract may be canceled or nonrenewed without the prior written approval of the commissioner only for nonpayment of premiums, for violation of published policies of the contractor which have been approved by the commissioner, for persons who are entitled to become

eligible for medicare benefits and fail to subscribe to a medicare supplement plan offered by the contractor, for failure of such subscriber to pay any deductible or copayment amount owed to the contractor and not the provider of health care services, for fraud, or for a material breach of the contract; and

(ii) The contract may be canceled or nonrenewed because of a change in the physical or mental condition or health of a covered person only with the prior written approval of the commissioner. Such approval shall be granted only when the contractor has discharged its obligation to continue coverage for such person by obtaining coverage with another insurer, health care service contractor, or health maintenance organization, which coverage is comparable in terms of premiums and benefits as defined by rule of the commissioner.

(b) It is an unfair practice for a contractor to modify the coverage provided or rates applying to an in-force contract and to fail to make such modification in all such issued and outstanding contracts.

(c) Subject to rules adopted by the commissioner, it is an unfair practice for a health care service contractor to:

(i) Cease the sale of a contract form unless it has received prior written authorization from the commissioner and has offered all subscribers covered under such discontinued contract the opportunity to purchase comparable coverage without health screening; or

(ii) Engage in a practice that subjects subscribers to rate increases on discontinued contract forms unless such subscribers are offered the opportunity to purchase comparable coverage without health screening.

(2) The health care service contractor may limit an offer of comparable coverage without health screening to a period not less than thirty days from the date the offer is first made.

NEW SECTION. **Sec. 285.** A new section is added to chapter 48.46 RCW to read as follows:

HEALTH MAINTENANCE AGREEMENTS--UNFAIR PRACTICES. (1) With respect to all health maintenance agreements issued or renewed on and after July 1, 1994, and in addition to the restrictions and limitations contained in RCW 48.46.060(4):

(a) Agreements shall guarantee continuity of coverage. Such provision, which shall be included in every agreement, shall provide that the agreement may be canceled or nonrenewed because of a change in

the physical or mental condition or health of a covered person only with the prior written approval of the commissioner. Such approval shall be granted only when the organization has discharged its obligation to continue coverage for such person by obtaining coverage with another insurer, health care service contractor, or health maintenance organization, which coverage is comparable in terms of premiums and benefits as defined by rule of the commissioner.

(b) It is an unfair practice for an organization to modify the coverage provided or rates applying to an in-force agreement and to fail to make such modification in all such issued and outstanding agreements.

(c) Subject to rules adopted by the commissioner, it is an unfair practice for a health maintenance organization to:

(i) Cease the sale of an agreement form unless it has received prior written authorization from the commissioner and has offered all enrollees covered under such discontinued agreement the opportunity to purchase comparable coverage without health screening; or

(ii) Engage in a practice that subjects enrollees to rate increases on discontinued agreement forms unless such enrollees are offered the opportunity to purchase comparable coverage without health screening.

(2) The health maintenance organization may limit an offer of comparable coverage without health screening to a period not less than thirty days from the date the offer is first made.

Sec. 286. RCW 48.44.260 and 1979 c 133 s 3 are each amended to read as follows:

HEALTH CARE SERVICE CONTRACTOR--NOTICE OF CANCELLATION. Every authorized health care service contractor, upon canceling, denying, or refusing to renew any individual health care service contract, shall, upon written request, directly notify in writing the applicant or ((~~insured~~)) subscriber, as the case may be, of the reasons for the action by the health care service contractor. Any benefits, terms, rates, or conditions of such a contract which are restricted, excluded, modified, increased, or reduced ((~~because of the presence of a sensory, mental, or physical handicap~~)) shall, upon written request, be set forth in writing and supplied to the ((~~insured~~)) subscriber. The written communications required by this section shall be phrased in simple language which is readily understandable to a person of average intelligence, education, and reading ability.

Sec. 287. RCW 48.46.380 and 1983 c 106 s 16 are each amended to read as follows:

HEALTH MAINTENANCE ORGANIZATION--NOTICE OF CANCELLATIONS. Every authorized health maintenance organization, upon canceling, denying, or refusing to renew any individual health maintenance agreement, shall, upon written request, directly notify in writing the applicant or enrolled participant as appropriate, of the reasons for the action by the health maintenance organization. Any benefits, terms, rates, or conditions of such agreement which are restricted, excluded, modified, increased, or reduced ((~~because of the presence of a sensory, mental, or physical handicap~~)) shall, upon written request, be set forth in writing and supplied to the individual. The written communications required by this section shall be phrased in simple language which is readily understandable to a person of average intelligence, education, and reading ability.

NEW SECTION. **Sec. 288.** REPEALERS--REPORT; STUDIES. The following acts or parts of acts are each repealed:

(1) RCW 48.46.160 and 1975 1st ex.s. c 290 s 17; and

(2) RCW 48.46.905 and 1975 1st ex.s. c 290 s 25.

NEW SECTION. **Sec. 289.** REPEALER--NONTERMINATION FOR CHANGE IN HEALTH. RCW 48.44.410 and 1986 c 223 s 12 are each repealed, effective July 1, 1994.

NEW SECTION. **Sec. 290.** A new section is added to chapter 48.20 RCW to read as follows:

CERTIFIED HEALTH PLAN PROVISIONS--APPLICATION. Whenever the provisions of this chapter conflict with the provision of sections 401 through 407, 409, and 424 through 456 of this act, sections 401 through 407, 409, and 424 through 456 of this act shall control.

NEW SECTION. **Sec. 291.** A new section is added to chapter 48.21 RCW to read as follows:

CERTIFIED HEALTH PLAN PROVISIONS--APPLICATION. Whenever the provisions of this chapter conflict with the provision of sections 401 through 407, 409, and 424 through 456 of this act, sections 401 through 407, 409, and 424 through 456 of this act shall control.

NEW SECTION. **Sec. 292.** A new section is added to chapter 48.44 RCW to read as follows:

CERTIFIED HEALTH PLAN PROVISIONS--APPLICATION. Whenever the provisions of this chapter conflict with the provision of sections 401 through 407, 409, and 424 through 456 of this act, sections 401 through 407, 409, and 424 through 456 of this act shall control.

NEW SECTION. **Sec. 293.** A new section is added to chapter 48.46 RCW to read as follows:

CERTIFIED HEALTH PLAN PROVISIONS--APPLICATION. Whenever the provisions of this chapter conflict with the provision of sections 401 through 407, 409, and 424 through 456 of this act, sections 401 through 407, 409, and 424 through 456 of this act shall control.

Sec. 294. RCW 48.44.095 and 1983 c 202 s 3 are each amended to read as follows:

ANNUAL STATEMENT. (1) Every health care service contractor shall annually, ((~~within one hundred twenty days of the closing date of its fiscal year~~)) before the first day of March, file with the commissioner a statement verified by at least two of the principal officers of the health care service contractor showing its financial condition as of the ((~~closing date of its fiscal year~~)) last day of the preceding calendar year. The statement shall be in such form as is furnished or prescribed by the commissioner. The commissioner may for good reason allow a reasonable extension of the time within which such annual statement shall be filed.

(2) The commissioner may suspend or revoke the certificate of registration of any health care service contractor failing to file its annual statement when due or during any extension of time therefor which the commissioner, for good cause, may grant.

Sec. 295. RCW 48.46.080 and 1983 c 202 s 10 and 1983 c 106 s 6 are each reenacted and amended to read as follows:

ANNUAL STATEMENT. (1) Every health maintenance organization shall annually, ((~~within one hundred twenty days of the closing date of its fiscal year~~)) before the first day of March, file with the commissioner a statement verified by at least two of the principal officers of the health maintenance organization showing its financial condition as of

the ((~~closing date of its fiscal year~~)) last day of the preceding calendar year.

(2) Such annual report shall be in such form as the commissioner shall prescribe and shall include:

(a) A financial statement of such organization, including its balance sheet and receipts and disbursements for the preceding year, which reflects at a minimum;

(i) all prepayments and other payments received for health care services rendered pursuant to health maintenance agreements;

(ii) expenditures to all categories of health care facilities, providers, insurance companies, or hospital or medical service plan corporations with which such organization has contracted to fulfill obligations to enrolled participants arising out of its health maintenance agreements, together with all other direct expenses including depreciation, enrollment, and commission; and

(iii) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation, or purchase of facilities and capital equipment;

(b) The number of participants enrolled and terminated during the report period. Every employer offering health care benefits to their employees through a group contract with a health maintenance organization shall furnish said health maintenance organization with a list of their employees enrolled under such plan;

(c) The number of doctors by type of practice who, under contract with or as an employee of the health maintenance organization, furnished health care services to consumers during the past year;

(d) A report of the names and addresses of all officers, directors, or trustees of the health maintenance organization during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to such organization. For partnership and professional service corporations, a report shall be made for partners or shareholders as to any compensation or expense reimbursement received by them for services, other than for services and expenses relating directly for patient care;

(e) Such other information relating to the performance of the health maintenance organization or the health care facilities or providers with which it has contracted as reasonably necessary to the proper and effective administration of this chapter, in accordance with rules and regulations; and

1 (f) Disclosure of any financial interests held by officers and
2 directors in any providers associated with the health maintenance
3 organization or any provider of the health maintenance organization.
4 (3) The commissioner may for good reason allow a reasonable
5 extension of the time within which such annual statement shall be
6 filed.
7 (4) The commissioner may suspend or revoke the certificate of
8 registration of any health maintenance organization failing to file its
9 annual statement when due or during any extension of time therefor
10 which the commissioner, for good cause, may grant.
11 (5) No person shall knowingly file with any public official or
12 knowingly make, publish, or disseminate any financial statement of a
13 health maintenance organization which does not accurately state the
14 health maintenance organization's financial condition.

15 **PART III. TAXES AND APPROPRIATIONS**

16 NEW SECTION. **Sec. 301.** A new section is added to chapter 48.14
17 RCW to read as follows:
18 TAX ON PREMIUMS AND PREPAYMENTS. (1) As used in this section,
19 "taxpayer" means a health maintenance organization, as defined in RCW
20 48.46.020, a health care service contractor, as defined in RCW
21 48.44.010, or a certified health plan certified under section 432 of
22 this act.
23 (2) Each taxpayer shall pay a tax on or before the first day of
24 March of each year to the state treasurer through the insurance
25 commissioner's office. The tax shall be equal to the total amount of
26 all premiums and prepayments for health care services received by the
27 taxpayer during the preceding calendar year multiplied by the rate of
28 two percent.
29 (3) Taxpayers shall prepay their tax obligations under this
30 section. The minimum amount of the prepayments shall be percentages of
31 the taxpayer's tax obligation for the preceding calendar year
32 recomputed using the rate in effect for the current year. For the
33 prepayment of taxes due during the first calendar year, the minimum
34 amount of the prepayments shall be percentages of the taxpayer's tax
35 obligation that would have been due had the tax been in effect during
36 the previous calendar year. The tax prepayments shall be paid to the

state treasurer through the commissioner's office by the due dates and in the following amounts:

(a) On or before June 15, forty-five percent;

(b) On or before September 15, twenty-five percent;

(c) On or before December 15, twenty-five percent.

(4) For good cause demonstrated in writing, the commissioner may approve an amount smaller than the preceding calendar year's tax obligation as recomputed for calculating the health maintenance organization's prepayment obligations for the current tax year.

(5) Moneys collected under this section shall be deposited in the health services account under section 464 of this act.

(6) The taxes imposed in this section do not apply to:

(a) Amounts received by any taxpayer from the United States or any instrumentality thereof as prepayments for health care services provided under Title XVIII (medicare) of the federal social security act. This exemption shall expire July 1, 1997.

(b) Amounts received by any health care service contractor, as defined in RCW 48.44.010, as prepayments for health care services included within the definition of practice of dentistry under RCW 18.32.020. This exemption does not apply to amounts received under a certified health plan certified under section 432 of this act.

Sec. 302. RCW 48.14.080 and 1949 c 190 s 21 are each amended to read as follows:

PREMIUM TAX IN LIEU OF OTHER FORMS. As to insurers other than title insurers, the taxes imposed by this title shall be in lieu of all other taxes, except taxes on real and tangible personal property ((~~and~~)), excise taxes on the sale, purchase or use of such property, and the tax imposed in RCW 82.04.260(15).

NEW SECTION. **Sec. 303.** A new section is added to chapter 82.04 RCW to read as follows:

EXEMPTION FROM BUSINESS AND OCCUPATION TAX. This chapter does not apply to any health maintenance organization, health care service contractor, or certified health plan in respect to premiums or prepayments that are taxable under section 301 of this act.

Sec. 304. RCW 82.04.260 and 1991 c 272 s 15 are each amended to read as follows:

1 TAX ON HOSPITALS OPERATED AS NONPROFIT CORPORATIONS. (1) Upon
2 every person engaging within this state in the business of buying
3 wheat, oats, dry peas, dry beans, lentils, triticale, corn, rye and
4 barley, but not including any manufactured or processed products
5 thereof, and selling the same at wholesale; the tax imposed shall be
6 equal to the gross proceeds derived from such sales multiplied by the
7 rate of one one-hundredth of one percent.
8 (2) Upon every person engaging within this state in the business of
9 manufacturing wheat into flour, barley into pearl barley, soybeans into
10 soybean oil, or sunflower seeds into sunflower oil; as to such persons
11 the amount of tax with respect to such business shall be equal to the
12 value of the flour, pearl barley, or oil manufactured, multiplied by
13 the rate of one-eighth of one percent.
14 (3) Upon every person engaging within this state in the business of
15 splitting or processing dried peas; as to such persons the amount of
16 tax with respect to such business shall be equal to the value of the
17 peas split or processed, multiplied by the rate of one-quarter of one
18 percent.
19 (4) Upon every person engaging within this state in the business of
20 manufacturing seafood products which remain in a raw, raw frozen, or
21 raw salted state at the completion of the manufacturing by that person;
22 as to such persons the amount of tax with respect to such business
23 shall be equal to the value of the products manufactured, multiplied by
24 the rate of one-eighth of one percent.
25 (5) Upon every person engaging within this state in the business of
26 manufacturing by canning, preserving, freezing or dehydrating fresh
27 fruits and vegetables; as to such persons the amount of tax with
28 respect to such business shall be equal to the value of the products
29 canned, preserved, frozen or dehydrated multiplied by the rate of
30 three-tenths of one percent.
31 (6) Upon every nonprofit corporation and nonprofit association
32 engaging within this state in research and development, as to such
33 corporations and associations, the amount of tax with respect to such
34 activities shall be equal to the gross income derived from such
35 activities multiplied by the rate of forty-four one-hundredths of one
36 percent.
37 (7) Upon every person engaging within this state in the business of
38 slaughtering, breaking and/or processing perishable meat products
39 and/or selling the same at wholesale only and not at retail; as to such

1 persons the tax imposed shall be equal to the gross proceeds derived
2 from such sales multiplied by the rate of twenty-five one-hundredths of
3 one percent through June 30, 1986, and one-eighth of one percent
4 thereafter.
5 (8) Upon every person engaging within this state in the business of
6 making sales, at retail or wholesale, of nuclear fuel assemblies
7 manufactured by that person, as to such persons the amount of tax with
8 respect to such business shall be equal to the gross proceeds of sales
9 of the assemblies multiplied by the rate of twenty-five one-hundredths
10 of one percent.
11 (9) Upon every person engaging within this state in the business of
12 manufacturing nuclear fuel assemblies, as to such persons the amount of
13 tax with respect to such business shall be equal to the value of the
14 products manufactured multiplied by the rate of twenty-five one-
15 hundredths of one percent.
16 (10) Upon every person engaging within this state in the business
17 of acting as a travel agent; as to such persons the amount of the tax
18 with respect to such activities shall be equal to the gross income
19 derived from such activities multiplied by the rate of twenty-five one-
20 hundredths of one percent.
21 (11) Upon every person engaging within this state in business as an
22 international steamship agent, international customs house broker,
23 international freight forwarder, vessel and/or cargo charter broker in
24 foreign commerce, and/or international air cargo agent; as to such
25 persons the amount of the tax with respect to only international
26 activities shall be equal to the gross income derived from such
27 activities multiplied by the rate of thirty-three one-hundredths of one
28 percent.
29 (12) Upon every person engaging within this state in the business
30 of stevedoring and associated activities pertinent to the movement of
31 goods and commodities in waterborne interstate or foreign commerce; as
32 to such persons the amount of tax with respect to such business shall
33 be equal to the gross proceeds derived from such activities multiplied
34 by the rate of thirty-three one hundredths of one percent. Persons
35 subject to taxation under this subsection shall be exempt from payment
36 of taxes imposed by chapter 82.16 RCW for that portion of their
37 business subject to taxation under this subsection. Stevedoring and
38 associated activities pertinent to the conduct of goods and commodities
39 in waterborne interstate or foreign commerce are defined as all

1 activities of a labor, service or transportation nature whereby cargo
2 may be loaded or unloaded to or from vessels or barges, passing over,
3 onto or under a wharf, pier, or similar structure; cargo may be moved
4 to a warehouse or similar holding or storage yard or area to await
5 further movement in import or export or may move to a consolidation
6 freight station and be stuffed, unstuffed, containerized, separated or
7 otherwise segregated or aggregated for delivery or loaded on any mode
8 of transportation for delivery to its consignee. Specific activities
9 included in this definition are: Wharfage, handling, loading,
10 unloading, moving of cargo to a convenient place of delivery to the
11 consignee or a convenient place for further movement to export mode;
12 documentation services in connection with the receipt, delivery,
13 checking, care, custody and control of cargo required in the transfer
14 of cargo; imported automobile handling prior to delivery to consignee;
15 terminal stevedoring and incidental vessel services, including but not
16 limited to plugging and unplugging refrigerator service to containers,
17 trailers, and other refrigerated cargo receptacles, and securing ship
18 hatch covers.
19 (13) Upon every person engaging within this state in the business
20 of disposing of low-level waste, as defined in RCW 43.145.010; as to
21 such persons the amount of the tax with respect to such business shall
22 be equal to the gross income of the business, excluding any fees
23 imposed under chapter 43.200 RCW, multiplied by the rate of fifteen
24 percent.
25 (a) The rate specified in this subsection shall be reduced to ten
26 percent on May 20, 1991.
27 (b) The rate specified in this subsection shall be further reduced
28 to five percent on January 1, 1992.
29 (c) The rate specified in this subsection shall be further reduced
30 to three percent on July 1, 1993.
31 If the gross income of the taxpayer is attributable to activities
32 both within and without this state, the gross income attributable to
33 this state shall be determined in accordance with the methods of
34 apportionment required under RCW 82.04.460.
35 (14) Upon every person engaging within this state as an insurance
36 agent, insurance broker, or insurance solicitor licensed under chapter
37 48.17 RCW; as to such persons, the amount of the tax with respect to
38 such licensed activities shall be equal to the gross income of such
39 business multiplied by the rate of one percent.

(15) Upon every person engaging within this state in business as a hospital, as defined in chapter 70.41 RCW, that is operated as a nonprofit corporation, as to such persons, the amount of tax with respect to such activities shall be equal to the gross income of the business multiplied by the rate of five-tenths of one percent through June 30, 1995, and one and five-tenths percent thereafter. The moneys collected under this subsection shall be deposited in the health services account created under section 464 of this act.

Sec. 305. RCW 82.04.4289 and 1981 c 178 s 2 are each amended to read as follows:

HOSPITAL EXEMPTION DELETED. ((~~In computing tax there may be deducted from the measure of tax~~)) This chapter does not apply to amounts derived as compensation for services rendered to patients or from sales of prescription drugs as defined in RCW 82.08.0281 furnished as an integral part of services rendered to patients by ((~~a hospital, as defined in chapter 70.41 RCW, which is operated as a nonprofit corporation,~~)) a kidney dialysis facility operated as a nonprofit corporation, ((~~whether or not operated in connection with a hospital,~~)) nursing homes, and homes for unwed mothers operated as religious or charitable organizations, but only if no part of the net earnings received by such an institution inures directly or indirectly, to any person other than the institution entitled to deduction hereunder. ((~~In no event shall any such deduction be allowed, unless the hospital building is entitled to exemption from taxation under the property tax laws of this state.~~))

NEW SECTION. **Sec. 306.** REPEALER--PRESCRIPTION DRUG DEDUCTION FOR PUBLICLY OPERATED HOSPITALS. RCW 82.04.4288 and 1980 c 37 s 9 are each repealed.

Sec. 307. RCW 82.24.020 and 1989 c 271 s 504 are each amended to read as follows:

TAX ON CIGARETTES. (1) There is levied and there shall be collected as ((~~hereinafter~~)) provided in this chapter, a tax upon the sale, use, consumption, handling, possession or distribution of all cigarettes, in an amount equal to the rate of eleven and one-half mills per cigarette.

(2) Until July 1, 1995, an additional tax is imposed upon the sale, use, consumption, handling, possession, or distribution of all cigarettes, in an amount equal to the rate of one and one-half mills per cigarette. All revenues collected during any month from this additional tax shall be deposited in the drug enforcement and education account under RCW 69.50.520 by the twenty-fifth day of the following month.

(3) An additional tax is imposed upon the sale, use, consumption, handling, possession, or distribution of all cigarettes, in an amount equal to the rate of ten mills per cigarette through June 30, 1994, eleven and one-fourth mills per cigarette for the period July 1, 1994, through June 30, 1995, twenty mills per cigarette for the period July 1, 1995, through June 30, 1996, and twenty and one-half mills per cigarette thereafter. All revenues collected during any month from this additional tax shall be deposited in the health services account created under section 464 of this act by the twenty-fifth day of the following month.

(4) Wholesalers and retailers subject to the payment of this tax may, if they wish, absorb one-half mill per cigarette of the tax and not pass it on to purchasers without being in violation of this section or any other act relating to the sale or taxation of cigarettes.

(((4))) (5) For purposes of this chapter, "possession" shall mean both (a) physical possession by the purchaser and, (b) when cigarettes are being transported to or held for the purchaser or his or her designee by a person other than the purchaser, constructive possession by the purchaser or his designee, which constructive possession shall be deemed to occur at the location of the cigarettes being so transported or held.

Sec. 308. RCW 82.24.080 and 1972 ex.s. c 157 s 4 are each amended to read as follows:

TAX LIABILITY--CIGARETTE TAX. It is the intent and purpose of this chapter to levy a tax on all of the articles taxed ((herein)) under this chapter, sold, used, consumed, handled, possessed, or distributed within this state and to collect the tax from the person who first sells, uses, consumes, handles, possesses (either physically or constructively, in accordance with RCW 82.24.020) or distributes them in the state. It is further the intent and purpose of this chapter that whenever any of the articles ((herein)) taxed under this chapter

is given away for advertising or any other purpose, it shall be taxed in the same manner as if it were sold, used, consumed, handled, possessed, or distributed in this state.

It is also the intent and purpose of this chapter that the tax shall be imposed at the time and place of the first taxable event occurring within this state((~~: PROVIDED, HOWEVER, That~~)). Failure to pay the tax with respect to a taxable event shall not prevent tax liability from arising by reason of a subsequent taxable event.

In the event of an increase in the rate of the tax imposed under this chapter, it is the intent of the legislature that the first person who sells, uses, consumes, handles, possesses, or distributes previously taxed articles after the effective date of the rate increase shall be liable for the additional tax represented by the rate increase, but the failure to pay the additional tax with respect to the first taxable event after the effective date of a rate increase shall not prevent tax liability for the additional tax from arising from a subsequent taxable event.

Sec. 309. RCW 82.26.020 and 1983 2nd ex.s. c 3 s 16 are each amended to read as follows:

TAX ON TOBACCO PRODUCTS. (1) ((~~From and after June 1, 1971,~~)) There is levied and there shall be collected a tax upon the sale, use, consumption, handling, or distribution of all tobacco products in this state at the rate of forty-five percent of the wholesale sales price of such tobacco products. ((~~Such tax~~))

(2) Taxes under this section shall be imposed at the time the distributor (a) brings, or causes to be brought, into this state from without the state tobacco products for sale, (b) makes, manufactures, or fabricates tobacco products in this state for sale in this state, or (c) ships or transports tobacco products to retailers in this state, to be sold by those retailers.

((~~(2)~~)) (3) An additional tax is imposed equal to ((~~the rate specified in RCW 82.02.030~~)) seven percent multiplied by the tax payable under subsection (1) of this section.

(4) An additional tax is imposed equal to ten percent of the wholesale sales price of tobacco products. The moneys collected under this subsection shall be deposited in the health services account created under section 464 of this act.

1 **Sec. 310.** RCW 82.08.150 and 1989 c 271 s 503 are each amended to
2 read as follows:
3 TAX ON SPIRITS. (1) There is levied and shall be collected a tax
4 upon each retail sale of spirits, or strong beer in the original
5 package at the rate of fifteen percent of the selling price. The tax
6 imposed in this subsection shall apply to all such sales including
7 sales by the Washington state liquor stores and agencies, but excluding
8 sales to class H licensees.
9 (2) There is levied and shall be collected a tax upon each sale of
10 spirits, or strong beer in the original package at the rate of ten
11 percent of the selling price on sales by Washington state liquor stores
12 and agencies to class H licensees.
13 (3) There is levied and shall be collected an additional tax upon
14 each retail sale of spirits in the original package at the rate of one
15 dollar and seventy-two cents per liter. The additional tax imposed in
16 this subsection shall apply to all such sales including sales by
17 Washington state liquor stores and agencies, and including sales to
18 class H licensees.
19 (4) An additional tax is imposed equal to ((~~the rate specified in~~
20 ~~RCW 82.02.030~~)) fourteen percent multiplied by the taxes payable under
21 subsections (1), (2), and (3) of this section.
22 (5) Until July 1, 1995, an additional tax is imposed upon each
23 retail sale of spirits in the original package at the rate of seven
24 cents per liter. The additional tax imposed in this subsection shall
25 apply to all such sales including sales by Washington state liquor
26 stores and agencies, and including sales to class H licensees. All
27 revenues collected during any month from this additional tax shall be
28 deposited in the drug enforcement and education account under RCW
29 69.50.520 by the twenty-fifth day of the following month.
30 (6)(a) An additional tax is imposed upon retail sale of spirits in
31 the original package at the rate of one and seven-tenths percent of the
32 selling price through June 30, 1995, two and six-tenths percent of the
33 selling price for the period July 1, 1995, through June 30, 1997, and
34 three and four-tenths of the selling price thereafter. This additional
35 tax applies to all such sales including sales by Washington state
36 liquor stores and agencies, but excluding sales to class H licensees.
37 (b) An additional tax is imposed upon retail sale of spirits in the
38 original package at the rate of one and one-tenth percent of the
39 selling price through June 30, 1995, one and seven-tenths percent of

1 the selling price for the period July 1, 1995, through June 30, 1997,
2 and two and three-tenths of the selling price thereafter. This
3 additional tax applies to all such sales to class H licensees.
4 (c) An additional tax is imposed upon each retail sale of spirits
5 in the original package at the rate of twenty cents per liter through
6 June 30, 1995, thirty cents per liter for the period July 1, 1995,
7 through June 30, 1997, and forty-one cents per liter thereafter. This
8 additional tax applies to all such sales including sales by Washington
9 state liquor stores and agencies, and including sales to class H
10 licensees.
11 (d) All revenues collected during any month from additional taxes
12 under this subsection shall be deposited in the health services account
13 created under section 464 of this act by the twenty-fifth day of the
14 following month.
15 (7) The tax imposed in RCW 82.08.020((, as now or hereafter
16 amended,)) shall not apply to sales of spirits or strong beer in the
17 original package.
18 (((7))) (8) The taxes imposed in this section shall be paid by the
19 buyer to the seller, and each seller shall collect from the buyer the
20 full amount of the tax payable in respect to each taxable sale under
21 this section. The taxes required by this section to be collected by
22 the seller shall be stated separately from the selling price and for
23 purposes of determining the tax due from the buyer to the seller, it
24 shall be conclusively presumed that the selling price quoted in any
25 price list does not include the taxes imposed by this section.
26 (((8))) (9) As used in this section, the terms, "spirits," "strong
27 beer," and "package" shall have the meaning ascribed to them in chapter
28 66.04 RCW.

29 **Sec. 311.** RCW 66.24.210 and 1991 c 192 s 3 are each amended to
30 read as follows:
31 TAX ON WINE--REDUCED RATE FOR CERTAIN WINERIES. (1) There is
32 hereby imposed upon all wines sold to wine wholesalers and the
33 Washington state liquor control board, within the state a tax at the
34 rate of twenty and one-fourth cents per liter((: PROVIDED, HOWEVER,
35 That)). Wine sold or shipped in bulk from one winery to another winery
36 shall not be subject to such tax. The tax provided for in this section
37 may, if so prescribed by the board, be collected by means of stamps to
38 be furnished by the board, or by direct payments based on wine

purchased by wine wholesalers. Every person purchasing wine under the provisions of this section shall on or before the twentieth day of each month report to the board all purchases during the preceding calendar month in such manner and upon such forms as may be prescribed by the board, and with such report shall pay the tax due from the purchases covered by such report unless the same has previously been paid. Any such purchaser of wine whose applicable tax payment is not postmarked by the twentieth day following the month of purchase will be assessed a penalty at the rate of two percent a month or fraction thereof. If this tax be collected by means of stamps, every such person shall procure from the board revenue stamps representing the tax in such form as the board shall prescribe and shall affix the same to the package or container in such manner and in such denomination as required by the board and shall cancel the same prior to the delivery of the package or container containing the wine to the purchaser. If the tax is not collected by means of stamps, the board may require that every such person shall execute to and file with the board a bond to be approved by the board, in such amount as the board may fix, securing the payment of the tax. If any such person fails to pay the tax when due, the board may forthwith suspend or cancel the license until all taxes are paid.

(2) An additional tax is imposed equal to ((~~the rate specified in RCW 82.02.030~~)) seven percent multiplied by the tax payable under subsection (1) of this section. All revenues collected during any month from this additional tax shall be transferred to the state general fund by the twenty-fifth day of the following month.

(3) An additional tax is imposed on wines subject to tax under subsection (1) of this section, at the rate of one-fourth of one cent per liter for wine sold after June 30, 1987. Such additional tax shall cease to be imposed on July 1, 1993. All revenues collected under this subsection (3) shall be disbursed quarterly to the Washington wine commission for use in carrying out the purposes of chapter 15.88 RCW.

(4) Until July 1, 1995, an additional tax is imposed on all wine subject to tax under subsection (1) of this section. The additional tax is equal to twenty-three and forty-four one-hundredths cents per liter on fortified wine as defined in RCW 66.04.010(34) when bottled or packaged by the manufacturer and one cent per liter on all other wine. All revenues collected during any month from this additional tax shall

be deposited in the drug enforcement and education account under RCW 69.50.520 by the twenty-fifth day of the following month.

(5)(a) An additional tax is imposed on all wine subject to tax under subsection (1) of this section. On fortified wine as defined in RCW 66.04.010(34) when bottled or packaged by the manufacturer the additional tax is equal to four and five-tenths cents per liter through June 30, 1995, five and seven-tenths cents per liter for the period July 1, 1995, through June 30, 1997, and twenty-two and seven-tenths cents per liter thereafter. On all other wines the additional tax is equal to two and three-tenths cents per liter through June 30, 1995, five and seven-tenths cents per liter for the period July 1, 1995, through June 30, 1997, and eleven and five-tenths cents per liter thereafter.

(b) The additional tax imposed under this subsection (5) does not apply in respect to nonfortified wine produced during a calendar year by any winery that produced one million gallons of wine or less during the previous calendar year.

(c) A single reduced tax rate applies under this subsection (5) in respect to all nonfortified wine produced during a calendar year by any winery that produced more than one million but less than two million gallons of wine during the previous calendar year. The reduced tax rate is equal to the rate per liter otherwise applicable under (a) of this subsection, multiplied by one percent for each ten thousand gallons produced in excess of one million gallons by the winery during the previous calendar year.

(d) All revenues collected from the additional tax imposed under this subsection (5) shall be deposited in the health services account under section 464 of this act by the twenty-fifth day of the following month.

Sec. 312. RCW 66.24.290 and 1989 c 271 s 502 are each amended to read as follows:

TAX ON BEER--REDUCED RATE FOR CERTAIN BREWERIES. (1) Any brewer or beer wholesaler licensed under this title may sell and deliver beer to holders of authorized licenses direct, but to no other person, other than the board; and every such brewer or beer wholesaler shall report all sales to the board monthly, pursuant to the regulations, and shall pay to the board as an added tax for the privilege of manufacturing and selling the beer within the state a tax of two dollars and sixty cents

per barrel of thirty-one gallons on sales to licensees within the state and on sales to licensees within the state of bottled and canned beer shall pay a tax computed in gallons at the rate of two dollars and sixty cents per barrel of thirty-one gallons. Any brewer or beer wholesaler whose applicable tax payment is not postmarked by the twentieth day following the month of sale will be assessed a penalty at the rate of two percent per month or fraction thereof. Each such brewer or wholesaler shall procure from the board revenue stamps representing such tax in form prescribed by the board and shall affix the same to the barrel or package in such manner and in such denominations as required by the board, and shall cancel the same prior to commencing delivery from his or her place of business or warehouse of such barrels or packages. Beer shall be sold by brewers and wholesalers in sealed barrels or packages. The revenue stamps ((~~herein~~)) provided ((~~for~~)) under this section need not be affixed and canceled in the making of resales of barrels or packages already taxed by the affixation and cancellation of stamps as provided in this section.

(2) An additional tax is imposed equal to ((~~the rate specified in RCW 82.02.030~~)) seven percent multiplied by the tax payable under subsection (1) of this section. All revenues collected during any month from this additional tax shall be transferred to the state general fund by the twenty-fifth day of the following month.

(3) Until July 1, 1995, an additional tax is imposed on all beer subject to tax under subsection (1) of this section. The additional tax is equal to two dollars per barrel of thirty-one gallons. All revenues collected during any month from this additional tax shall be deposited in the drug enforcement and education account under RCW 69.50.520 by the twenty-fifth day of the following month.

(4)(a) An additional tax is imposed on all beer subject to tax under subsection (1) of this section. The additional tax is equal to ninety-six cents per barrel of thirty-one gallons through June 30, 1995, two dollars and thirty-nine cents per barrel of thirty-one gallons for the period July 1, 1995, through June 30, 1997, and four dollars and seventy-eight cents per barrel of thirty-one gallons thereafter.

(b) The additional tax imposed under this subsection does not apply to the sale of the first sixty thousand barrels of beer each year by breweries that are entitled to a reduced rate of tax under 26 U.S.C.

Sec. 5051, as existing on the effective date of this section or such subsequent date as may be provided by the board by rule consistent with the purposes of this exemption.

(c) All revenues collected from the additional tax imposed under this subsection (4) shall be deposited in the health services account under section 464 of this act.

(5) The tax imposed under this section shall not apply to "strong beer" as defined in this title.

Sec. 313. RCW 82.02.030 and 1990 c 42 s 319 are each amended to read as follows:

ADDITIONAL TAX RATES. ((~~(1)~~)) The rate of the additional taxes under RCW 54.28.020(2), 54.28.025(2), ((~~66.24.210(2), 66.24.290(2),~~)) 82.04.2901, 82.16.020(2), ((~~82.26.020(2),~~)) 82.27.020(5), and 82.29A.030(2) shall be seven percent((~~; and~~

~~(2) The rate of the additional taxes under RCW 82.08.150(4) shall be fourteen percent~~)).

NEW SECTION. **Sec. 314.** APPROPRIATIONS. The following appropriations are made for the biennium ending June 30, 1995, to implement this act:

(1) The sum of one hundred seventy three million nine hundred thousand dollars is appropriated from the health services account to the personal health services account for subsidized health access for low-income Washington residents.

(2) The sum of five million dollars is appropriated from the health services account to the personal health services account for community and migrant clinic services to low-income individuals and families.

(3) The sum of twenty million dollars is appropriated from the health services account to the public health services account for the purpose of maintaining and improving the health of Washington residents. Specific improvements shall include but are not limited to: Expanded immunization, counter message advertising, pregnancy and sexually transmitted disease prevention services, tuberculosis control, and HIV programs.

(4) The sum of four million three hundred thousand dollars is appropriated from the health services account to the health system capacity account for the state-wide family medicine program and training of physician assistants and nurse practitioners, for health

1 professional scholarship and loan repayment programs, and for other
2 activities designed to improve the supply of primary health care
3 providers.
4 (5) The sum of four million dollars is appropriated to the public
5 health services account for maintaining and enhancing services provided
6 through the department of health.
7 (6) The sum of six million five hundred thousand dollars is
8 appropriated to the health system capacity account for the operation of
9 the health care commission and data services and analytical activities
10 in support of the health care system.

11 **PART IV. HEALTH AND MEDICAL SYSTEM REFORM**

12 NEW SECTION. **Sec. 401.** INTENT. The legislature intends that
13 chapter . . ., Laws of 1993 (this act) establish structures, processes,
14 and specific financial limits to stabilize the overall cost of medical
15 care within the economy, reduce the demand for unneeded medical care,
16 provide access to essential health and medical services, improve public
17 health, and ensure that medical system costs do not undermine the
18 financial viability of nonmedical care businesses.

19 NEW SECTION. **Sec. 402.** DEFINITIONS. In this chapter, unless the
20 context otherwise requires:
21 (1)(a) "Certified health plan" or "plan" means a disability insurer
22 regulated under chapter 48.20 or 48.21 RCW, a health care service
23 contractor as defined in RCW 48.44.010, a health maintenance
24 organization as defined in RCW 48.46.020, or an entity certified in
25 accordance with sections 431 through 442 of this act which insurer,
26 contractor, health maintenance organization, or entity contracts to
27 administer or provide the uniform benefits package in a managed care
28 setting consistent with the requirements of this chapter.
29 (b) "Certified health plan" or "plan" also means an employee health
30 benefits plan maintained by an employer who self-insures such benefits
31 and chooses to comply with sections 431 through 442 of this act.
32 (2) "Chair" means the presiding officer of the Washington health
33 services commission.
34 (3) "Commission" means the Washington health services commission.
35 (4) "Community rate" means the rating method used to establish the
36 premium for the uniform benefits package adjusted to reflect

1 actuarially demonstrated differences in utilization or cost
2 attributable to geographic region and family size as determined by the
3 commission.

4 (5) "Continuous quality improvement and total quality management"
5 means a continuous process to improve health services while reducing
6 costs.

7 (6) "Employee" means a resident who is in the employment of an
8 employer, as defined by chapter 50.04 RCW. A qualified employee for
9 full employer contributions is an employee who is employed at least
10 thirty hours during a week or one hundred twenty hours during a
11 calendar month.

12 (7) "Enrollee" means any person who is a Washington resident
13 enrolled in a certified health plan.

14 (8) "Enrollee point of service cost-sharing" means copayments or
15 coinsurance paid to certified health plans directly providing services,
16 health care providers, or health care facilities by enrollees for
17 receipt of specific uniform benefits package services, within limits
18 established by the commission.

19 (9) "Enrollee premium sharing" means that portion of the premium,
20 determined by the commission, that is paid by enrollees or their family
21 members.

22 (10) "Federal poverty level" means the federal poverty guidelines
23 determined annually by the United States department of health and human
24 services or successor agency.

25 (11) "Health care facility" or "facility" means hospices licensed
26 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
27 rural health facilities as defined in RCW 70.175.020, psychiatric
28 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
29 under chapter 18.51 RCW, community mental health centers licensed under
30 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed
31 under chapter 70.41 RCW, ambulatory diagnostic, treatment or surgical
32 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment
33 facilities licensed under chapter 70.96A RCW, and home health agencies
34 licensed under chapter 70.127 RCW, and includes such facilities if
35 owned and operated by a political subdivision or instrumentality of the
36 state and such other facilities as required by federal law and
37 implementing regulations, but does not include Christian Science
38 sanatoriums operated, listed, or certified by the First Church of
39 Christ Scientist, Boston, Massachusetts.

1 (12) "Health care provider" or "provider" means:
2 (a) A person regulated under Title 18 RCW and chapter 70.127 RCW,
3 to practice health or health-related services or otherwise practicing
4 health care services in this state consistent with state law; or
5 (b) An employee or agent of a person described in (a) of this
6 subsection, acting in the course and scope of his or her employment.
7 (13) "Health insurance purchasing cooperative" or "cooperative"
8 means a member-owned and governed nonprofit organization certified in
9 accordance with sections 424 and 425 of this act.
10 (14) "Long-term care" means institutional, residential, outpatient,
11 or community-based services that meet the individual needs of persons
12 of all ages who are limited in their functional capacities or have
13 disabilities and require assistance with performing two or more
14 activities of daily living for an extended or indefinite period of
15 time. These services include case management, protective supervision,
16 in-home care, nursing services, convalescent, custodial, chronic, and
17 terminally ill care.
18 (15) "Major capital expenditure" means any single expenditure for
19 capital construction, renovations, or acquisition, including medical
20 technological equipment, as defined by the commission, costing more
21 than one million dollars.
22 (16) "Managed care" means an integrated system of insurance,
23 financing, and health services delivery functions that assumes
24 financial risk for delivery of health services and that uses a defined
25 network of providers or that promotes the efficient delivery of health
26 services through provider assumption of some financial risk including
27 capitation, prospective payment, resource-based relative value scales,
28 fee schedules, or similar method of limiting payments to health care
29 providers.
30 (17) "Maximum enrollee financial participation" means the income-
31 related total annual payments that may be required of an enrollee per
32 family who chooses one of the three lowest priced plans in a geographic
33 region including both premium-sharing and enrollee point of service
34 cost-sharing.
35 (18) "Persons of color" means Asians/Pacific Islanders, African,
36 Hispanic, and Native Americans.
37 (19) "Premium" means all sums charged, received, or deposited by a
38 certified health plan as consideration for a uniform benefits package
39 or the continuance of a uniform benefits package. Any assessment, or

1 any "membership," "policy," "contract," "service," or similar fee or
2 charge made by the certified health plan in consideration for the
3 uniform benefits package is deemed part of the premium.
4 (20) "Supplemental benefits" means those appropriate and effective
5 health services, defined by the commission, in accordance with section
6 449 of this act, that expand coverage under the uniform benefits
7 package and that may be offered to all Washington residents through
8 certified health plans.
9 (21) "Technology" means the drugs, devices, equipment, and medical
10 or surgical procedures used in the delivery of health services, and the
11 organizational or supportive systems within which such services are
12 provided. It also means sophisticated and complicated machinery
13 developed as a result of ongoing research in the basic biological and
14 physical sciences, clinical medicine, electronics, and computer
15 sciences, as well as specialized professionals, medical equipment,
16 procedures, and chemical formulations used for both diagnostic and
17 therapeutic purposes.
18 (22) "Uniform benefits package" or "package" means those
19 appropriate and effective health services, defined by the commission
20 under section 448 of this act, that must be offered to all Washington
21 residents through certified health plans.
22 (23) "Washington resident" or "resident" means a person who intends
23 to reside in the state permanently or indefinitely and who did not move
24 to Washington for the primary purpose of securing health services under
25 sections 426 through 456 of this act. "Washington resident" also
26 includes people and their accompanying family members who are in the
27 state for the purpose of engaging in employment for at least one month,
28 who did not enter the state for the primary purpose of obtaining health
29 services. The confinement of a person in a nursing home, hospital, or
30 other medical institution in the state shall not by itself be
31 sufficient to qualify such person as a resident.

32 **A. THE WASHINGTON HEALTH SERVICES COMMISSION**

33 NEW SECTION. **Sec. 403.** CREATION OF COMMISSION--MEMBERSHIP--TERMS
34 OF OFFICE--VACANCIES--SALARIES. (1) There is created an agency of
35 state government to be known as the Washington health services
36 commission. The commission shall consist of five members reflecting
37 ethnic and racial diversity, appointed by the governor, with the

1 consent of the senate. One member shall be designated by the governor
2 as chair and shall serve at the pleasure of the governor. The
3 insurance commissioner shall serve as a nonvoting member. Of the
4 initial members, one shall be appointed to a term of three years, two
5 shall be appointed to a term of four years, and two shall be appointed
6 to a term of five years. Thereafter, members shall be appointed to
7 five-year terms. Vacancies shall be filled by appointment for the
8 remainder of the unexpired term of the position being vacated.
9 (2) Members of the commission shall have no pecuniary interest in
10 any business subject to regulation by the commission and shall be
11 subject to chapter 42.18 RCW, the executive branch conflict of interest
12 act.
13 (3) Members of the commission shall occupy their positions on a
14 full-time basis and are exempt from the provisions of chapter 41.06
15 RCW. Commission members and the professional commission staff are
16 subject to the public disclosure provisions of chapter 42.17 RCW.
17 Members shall be paid a salary to be fixed by the governor in
18 accordance with RCW 43.03.040. A majority of the members of the
19 commission constitutes a quorum for the conduct of business.

20 NEW SECTION. **Sec. 404.** ADVISORY COMMITTEES. (1)(a) The
21 commission shall appoint a technical advisory committee with a balanced
22 representation of members representing consumers, business, government,
23 labor, insurers, practicing health care providers, and health services
24 researchers; the membership shall reflect ethnic and racial diversity.
25 The chair may also appoint ad hoc and special committees for a
26 specified time period.
27 (b) The commission shall also appoint health services effectiveness
28 panels for specified periods of time to provide specific technical
29 guidance related to appropriate and effective health services, use of
30 technology and practice guidelines, and development of the uniform
31 benefits package. Panels should include technical experts, such as
32 general practitioners, specialty physicians or providers, health
33 service researchers, health ethicists, epidemiologists, and public
34 health experts who reflect the state's ethnic and cultural diversity.
35 (c) The commission shall also appoint a small business advisory
36 committee composed of seven small business owners to assist the
37 commission in development of the small business economic impact

1 statement and the small business assistance program, as provided in
2 sections 448(7) and 456 of this act.
3 (d) The commission shall also appoint an organized labor advisory
4 committee composed of seven representatives of employee organizations
5 representing employees of public or private employers. The committee
6 shall assist the commission in conducting the evaluation of Taft-
7 Hartley health care trusts and self-insured employee health benefits
8 plans, as provided in section 406(25) of this act, and shall advise the
9 commission on issues related to the impact of chapter . . ., Laws of
10 1993 (this act) on negotiated health benefits agreements and other
11 employee health benefits plans.
12 (2) Members of committees and panels shall serve without
13 compensation for their services but shall be reimbursed for their
14 expenses while attending meetings on behalf of the commission in
15 accordance with RCW 43.03.050 and 43.03.060.

16 NEW SECTION. **Sec. 405.** POWERS AND DUTIES OF THE CHAIR. The chair
17 shall be the chief administrative officer and the appointing authority
18 of the commission and has the following powers and duties:
19 (1) Direct and supervise the commission's administrative and
20 technical activities in accordance with the provisions of this chapter
21 and rules and policies adopted by the commission;
22 (2) Employ personnel of the commission, representative of ethnic
23 diversity, in accordance with chapter 41.06 RCW, and prescribe their
24 duties. With the approval of a majority of the commission, the chair
25 may appoint persons to administer any entity established pursuant to
26 subsection (8) of this section, and up to seven additional employees
27 all of whom shall be exempt from the provisions of chapter 41.06 RCW;
28 (3) Enter into contracts on behalf of the commission;
29 (4) Accept and expend gifts, donations, grants, and other funds
30 received by the commission;
31 (5) Delegate administrative functions of the commission to
32 employees of the commission as the chair deems necessary to ensure
33 efficient administration;
34 (6) Subject to approval of the commission, appoint advisory
35 committees and undertake studies, research, and analysis necessary to
36 support activities of the commission;
37 (7) Preside at meetings of the commission;

1 (8) Consistent with policies and rules established by the
2 commission, establish such administrative divisions, offices, or
3 programs as are necessary to carry out the purposes of chapter . . .,
4 Laws of 1993 (this act); and
5 (9) Perform such other administrative and technical duties as are
6 consistent with chapter . . ., Laws of 1993 (this act) and the rules
7 and policies of the commission.

8 NEW SECTION. **Sec. 406.** POWERS AND DUTIES OF THE COMMISSION. The
9 commission has the following powers and duties:
10 (1) Ensure that all residents of Washington state are enrolled in
11 a certified health plan to receive the uniform benefits package,
12 regardless of age, sex, family structure, ethnicity, race, health
13 condition, geographic location, employment, or economic status.
14 (2) Endeavor to ensure that all residents of Washington state have
15 access to appropriate, timely, confidential, and effective health
16 services, and monitor the degree of access to such services. If the
17 commission finds that individuals or populations lack access to
18 certified health plan services, the commission shall:
19 (a) Authorize appropriate state agencies, local health departments,
20 community or migrant health clinics, public hospital districts, or
21 other nonprofit health service entities to take actions necessary to
22 assure such access. This includes authority to contract for or
23 directly deliver services described within the uniform benefits package
24 to special populations; or
25 (b) Notify appropriate certified health plans and the insurance
26 commissioner of such findings. The commission shall adopt by rule
27 standards by which the insurance commissioner may, in such event,
28 require certified health plans in closest proximity to such individuals
29 and populations to extend their catchment areas to those individuals
30 and populations and offer them enrollment.
31 (3) Adopt necessary rules in accordance with chapter 34.05 RCW to
32 carry out the purposes of chapter . . ., Laws of 1993 (this act). An
33 initial set of draft rules establishing at least the commission's
34 organization structure, the uniform benefits package, enrollee and
35 employer financial participation, levels of and standards for certified
36 health plan certification, must be submitted in draft form to
37 appropriate committees of the legislature by December 1, 1994.

1 (4) Establish and modify as necessary, in consultation with the
2 state board of health and the department of health, and coordination
3 with the planning process set forth in section 462 of this act a
4 uniform set of health services based on the recommendations of the
5 health care cost control and access commission.
6 (5) Establish and modify as necessary, the uniform benefits package
7 and supplemental benefits packages, as provided in sections 448 and 449
8 of this act, which shall be offered to enrollees of a certified health
9 plan. The benefit package shall be provided at no more than the
10 maximum premium specified in subsection (6) of this section.
11 (6)(a) Establish for each year a community-rated maximum premium
12 for the uniform benefits package that shall operate to control overall
13 health care costs in the case that the limited sponsor contribution to
14 a percentage of the lowest priced plan and other market reforms do not
15 stimulate effective price competition and control costs. The premium
16 cost of the uniform benefits package in 1995 shall be based upon an
17 actuarial determination of the costs of providing the uniform benefits
18 package, assuming cost savings that may result from reductions in cost
19 shifting, the use of managed care, identification of cost-effective and
20 clinically efficacious services, assuming cost increases that may
21 result from the direct or indirect effect of changes in taxation, aging
22 of the population, and availability and effectiveness of new medical
23 technology, and any other factors deemed relevant by the commission.
24 Beginning in 1996, the growth rate of the premium cost of the uniform
25 benefits package for each certified health plan shall be allowed to
26 increase by a rate no greater than the average growth rate in the cost
27 of the package between 1990 and 1993 as actuarially determined, reduced
28 by two percentage points per year until the growth rate is no greater
29 than the five-year rolling average of growth in Washington per capita
30 personal income, as determined by the office of financial management.
31 (b) In establishing the community-rated maximum premium under this
32 subsection, the commission shall endeavor to minimize any economic
33 incentive to an employer to discriminate between prospective employees
34 based upon whether or not they have dependents for whom coverage would
35 be required.
36 (c) If the commission adds or deletes services or benefits to the
37 uniform benefits package in subsequent years, it may increase or
38 decrease the maximum premium to reflect the actual cost experience of
39 a broad sample of providers of that service in the state, considering

1 the factors enumerated in (a) of this subsection and adjusted
2 actuarially. The addition of services or benefits shall not result in
3 a redetermination of the entire cost of the uniform benefits package.
4 (d) The level of expenditures for the uniform benefits package is
5 conditioned upon the appropriation of funds specifically for this
6 purpose.
7 (7) Establish enrollee premium share levels that are related to
8 enrollee household income and that do not apply to enrollees with
9 income less than the federal poverty level. The commission shall
10 develop mechanisms through which enrollees whose premium share levels
11 are reduced as a result of low household income can obtain subsidies
12 necessary for enrollment in a certified health plan. The availability
13 of subsidies shall be conditioned upon the appropriation of funds
14 specifically for this purpose.
15 (8) Determine the need for medical risk adjustment mechanisms to
16 minimize financial incentives for certified health plans to enroll
17 individuals who present lower health risks and avoid enrolling
18 individuals who present higher health risks, and to minimize financial
19 incentives for employer hiring practices that discriminate against
20 individuals who present higher health risks. In the design of medical
21 risk distribution mechanisms under this subsection, the commission
22 shall (a) balance the benefits of price competition with the need to
23 protect certified health plans from any unsustainable negative effects
24 of adverse selection and (b) consider the development of a system that
25 creates a risk profile of each certified health plan's enrollee
26 population that does not create disincentives for a plan to control
27 benefit utilization, that requires contributions from plans that enjoy
28 a low-risk enrollee population to plans that have a high-risk enrollee
29 population, and that does not permit an adjustment of the premium
30 charged for the uniform benefits package or supplemental coverage based
31 upon either receipt or contribution of assessments. Proposed medical
32 risk adjustment mechanisms shall be submitted to the legislature as
33 provided in section 450 of this act.
34 (9) Design a mechanism to assure minors have access to confidential
35 health care services as currently provided in RCW 70.24.110 and
36 71.34.030.
37 (10) Monitor the actual growth in total annual health services
38 costs.

(11) Monitor the increased application of technology as required by chapter . . ., Laws of 1993 (this act) and take necessary action to ensure that such application is made in a cost-effective and efficient manner and consistent with existing laws that protect individual privacy.

(12) Establish reporting requirements for certified health plans that own or manage health care facilities, health care facilities, and health care providers to periodically report to the commission regarding major capital expenditures of the plans. The commission shall review and monitor such reports from providers and shall report to the legislature regarding major capital expenditures by providers on at least an annual basis. The Washington health care facilities authority and the commission shall develop jointly standards for evaluating and approving major capital expenditure financing through the Washington health care facilities authority, as authorized pursuant to chapter 70.37 RCW. By December 1, 1994, the commission and the authority shall submit jointly to the legislature such proposed standards. The commission and the authority shall, after legislative review, but no later than June 1, 1995, publish such standards. Upon publication, the authority may not approve financing for major capital expenditures unless approved by the commission.

(13) Establish maximum enrollee financial participation levels. The levels shall be related to enrollee household income and shall not result in household income being reduced below the federal poverty level.

(14) For health services provided under the uniform benefits package, adopt standards for enrollment, and standardized billing and claims processing forms. The standards shall ensure that these procedures minimize administrative burdens on health care providers, certified health plans, and consumers. Subject to federal approval or phase-in schedules whenever necessary or appropriate, the standards also shall apply to state-purchased health services, as defined in RCW 41.05.011.

(15) Suggest that certified health plans adopt certain practice indicators or risk management protocols for quality assurance, utilization review, or provider payment. The commission may consider indicators or protocols recommended according to section 410 of this act for these purposes.

1 (16) Suggest other guidelines to certified health plans for
2 utilization management, use of technology and methods of payment, such
3 as diagnosis-related groups and a resource-based relative value scale.
4 Such guidelines shall be voluntary and shall be designed to promote
5 improved management of care, and provide incentives for improved
6 efficiency and effectiveness within the delivery system.
7 (17) Adopt standards and oversee and develop policy for personal
8 health data and information system as provided in chapter 70.170 RCW.
9 (18) Adopt standards that prevent conflict of interest by health
10 care providers as provided in section 408 of this act.
11 (19) Consider the extent to which medical research activities
12 should be included within the health service system set forth in this
13 chapter . . ., Laws of 1993 (this act).
14 (20) Evaluate and monitor the extent to which racial and ethnic
15 minorities have access and to receive health services within the state,
16 and develop strategies to address barriers to access.
17 (21) Develop standards for the certification process to certify
18 health plans to provide the uniform benefits package, according to the
19 provisions for certified health plans under chapter . . ., Laws of 1993
20 (this act).
21 (22) Develop rules for implementation of individual and employer
22 participation under sections 454 and 455 of this act specifically
23 applicable to persons who work in this state but do not live in the
24 state or persons who live in this state but work outside of the state.
25 The rules shall be designed so that these persons receive coverage and
26 financial requirements that are comparable to that received by persons
27 who both live and work in the state.
28 (23) Establish a process for purchase of uniform benefits package
29 services by enrollees when they are out-of-state.
30 (24) Develop recommendations to the legislature as to whether state
31 and school district employees, on whose behalf health benefits are or
32 will be purchased by the health care authority pursuant to chapter
33 41.05 RCW, should have the option to purchase health benefits through
34 health insurance purchasing cooperatives on and after July 1, 1997. In
35 developing its recommendations, the commission shall consider:
36 (a) The impact of state or school district employees purchasing
37 through health insurance purchasing cooperatives on the ability of the
38 state to control its health care costs; and

(b) Whether state or school district employees purchasing through health insurance purchasing cooperatives will result in inequities in health benefits between or within groups of state and school district employees.

(25) Establish guidelines for providers dealing with terminal or static conditions, taking into consideration the ethics of providers, patient and family wishes, costs, and survival possibilities.

(26) Evaluate the extent to which Taft-Hartley health care trusts and self-insured employee health benefit plans provide benefits to certain individuals in the state; review the federal laws under which these joint employee-employer entities and self-insured employee health benefit plans are organized; and make appropriate recommendations to the governor and the legislature on or before December 1, 1994, about how these trusts and benefits plans can be brought under the provisions of chapter . . ., Laws of 1993 (this act) when it is fully implemented.

(27) Evaluate whether Washington is experiencing a higher percentage in in-migration of residents from other states and territories than would be expected by normal trends as a result of the availability of comprehensive subsidized health care benefits for all residents and report to the governor and the legislature their findings.

(28) In developing the uniform benefits package and other standards pursuant to this section, consider the likelihood of the establishment of a national health services plan adopted by the federal government and its implications.

(29) Evaluate the effect of reforms under chapter . . ., Laws of 1993 (this act) on access to care and economic development in rural areas.

To the extent that the exercise of any of the powers and duties specified in this section may be inconsistent with the powers and duties of other state agencies, offices, or commissions, the authority of the commission shall supersede that of such other state agency, office, or commission, except in matters of personal health data, where the commission shall have primary data system policymaking authority and the department of health shall have primary responsibility for the maintenance and routine operation of personal health data systems.

NEW SECTION. **Sec. 407.** MODIFICATION OF MAXIMUM PREMIUM. Upon the recommendation of the insurance commissioner, and on the basis of

1 evidence established by independent actuarial analysis, if the
2 commission finds that the economic viability of a significant number of
3 the state's certified health plans is seriously threatened, the
4 commission may increase the maximum premium to the extent mandated by
5 the Constitution, and must immediately thereafter submit to the
6 legislature a proposal for a new formula for adjusting the maximum
7 premium that must be approved in law by each house of the legislature
8 by a sixty percent vote.

9 NEW SECTION. **Sec. 408.** A new section is added to chapter 18.130
10 RCW to read as follows:
11 CONFLICT OF INTEREST STANDARDS. The Washington health services
12 commission established by section 403 of this act, in consultation with
13 the secretary of health, and the health care disciplinary authorities
14 under RCW 18.130.040(2)(b), shall establish standards and monetary
15 penalties in rule prohibiting provider investments and referrals that
16 present a conflict of interest resulting from inappropriate financial
17 gain for the provider or his or her immediate family. These standards
18 are not intended to inhibit the efficient operation of managed health
19 care systems or certified health plans. The commission shall report to
20 the health policy committees of the senate and house of representatives
21 by December 1, 1994, on the development of the standards and any
22 recommended statutory changes necessary to implement the standards.

23 NEW SECTION. **Sec. 409.** CONTINUOUS QUALITY IMPROVEMENT AND TOTAL
24 QUALITY MANAGEMENT. To ensure the highest quality health services at
25 the lowest total cost, the commission shall establish a total quality
26 management system of continuous quality improvement. Such endeavor
27 shall be based upon the recognized quality science for continuous
28 quality improvement. The commission shall impanel a committee composed
29 of persons from the private sector and related sciences who have broad
30 knowledge and successful experiences in continuous quality improvement
31 and total quality management applications. It shall be the
32 responsibility of the committee to develop standards for a Washington
33 state health services supplier certification process and recommend such
34 standards to the commission for review and adoption. Once adopted, the
35 commission shall establish a schedule, with full compliance no later
36 than July 1, 1996, whereby all health service providers and health

1 service facilities shall be certified prior to providing uniform
2 benefits package services.

3 **B. PRACTICE INDICATORS**

4 NEW SECTION. **Sec. 410.** A new section is added to chapter 43.70
5 RCW to read as follows:
6 PRACTICE INDICATORS. The department of health shall consult with
7 health care providers, purchasers, health professional regulatory
8 authorities under RCW 18.130.040, appropriate research and clinical
9 experts, and consumers of health care services to identify specific
10 practice areas where practice indicators and risk management protocols
11 have been developed, including those that have been demonstrated to be
12 effective among persons of color. Practice indicators shall be based
13 upon expert consensus and best available scientific evidence. The
14 department shall:
15 (1) Develop a definition of expert consensus and best available
16 scientific evidence so that practice indicators can serve as a standard
17 for excellence in the provision of health care services.
18 (2) Establish a process to identify and evaluate practice
19 indicators and risk management protocols as they are developed by the
20 appropriate professional, scientific, and clinical communities.
21 (3) Recommend the use of practice indicators and risk management
22 protocols in quality assurance, utilization review, or provider payment
23 to the health services commission.

24 **C. HEALTH CARE LIABILITY REFORMS**

25 **Sec. 411.** RCW 43.70.320 and 1991 sp.s. c 13 s 18 are each amended
26 to read as follows:
27 HEALTH PROFESSIONS ACCOUNT. (1) There is created in the state
28 treasury an account to be known as the health professions account. All
29 fees received by the department for health professions licenses,
30 registration, certifications, renewals, or examinations and the civil
31 penalties assessed and collected by the department under RCW 18.130.190
32 shall be forwarded to the state treasurer who shall credit such moneys
33 to the health professions account.
34 (2) All expenses incurred in carrying out the health professions
35 licensing activities of the department shall be paid from the account

as authorized by legislative appropriation. Any residue in the account shall be accumulated and shall not revert to the general fund at the end of the biennium.

(3) The secretary shall biennially prepare a budget request based on the anticipated costs of administering the health professions licensing activities of the department which shall include the estimated income from health professions fees.

NEW SECTION. **Sec. 412.** A new section is added to chapter 18.130 RCW to read as follows:

MALPRACTICE INSURANCE COVERAGE MANDATE. Except to the extent that liability insurance is not available, every licensed health care practitioner whose services are included in the uniform benefits package, as determined by section 448 of this act, and whose scope of practice includes independent practice, shall, as a condition of licensure and relicensure, be required to provide evidence of a minimum level of malpractice insurance coverage issued by a company authorized to do business in this state. On or before January 1, 1994, the department shall designate by rule:

(1) Those health professions whose scope of practice includes independent practice;

(2) For each health profession whose scope of practice includes independent practice, whether malpractice insurance is available; and

(3) If such insurance is available, the appropriate minimum level of mandated coverage.

NEW SECTION. **Sec. 413.** A new section is added to chapter 48.22 RCW to read as follows:

RISK MANAGEMENT TRAINING OF INDEPENDENT HEALTH CARE PRACTITIONERS. Effective July 1, 1994, a casualty insurer's issuance of a new medical malpractice policy or renewal of an existing medical malpractice policy to a physician or other independent health care practitioner shall be conditioned upon that practitioner's participation in, and completion of, an insurer-designed health care liability risk management training program once every three years. The risk management training shall provide information related to avoiding adverse health outcomes resulting from substandard practice and minimizing damages associated with the adverse health outcomes that do occur. For purposes of this section, "independent health care practitioners" means those health

care practitioner licensing classifications designated by the department of health in rule pursuant to section 412 of this act.

NEW SECTION. **Sec. 414.** A new section is added to chapter 48.05 RCW to read as follows:

RISK MANAGEMENT TRAINING OF INDEPENDENT HEALTH CARE PRACTITIONERS. Effective July 1, 1994, each health care provider, facility, or health maintenance organization that self-insures for liability risks related to medical malpractice and employs physicians or other independent health care practitioners in Washington state shall condition each physician's and practitioner's liability coverage by that entity upon that physician's or practitioner's participation in risk management training offered by the provider, facility, or health maintenance organization to its employees. The risk management training shall provide information related to avoiding adverse health outcomes resulting from substandard practice and minimizing damages associated with those adverse health outcomes that do occur. For purposes of this section, "independent health care practitioner" means those health care practitioner licensing classifications designated by the department of health in rule pursuant to section 412 of this act.

Sec. 415. RCW 70.41.200 and 1991 c 3 s 336 are each amended to read as follows:

QUALITY IMPROVEMENT PROGRAM. (1) Every hospital shall maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The program shall include at least the following:

(a) The establishment of a quality ((~~assurance~~)) improvement committee with the responsibility to review the services rendered in the hospital, both retrospectively and prospectively, in order to improve the quality of medical care of patients and to prevent medical malpractice. The committee shall oversee and coordinate the quality improvement and medical malpractice prevention program and shall insure that information gathered pursuant to the program is used to review and to revise hospital policies and procedures((~~. At least one member of the committee shall be a member of the governing board of the hospital who is not otherwise affiliated with the hospital in an employment or contractual capacity~~));

(b) A medical staff privileges sanction procedure through which credentials, physical and mental capacity, and competence in delivering health care services are periodically reviewed as part of an evaluation of staff privileges;

(c) The periodic review of the credentials, physical and mental capacity, and competence in delivering health care services of all persons who are employed or associated with the hospital;

(d) A procedure for the prompt resolution of grievances by patients or their representatives related to accidents, injuries, treatment, and other events that may result in claims of medical malpractice;

(e) The maintenance and continuous collection of information concerning the hospital's experience with negative health care outcomes and incidents injurious to patients, patient grievances, professional liability premiums, settlements, awards, costs incurred by the hospital for patient injury prevention, and safety improvement activities;

(f) The maintenance of relevant and appropriate information gathered pursuant to (a) through (e) of this subsection concerning individual physicians within the physician's personnel or credential file maintained by the hospital;

(g) Education programs dealing with quality improvement, patient safety, injury prevention, staff responsibility to report professional misconduct, the legal aspects of patient care, improved communication with patients, and causes of malpractice claims for staff personnel engaged in patient care activities; and

(h) Policies to ensure compliance with the reporting requirements of this section.

(2) Any person who, in substantial good faith, provides information to further the purposes of the quality improvement and medical malpractice prevention program or who, in substantial good faith, participates on the quality ((~~assurance~~)) improvement committee shall not be subject to an action for civil damages or other relief as a result of such activity.

(3) Information and documents, including complaints and incident reports, created specifically for, and collected, and maintained ((~~about health care providers arising out of the matters that are under review or have been evaluated~~)) by a ((~~review~~)) quality improvement committee ((~~conducting quality assurance reviews~~)) are not subject to discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or

((~~board~~)) who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts which form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; ((~~(b)~~)) (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality ((~~assurance~~)) improvement committees regarding such health care provider; ((~~(c)~~)) (d) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or ((~~(d)~~)) (e) in any civil action, discovery and introduction into evidence of the patient's medical records required by regulation of the department of health to be made regarding the care and treatment received.

(4) The department of health shall adopt such rules as are deemed appropriate to effectuate the purposes of this section.

(5) The medical disciplinary board or the board of osteopathic medicine and surgery, as appropriate, may review and audit the records of committee decisions in which a physician's privileges are terminated or restricted. Each hospital shall produce and make accessible to the board the appropriate records and otherwise facilitate the review and audit. Information so gained shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (3) of this section. Failure of a hospital to comply with this subsection is punishable by a civil penalty not to exceed two hundred fifty dollars.

(6) Violation of this section shall not be considered negligence per se.

Sec. 416. RCW 70.41.230 and 1991 c 3 s 337 are each amended to read as follows:

REQUEST FOR STAFF PRIVILEGES. (1) Prior to granting or renewing clinical privileges or association of any physician or hiring a physician, a hospital or facility approved pursuant to this chapter shall request from the physician and the physician shall provide the following information:

(a) The name of any hospital or facility with or at which the physician had or has any association, employment, privileges, or practice;

(b) If such association, employment, privilege, or practice was discontinued, the reasons for its discontinuation;

(c) Any pending professional medical misconduct proceedings or any pending medical malpractice actions in this state or another state, the substance of the allegations in the proceedings or actions, and any additional information concerning the proceedings or actions as the physician deems appropriate;

(d) The substance of the findings in the actions or proceedings and any additional information concerning the actions or proceedings as the physician deems appropriate;

(e) A waiver by the physician of any confidentiality provisions concerning the information required to be provided to hospitals pursuant to this subsection; and

(f) A verification by the physician that the information provided by the physician is accurate and complete.

(2) Prior to granting privileges or association to any physician or hiring a physician, a hospital or facility approved pursuant to this chapter shall request from any hospital with or at which the physician had or has privileges, was associated, or was employed, the following information concerning the physician:

(a) Any pending professional medical misconduct proceedings or any pending medical malpractice actions, in this state or another state;

(b) Any judgment or settlement of a medical malpractice action and any finding of professional misconduct in this state or another state by a licensing or disciplinary board; and

(c) Any information required to be reported by hospitals pursuant to RCW 18.72.265.

(3) The medical disciplinary board shall be advised within thirty days of the name of any physician denied staff privileges, association, or employment on the basis of adverse findings under subsection (1) of this section.

(4) A hospital or facility that receives a request for information from another hospital or facility pursuant to subsections (1) and (2) of this section shall provide such information concerning the physician in question to the extent such information is known to the hospital or facility receiving such a request, including the reasons for suspension, termination, or curtailment of employment or privileges at the hospital or facility. A hospital, facility, or other person providing such information in good faith is not liable in any civil action for the release of such information.

(5) Information and documents, including complaints and incident reports, created specifically for, and collected, and maintained ((~~about health care providers arising out of the matters that are under review or have been evaluated~~)) by a ((~~review~~)) quality improvement committee ((~~conducting quality assurance reviews~~)) are not subject to discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or ((~~board~~)) who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts which form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; ((~~(b)~~)) (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality ((~~assurance~~)) improvement committees regarding such health care provider; ((~~(c)~~)) (d) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or ((~~(d)~~)) (e) in any civil action, discovery and introduction into evidence of the patient's medical records required by regulation of the department of health to be made regarding the care and treatment received.

1 (6) Hospitals shall be granted access to information held by the
2 medical disciplinary board and the board of osteopathic medicine and
3 surgery pertinent to decisions of the hospital regarding credentialing
4 and recredentialing of practitioners.
5 (7) Violation of this section shall not be considered negligence
6 per se.

7 NEW SECTION. **Sec. 417.** A new section is added to chapter 43.70
8 RCW to read as follows:
9 COORDINATED QUALITY IMPROVEMENT PROGRAM. (1)(a) Health care
10 institutions and medical facilities, other than hospitals, that are
11 licensed by the department, professional societies or organizations,
12 and certified health plans approved pursuant to section 427 of this act
13 may maintain a coordinated quality improvement program for the
14 improvement of the quality of health care services rendered to patients
15 and the identification and prevention of medical malpractice as set
16 forth in RCW 70.41.200.
17 (b) All such programs shall comply with the requirements of RCW
18 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to
19 reflect the structural organization of the institution, facility,
20 professional societies or organizations, or certified health plan,
21 unless an alternative quality improvement program substantially
22 equivalent to RCW 70.41.200(1)(a) is developed. All such programs,
23 whether complying with the requirement set forth in RCW 70.41.200(1)(a)
24 or in the form of an alternative program, must be approved by the
25 department before the discovery limitations provided in subsections (3)
26 and (4) of this section shall apply. In reviewing plans submitted by
27 licensed entities that are associated with physicians' offices, the
28 department shall ensure that the discovery limitations of this section
29 are applied only to information and documents related specifically to
30 quality improvement activities undertaken by the licensed entity.
31 (2) Health care provider groups of ten or more providers may
32 maintain a coordinated quality improvement program for the improvement
33 of the quality of health care services rendered to patients and the
34 identification and prevention of medical malpractice as set forth in
35 RCW 70.41.200. All such programs shall comply with the requirements of
36 RCW 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to
37 reflect the structural organization of the health care provider group.
38 All such programs must be approved by the department before the

discovery limitations provided in subsections (3) and (4) of this section shall apply.

(3) Any person who, in substantial good faith, provides information to further the purposes of the quality improvement and medical malpractice prevention program or who, in substantial good faith, participates on the quality improvement committee shall not be subject to an action for civil damages or other relief as a result of such activity.

(4) Information and documents, including complaints and incident reports, created specifically for, and collected, and maintained by a quality improvement committee are not subject to discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts that form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality improvement committees regarding such health care provider; (d) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or (e) in any civil action, discovery and introduction into evidence of the patient's medical records required by rule of the department of health to be made regarding the care and treatment received.

(5) The department of health shall adopt rules as are necessary to implement this section.

NEW SECTION. **Sec. 418.** MEDICAL MALPRACTICE REVIEW. (1) The administrator for the courts shall coordinate a collaborative effort to

develop a voluntary system for review of medical malpractice claims by health services experts prior to the filing of a cause of action under chapter 7.70 RCW.

(2) The system shall have at least the following components:

(a) Review would be initiated, by agreement of the injured claimant and the health care provider, at the point at which a medical malpractice claim is submitted to a malpractice insurer or a self-insured health care provider.

(b) By agreement of the parties, an expert would be chosen from a pool of health services experts who have agreed to review claims on a voluntary basis.

(c) The mutually agreed upon expert would conduct an impartial review of the claim and provide his or her opinion to the parties.

(d) A pool of available experts would be established and maintained for each category of health care practitioner by the corresponding practitioner association, such as the Washington state medical association and the Washington state nurses association.

(3) The administrator for the courts shall seek to involve at least the following organizations in a collaborative effort to develop the informal review system described in subsection (2) of this section:

(a) The Washington defense trial lawyers association;

(b) The Washington state trial lawyers association;

(c) The Washington state medical association;

(d) The Washington state nurses association and other employee organizations representing nurses;

(e) The Washington state hospital association;

(f) The Washington state physicians insurance exchange and association;

(g) The Washington casualty company;

(h) The doctor's agency;

(i) Group health cooperative of Puget Sound;

(j) The University of Washington;

(k) Washington osteopathic medical association;

(l) Washington state chiropractic association;

(m) Washington association of naturopathic physicians; and

(n) The department of health.

(4) On or before January 1, 1994, the administrator for the courts shall provide a report on the status of the development of the system

described in this section to the governor and the appropriate committees of the senate and the house of representatives.

NEW SECTION. **Sec. 419.** A new section is added to chapter 7.70 RCW to read as follows:

MANDATORY MEDIATION OF HEALTH CARE MALPRACTICE CLAIMS. (1) All causes of action, whether based in tort, contract, or otherwise, for damages arising from injury occurring as a result of health care provided after the effective date of this section shall be subject to mandatory mediation prior to trial.

(2) The supreme court shall by rule adopt procedures to implement mandatory mediation of actions under this chapter. The rules shall address, at a minimum:

(a) Procedures for the appointment of, and qualifications of, mediators. A mediator shall have experience or expertise related to actions arising from injury occurring as a result of health care, and be a member of the state bar association who has been admitted to the bar for a minimum of five years or who is a retired judge. The parties may stipulate to a nonlawyer mediator. The court may prescribe additional qualifications of mediators. Mediators shall be compensated in the same amount and manner as judges pro tempore of the superior court unless the parties agree to a different amount or manner of compensation;

(b) The number of days following the filing of a claim under this chapter within which a mediator must be selected;

(c) The method by which a mediator is selected. The rule shall provide for designation of a mediator by the superior court if the parties are unable to agree upon a mediator;

(d) The number of days following the selection of a mediator within which a mediation conference must be held;

(e) A means by which mediation of an action under this chapter may be waived by a mediator who has determined that the claim is not appropriate for mediation; and

(f) Any other matters deemed necessary by the court.

(3) Mediators shall not impose discovery schedules upon the parties.

NEW SECTION. **Sec. 420.** A new section is added to chapter 7.70 RCW to read as follows:

MANDATORY MEDIATION OF HEALTH CARE MALPRACTICE. The making of a written, good faith request for mediation of a dispute related to damages for injury occurring as a result of health care provided prior to filing a cause of action under this chapter shall toll the statute of limitations provided in RCW 4.16.350.

NEW SECTION. **Sec. 421.** A new section is added to chapter 7.70 RCW to read as follows:

MANDATORY MEDIATION OF HEALTH CARE MALPRACTICE CLAIMS. Section 419 of this act may not be construed to abridge the right to trial by jury following an unsuccessful attempt at mediation.

Sec. 422. RCW 5.60.070 and 1991 c 321 s 1 are each amended to read as follows:

MEDIATION--COMMUNICATIONS PRIVILEGED. (1) If there is a court order to mediate ((~~or~~)), a written agreement between the parties to mediate, or if mediation is mandated under section 419 of this act, then any communication made or materials submitted in, or in connection with, the mediation proceeding, whether made or submitted to or by the mediator, a mediation organization, a party, or any person present, are privileged and confidential and are not subject to disclosure in any judicial or administrative proceeding except:

(a) When all parties to the mediation agree, in writing, to disclosure;

(b) When the written materials or tangible evidence are otherwise subject to discovery, and were not prepared specifically for use in and actually used in the mediation proceeding;

(c) When a written agreement to mediate permits disclosure;

(d) When disclosure is mandated by statute;

(e) When the written materials consist of a written settlement agreement or other agreement signed by the parties resulting from a mediation proceeding;

(f) When those communications or written materials pertain solely to administrative matters incidental to the mediation proceeding, including the agreement to mediate; or

(g) In a subsequent action between the mediator and a party to the mediation arising out of the mediation.

(2) When there is a court order ((~~or~~)), a written agreement to mediate, or when mediation is mandated under section 419 of this act,

as described in subsection (1) of this section, the mediator or a representative of a mediation organization shall not testify in any judicial or administrative proceeding unless:

(a) All parties to the mediation and the mediator agree in writing; or

(b) In an action described in subsection (1)(g) of this section.

Sec. 423. RCW 4.22.070 and 1986 c 305 s 401 are each amended to read as follows:

PERCENTAGE OF FAULT--JOINT AND SEVERAL LIABILITY. (1) Except as provided in subsection (4) of this section, 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 damages, including the claimant or person suffering personal injury or incurring property damage, 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 or incurring property damages 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 claimants total damages.

(2) If a defendant is jointly and severally liable under one of the exceptions listed in subsection((s)) (1)(a) or (1)(b) or (4) (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.

(3)(a) Nothing in this section affects any cause of action relating to hazardous wastes or substances or solid waste disposal sites.

(b) Nothing in this section shall affect a cause of action arising from the tortious interference with contracts or business relations.

(c) Nothing in this section shall affect any cause of action arising from the manufacture or marketing of a fungible product in a generic form which contains no clearly identifiable shape, color, or marking.

(4) In all actions governed by chapter 7.70 RCW involving fault of more than one entity, the trier of fact shall determine the percentage of the total fault that is attributable to every entity that caused the claimant's damages, including the claimant or person suffering personal injury or incurring property damage, 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 that represents that party's proportionate share of the claimant's total damages. The total damages shall first be reduced by any amount paid to the claimant by a released entity. 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 or incurring property damages 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 total damages.

(c) A defendant shall be responsible to the claimant for any fault of an entity released by the claimant. The total damages shall first be reduced by any amount paid to the claimant by a released entity, and, where some fault has been attributed to the claimant, by the claimant's proportionate share of his or her total damages.

D. HEALTH INSURANCE PURCHASING COOPERATIVES

1 NEW SECTION. **Sec. 424.** HEALTH INSURANCE PURCHASING COOPERATIVES--
2 DESIGNATION OF REGIONS BY COMMISSION, INFORMATION SYSTEMS, MINIMUM
3 STANDARDS, AND RULES. (1) The commission shall designate large
4 geographic regions within the state in which health insurance
5 purchasing cooperatives may operate, based upon population, assuming
6 that each cooperative must serve no less than one hundred fifty
7 thousand persons; geographic factors; market conditions; and other
8 factors deemed appropriate by the commission. The commission shall
9 designate one health insurance purchasing cooperative per region.
10 However, the commission may designate certain regions of the state as
11 areas where more than one cooperative may operate upon a determination
12 that a sufficient population base exists within such region to
13 efficiently support more than one cooperative.
14 (2) In coordination with the commission and consistent with the
15 provisions of chapter 70.170 RCW, the department of health shall
16 establish an information clearinghouse for the collection and
17 dissemination of information necessary for the efficient operation of
18 cooperatives, including the establishment of a risk profile information
19 system related to certified health plan enrollees that would permit the
20 equitable distribution of losses among plans in accordance with section
21 406(8) of this act.
22 (3) Every health insurance purchasing cooperative shall:
23 (a) Admit all individuals, employers, or other groups wishing to
24 participate in the cooperative;
25 (b) Make available for purchase by cooperative members every health
26 care program offered by every certified health plan operating within
27 the cooperative's region;
28 (c) Be operated as a member-governed and owned, nonprofit
29 cooperative in which no certified health plan, health maintenance
30 organization, health care service contractor, independent practice
31 association, independent physician organization, or any individual with
32 a pecuniary interest in any such organization, shall have any pecuniary
33 interest in or management control of the cooperative;
34 (d) Provide for centralized enrollment and premium collection and
35 distribution among certified health plans; and
36 (e) Serve as an ombudsman for its members to resolve inquiries,
37 complaints, or other concerns with certified health plans.
38 (4) Every health insurance purchasing cooperative shall assist
39 members in selecting certified health plans and for this purpose may

devise a rating system or similar system to judge the quality and cost-effectiveness of certified health plans consistent with guidelines established by the commission. For this purpose, each cooperative and directors, officers, and other employees of the cooperative are immune from liability in any civil action or suit arising from the publication of any report, brochure, or guide, or dissemination of information related to the services, quality, price, or cost-effectiveness of certified plans unless actual malice, fraud, or bad faith is shown. Such immunity is in addition to any common law or statutory privilege or immunity enjoyed by such person, and nothing in this section is intended to abrogate or modify in any way such common law or statutory privilege or immunity.

(5) Every health insurance purchasing cooperative shall bear the full cost of its operations, including the costs of participating in the information clearinghouse, through assessments upon its members. Such assessments shall be billed and accounted for separately from premiums collected and distributed for the purchase of the uniform benefits package or any other supplemental insurance or health services program.

(6) No health insurance purchasing cooperative may bear any financial risk for the delivery of uniform benefits package services, or for any other supplemental insurance or health services program.

(7) No health insurance purchasing cooperative may directly broker, sell, contract for, or provide any insurance or health services program. However, nothing contained in this section shall be deemed to prohibit the use or employment of insurance agents or brokers by the cooperative for other purposes or to prohibit the facilitation of the sale and purchase by members of supplemental insurance or health services programs.

(8) The commission may adopt rules necessary for the implementation of this section including rules governing charter and bylaw provisions of cooperatives and may adopt rules prohibiting or permitting other activities by cooperatives.

(9) The commission shall consider ways in which cooperatives can develop, encourage, and provide incentives for employee wellness programs.

NEW SECTION. **Sec. 425.** LICENSING AND REGULATION OF HEALTH INSURANCE PURCHASING COOPERATIVES BY THE INSURANCE COMMISSIONER. (1)

No person may establish or operate a health insurance purchasing cooperative without having first obtained a certificate of authority from the insurance commissioner.

(2) Every proposed cooperative shall furnish notice to the insurance commissioner that shall:

(a) Identify the principal name and address of the cooperative;

(b) Furnish the names and addresses of the initial officers of the cooperative;

(c) Include copies of letters of agreement for participation in the cooperative including minimum term of participation;

(d) Furnish copies of its proposed articles and bylaws; and

(e) Provide other information as prescribed by the insurance commissioner in consultation with the health services commission to verify that the cooperative is qualified and is managed by competent and trustworthy individuals.

(3)(a) The commissioner shall approve applications for certificates in accordance with the order received.

(b) The commissioner shall establish by rule a fee to be paid by cooperatives in an amount necessary to review and approve applications for a certificate of authority. Such fee shall accompany the application and no certificate may be issued until such fee is paid. Fees collected for such purpose shall be deposited in the insurance commissioner's regulatory account in the state treasury.

(4) All funds representing premiums or return premiums received by a cooperative in its fiduciary capacity shall be accounted for and maintained in a separate account from all other funds. Each willful violation of this section constitutes a misdemeanor.

(5) Every cooperative shall keep at its principal address, a record of all transactions it has consummated on behalf of its members with certified health plans. All such records shall be kept available and open to the inspection of the insurance commissioner at any business time during a five-year period immediately after the date of completion of the transaction.

E. CERTIFIED HEALTH PLANS

NEW SECTION. **Sec. 426.** CERTIFIED HEALTH PLANS--REGISTRATION REQUIRED--PENALTY. (1) On and after July 1, 1995, no person or entity in this state shall provide the uniform benefits package and

1 supplemental benefits as defined in section 402 of this act without
2 being certified as a certified health plan by the insurance
3 commissioner.
4 (2) On and after July 1, 1995, the uniform benefits package and
5 supplemental benefits shall be purchased only from entities certified
6 as certified health plans.
7 (3) On and after July 1, 1995, the uniform benefits package shall
8 be the minimum benefits package of any certified health plan.

9 NEW SECTION. **Sec. 427.** HEALTH PLAN CERTIFICATION STANDARDS. A
10 certified health plan shall:
11 (1) Provide the benefits included in the uniform benefits package
12 and offer supplemental benefits packages to enrolled Washington
13 residents for a prepaid per capita community-rated premium not to
14 exceed the maximum premium established by the commission and provide
15 such benefits through managed care in accordance with rules adopted by
16 the commission;
17 (2) Accept for enrollment any state resident within the plan's
18 service area and provide or assure the provision of all services within
19 the uniform benefits package and offer supplemental benefits packages
20 regardless of factors referenced in RCW 49.60.020, including age, sex,
21 family structure, ethnicity, race, health condition, geographic
22 location, employment status, socioeconomic status, or other condition
23 or situation, however, the insurance commissioner may grant a temporary
24 exemption from this subsection, if, upon application by a certified
25 health plan, the commissioner finds that the clinical, financial, or
26 administrative capacity to serve existing enrollees will be impaired if
27 a certified health plan is required to continue enrollment of
28 additional eligible individuals;
29 (3) If the plan provides benefits through contracts with, ownership
30 of, or management of health care facilities and contracts with or
31 employs health care providers, demonstrate to the satisfaction of the
32 insurance commissioner in consultation with the department of health
33 and the commission that its facilities and personnel are adequate to
34 provide the benefits prescribed in the uniform benefits package and
35 offer supplemental benefits packages to enrolled Washington residents,
36 and that it is financially capable of providing such residents with, or
37 has made adequate contractual arrangements with health care providers
38 and facilities to provide enrollees with such benefits;

1 (4) Comply with portability of benefits requirements prescribed by
2 the commission;
3 (5) Comply with administrative rules prescribed by the commission,
4 the insurance commissioner, and other state agencies governing
5 certified health plans;
6 (6) Provide all enrollees with instruction and informational
7 materials to increase individual and family awareness of injury and
8 illness prevention; encourage assumption of personal responsibility for
9 protecting personal health; and stimulate discussion about the use and
10 limits of medical care in improving the health of individuals and
11 communities;
12 (7) Discloses to enrollees the charity care requirements under
13 chapter 70.170 RCW;
14 (8) Include in all of its contracts with health care providers and
15 health care facilities a provision prohibiting such providers and
16 facilities from billing enrollees for any amounts in excess of
17 applicable enrollee point of service cost-sharing obligations for
18 services included in the uniform benefits package and the supplemental
19 benefits package;
20 (9) Include in all of its contracts issued for uniform benefits
21 package and supplemental benefits package coverage a subrogation
22 provision that allows the certified health plan to recover the costs of
23 uniform benefits package and supplemental benefits package services
24 incurred to care for an enrollee injured by a negligent third party.
25 The costs recovered shall be limited to:
26 (a) If the certified health plan has not intervened in the action
27 by an injured enrollee against a negligent third party, then the amount
28 of costs the certified health plan can recover shall be limited to the
29 excess remaining after the enrollee has been fully compensated for his
30 or her loss minus a proportionate share of the enrollee's costs and
31 fees in bringing the action. The proportionate share shall be
32 determined by:
33 (i) The fees and costs approved by the court in which the action
34 was initiated; or
35 (ii) The written agreement between the attorney and client that
36 established fees and costs when fees and costs are not addressed by the
37 court.
38 When fees and costs have been approved by a court, after notice to
39 the certified health plan, the certified health plan shall have the

1 right to be heard on the matter of attorneys' fees and costs or its
2 proportionate share;
3 (b) If the certified health plan has intervened in the action by an
4 injured enrollee against a negligent third party, then the amount of
5 costs the certified health plan can recover shall be the excess
6 remaining after the enrollee has been fully compensated for his or her
7 loss or the amount of the plan's incurred costs, whichever is less;
8 (10) Establish and maintain a grievance procedure approved by the
9 commissioner, to provide a reasonable and effective resolution of
10 complaints initiated by enrollees concerning any matter relating to the
11 provision of benefits under the uniform benefits package and
12 supplemental benefits, access to health care services, and quality of
13 services. Each certified health plan shall respond to complaints filed
14 with the insurance commissioner within fifteen working days. The
15 insurance commissioner in consultation with the commission shall
16 establish standards for grievance procedures and resolution;
17 (11) Comply with the provisions of chapter 48.30 RCW prohibiting
18 unfair and deceptive acts and practices to the extent such provisions
19 are not modified or superseded by the provisions of chapter . . ., Laws
20 of 1993 (this act) and be prohibited from offering or supplying
21 incentives that would have the effect of avoiding the requirements of
22 subsection (2) of this section;
23 (12) Have culturally sensitive health promotion programs that
24 include approaches that are specifically effective for persons of color
25 and accommodating to different cultural value systems, gender, and age;
26 and
27 (13) Permit every class of health care providers to provide health
28 services or care for conditions included in the uniform benefits
29 package and in the supplemental benefits package to the extent that:
30 (a) The provision of such health services or care is within the
31 health care providers' permitted scope of practice; and
32 (b) The providers agree to abide by standards related to:
33 (i) Provision, utilization review, and cost containment of health
34 services;
35 (ii) Management and administrative procedures; and
36 (iii) Provision of cost-effective and clinically efficacious health
37 services.

NEW SECTION. **Sec. 428.** LIMITED CERTIFIED HEALTH PLAN FOR DENTAL SERVICES. (1) For the purposes of this section "limited certified dental plan" or "dental plan" means a certified health plan offering coverage for dental services only and that complies with all certified health plan requirements for managed care, community rating, portability, and nondiscrimination.

(2) A dental plan may provide coverage for dental services directly to individuals or to employers for the benefit of employees. If an individual or an employer purchases uniform dental services from a dental plan, the certified health plan covering the individual or the employees need not provide dental services required under the uniform benefits package. A certified health plan may subcontract with a dental plan to provide the dental benefits required under the uniform benefits package.

(3) The commission shall establish maximum premiums and maximum enrollee financial participation amounts that may be charged by dental plans and shall adopt rules defining the minimum, uniform dental services identified in section 448 of this act that must be offered by dental plans. The commission shall also establish maximum premiums and maximum enrollee financial participation amounts for certified health plans not providing dental benefits by virtue of the individual's or employee's coverage by a dental plan, and rules governing the percentage change in the premium charged by a dental plan subcontracting with a certified health plan when the maximum premiums are changed by the commission.

(4) Rules governing dental plan premiums and financial participation amounts, and rules defining minimum, uniform dental services identified in section 448 of this act shall be adopted and shall apply to dental plans in accordance with the implementation dates applicable to certified health plans with respect to similar requirements.

NEW SECTION. **Sec. 429.** CONTRACTS BETWEEN CERTIFIED HEALTH PLANS AND HEALTH CARE PROVIDERS. (1) Balancing the need for health care reform and the need to protect health care providers, as a class and as individual providers, from improper exclusion presents a problem that can be satisfied with the creation of a process to ensure fair consideration of the inclusion of health care providers in managed care systems operated by certified health plans. It is therefore the intent

1 of the legislature that the health services commission in developing
2 rules in accordance with this section and the attorney general in
3 monitoring the level of competition in the various geographic markets,
4 balance the need for cost-effective and quality delivery of health
5 services with the need for inclusion of both individual health care
6 providers and classes of health care providers in managed care programs
7 developed by certified health plans.
8 (2) All licensed health care providers licensed by the state,
9 irrespective of the type or kind of practice, should be afforded the
10 opportunity for inclusion in certified health plans consistent with the
11 goals of health care reform.
12 The health services commission shall adopt rules requiring
13 certified health plans to publish general criteria for the plan's
14 selection or termination of health care providers. Such rules shall
15 not require the disclosure of criteria deemed by the plan to be of a
16 proprietary or competitive nature that would hurt the plan's ability to
17 compete or to manage health services. Disclosure of criteria is
18 proprietary or anticompetitive if revealing the criteria would have the
19 tendency to cause health care providers to alter their practice pattern
20 in a manner that would harm efforts to contain health care costs and is
21 proprietary if revealing the criteria would cause the plan's
22 competitors to obtain valuable business information.
23 If a certified health plan uses unpublished criteria to judge the
24 quality and cost-effectiveness of a health care provider's practice
25 under any specific program within the plan, the plan may not reject or
26 terminate the provider participating in that program based upon such
27 criteria until the provider has been informed of the criteria that his
28 or her practice fails to meet and is given a reasonable opportunity to
29 conform to such criteria.
30 (3)(a) Whenever a determination is made under (b) of this
31 subsection that a plan's share of the market reaches a point where the
32 plan's exclusion of health care providers from a program of the plan
33 would result in the substantial inability of providers to continue
34 their practice thereby unreasonably restricting consumer access to
35 needed health services or whenever a certified health plan is the only
36 plan within the relevant market, the certified health plan must allow
37 all providers within the affected market to participate in the programs
38 of the certified health plan. All such providers must meet the
39 published criteria and requirements of the programs.

1 (b) The attorney general with the assistance of the insurance
2 commissioner shall periodically analyze the market power of certified
3 health plans to determine when the market share of any program of a
4 certified health plan reaches a point where the plan's exclusion of
5 health service providers from a program of the plan would result in the
6 substantial inability of providers to continue their practice thereby
7 unreasonably restricting consumer access to needed health services. In
8 analyzing the market power of a certified health plan, the attorney
9 general shall consider:
10 (i) The ease with which providers may obtain contracts with other
11 plans;
12 (ii) The amount of the private pay and government employer business
13 that is controlled by the certified health plan taking into account the
14 selling of its provider network to self-insured employer plans;
15 (iii) The difficulty in establishing new competing plans in the
16 relevant geographic market; and
17 (iv) The sufficiency of the number or type of providers under
18 contract with the plan available to meet the needs of plan enrollees.
19 Notwithstanding the provisions of this subsection, if the certified
20 health plan demonstrates to the satisfaction of the attorney general
21 that health service utilization data and similar information shows that
22 the inclusion of additional health service providers would
23 substantially lessen the plan's ability to control health care costs
24 and that the plan's procedures for selection of providers are not
25 improperly exclusive of providers, the plan need not include additional
26 providers within the plan's program.
27 (4) The health services commission shall adopt rules for the
28 resolution of disputes between providers and certified health plans
29 including disputes regarding the decision of a plan not to include the
30 services of a provider.
31 (5) Nothing contained in this section shall be construed to require
32 a plan to allow or continue the participation of a provider if the plan
33 is a federally qualified health maintenance organization and the
34 participation of the provider or providers would prevent the health
35 maintenance organization from operating as a health maintenance
36 organization in accordance with 42 U.S.C. Sec. 300e.

37 NEW SECTION. **Sec. 430.** CERTIFIED HEALTH PLANS--REGISTRATION
38 REQUIRED--PENALTY. (1) No person or entity in this state may, by mail

or otherwise, act or hold himself or herself out to be a certified health plan as defined by section 402 of this act without being registered as a certified health plan with the insurance commissioner.

(2) Anyone violating subsection (1) of this section is liable for a fine not to exceed ten thousand dollars and imprisonment not to exceed six months for each instance of such violation.

NEW SECTION. **Sec. 431.** ELIGIBILITY REQUIREMENTS FOR CERTIFICATE OF REGISTRATION--APPLICATION REQUIREMENTS. Any corporation, cooperative group, partnership, association, or groups of health professionals licensed by the state of Washington, public hospital district, or public institutions of higher education are entitled to a certificate from the insurance commissioner as a certified health plan if it:

(1) Submits an application for certification as a certified health plan, which shall be verified by an officer or authorized representative of the applicant, being in a form as the insurance commissioner prescribes in consultation with the health services commission;

(2) Meets the minimum net worth requirements set forth in section 437 of this act and the funding reserve requirements set forth in section 438 of this act;

(3) A certified health plan may establish the geographic boundaries in which they will obligate themselves to deliver the services required under the uniform benefits package and include such information in their application for certification, but the commissioner shall review such boundaries and may disapprove, in conformance to guidelines adopted by the commission, those which have been clearly drawn to be exclusionary within a health care catchment area.

NEW SECTION. **Sec. 432.** ISSUANCE OF CERTIFICATE--GROUNDS FOR REFUSAL. The commissioner shall issue a certificate as a certified health plan to an applicant within one hundred twenty days of such filing unless the commissioner notifies the applicant within such time that such application is not complete and the reasons therefor; or that the commissioner is not satisfied that:

(1) The basic organization document of the applicant permits the applicant to conduct business as a certified health plan;

1 (2) The applicant has demonstrated the intent and ability to assure
2 that the health services will be provided in a manner to assure both
3 their availability and accessibility;
4 (3) The organization is financially responsible and may be
5 reasonably expected to meet its obligations to its enrolled
6 participants. In making this determination, the commissioner shall
7 consider among other relevant factors:
8 (a) Any agreements with a casualty insurer, a government agency, or
9 any other organization paying or insuring payment for health care
10 services;
11 (b) Any agreements with providers for the provision of health care
12 services; and
13 (c) Any arrangements for liability and malpractice insurance
14 coverage.
15 (4) The procedures for offering health care services are reasonable
16 and equitable; and
17 (5) Procedures have been established to:
18 (a) Monitor the quality of care provided by the certified health
19 plan including standards and guidelines provided by the health services
20 commission and other appropriate state agencies;
21 (b) Operate internal peer review mechanisms; and
22 (c) Resolve complaints and grievances in accordance with section
23 442 of this act and rules established by the insurance commissioner in
24 consultation with the commission.

25 NEW SECTION. **Sec. 433.** PREMIUMS AND ENROLLEE PAYMENT AMOUNTS--
26 FILING OF PREMIUMS AND ENROLLEE PAYMENT AMOUNTS--ADDITIONAL CHARGES
27 PROHIBITED. (1) The insurance commissioner shall verify that the
28 certified health plan and its providers are charging no more than the
29 maximum premiums and enrollee financial participation amounts during
30 the course of financial and market conduct examinations or more
31 frequently if justified in the opinion of the insurance commissioner or
32 upon request by the health services commission.
33 (2) The certified health plans shall file the premium schedules
34 including employer contributions, enrollee premium sharing, and
35 enrollee point of service cost sharing amounts with the insurance
36 commissioner, within thirty days of establishment by the health
37 services commission.

1 (3) No certified health plan or its provider may charge any fees,
2 assessments, or charges in addition to the premium amount or in excess
3 of the maximum enrollee financial participation limits established by
4 the health services commission. The certified health plan that
5 directly provides health care services may charge and collect the
6 enrollee point of service cost sharing fees as established in the
7 uniform benefits package or other approved benefit plan.

8 NEW SECTION. **Sec. 434.** ANNUAL STATEMENT FILING--CONTENTS--PENALTY
9 FOR FAILURE TO FILE--ACCURACY REQUIRED. (1) Every certified health
10 plan shall annually not later than March 1 of the calendar year, file
11 with the insurance commissioner a statement verified by at least two of
12 its principal officers showing its financial condition as of December
13 31 of the preceding year.
14 (2) Such annual report shall be in such form as the insurance
15 commissioner shall prescribe and shall include:
16 (a) A financial statement of the certified health plan, including
17 its balance sheet and receipts and disbursements for the preceding
18 year, which reflects at a minimum;
19 (i) All prepayments and other payments received for health care
20 services rendered pursuant to certified health plan benefit packages;
21 (ii) Expenditures to all categories of health care facilities,
22 providers, and organizations with which the plan has contracted to
23 fulfill obligations to enrolled residents arising out of the uniform
24 benefits package and other approved supplemental benefit agreements,
25 together with all other direct expenses including depreciation,
26 enrollment, and commission; and
27 (iii) Expenditures for capital improvements, or additions thereto,
28 including but not limited to construction, renovation, or purchase of
29 facilities and capital equipment;
30 (b) A report of the names and addresses of all officers, directors,
31 or trustees of the certified health plan during the preceding year, and
32 the amount of wages, expense reimbursements, or other payments to such
33 individuals. For partnership and professional service corporations, a
34 report shall be made for partners or shareholders as to any
35 compensation or expense reimbursement received by them for services,
36 other than for services and expenses relating directly for patient
37 care;

(c) The number of residents enrolled and terminated during the report period. Additional information regarding the enrollment and termination pattern for a certified health plan may be required by the commissioner to demonstrate compliance with the open enrollment and free access requirements of chapter . . ., Laws of 1993 (this act). The insurance commissioner shall specify additional information to be reported, which may include but not be limited to age, sex, location, and health status information;

(d) Such other information relating to the performance of the certified health plan or the health care facilities or providers with which it has contracted as reasonably necessary to the proper and effective administration of this chapter in accordance with rules;

(e) Disclosure of any financial interests held by officers and directors in any providers associated with the certified health plan or provider of the certified health plan.

(3) The commissioner may require quarterly reporting of financial information, such information to be furnished in a format prescribed by the commissioner in consultation with the commission.

(4) The commissioner may for good reason allow a reasonable extension of time within which such annual statement shall be filed.

(5) The commissioner may suspend or revoke the certificate of a certified health plan for failing to file its annual statement when due or during any extension of time therefor that the commissioner, for good cause, may grant.

(6) The commissioner shall publish and make available to the health services commission and the major newspapers of the state an annual summary report of at least the information required in subsections (2) and (3) of this section.

(7) No person may knowingly file with any public official or knowingly make, publish, or disseminate any financial statement of a certified health plan that does not accurately state the certified health plan's financial condition.

NEW SECTION. **Sec. 435.** PENALTY FOR VIOLATIONS. A certified health plan that, or person who, violates any provision of this chapter is guilty of a gross misdemeanor, unless the penalty is otherwise specifically provided.

NEW SECTION. **Sec. 436.** PROVIDER CONTRACTS--ENROLLED RESIDENT'S LIABILITY, COMMISSIONER'S REVIEW. (1) Subject to subsection (2) of this section, every contract between a certified health plan and its providers of health care services shall be in writing and shall set forth that in the event the certified health plan fails to pay for health care services as set forth in the uniform benefits package, the enrollee is not liable to the provider for any sums owed by the certified health plan. Every such contract shall provide that this requirement shall survive termination of the contract.

(2) The provisions of subsection (1) of this section shall not apply to emergency care from a provider who is not a contracting provider with the certified health plan, or to emergent and urgently needed out-of-area services.

(3) The certified health plan shall file the contracts with the insurance commissioner for approval thirty days prior to use.

NEW SECTION. **Sec. 437.** MINIMUM NET WORTH--REQUIREMENTS TO MAINTAIN--DETERMINATION OF AMOUNT. (1) Every certified health plan must maintain a minimum net worth equal to the greater of:

(a) One million dollars; or

(b) Two percent of annual premium revenues as reported on the most recent annual financial statement filed with the insurance commissioner on the first one hundred fifty million dollars of premium and one percent of annual premium on the premium in excess of one hundred fifty million dollars; or

(c) An amount equal to the sum of three months' uncovered expenditures as reported on the most recent financial statement filed with the commissioner.

(2)(a) In determining net worth, no debt may be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. An interest obligation relating to the repayment of a subordinated debt must be similarly subordinated.

(b) The interest expenses relating to the repayment of a fully subordinated debt may not be considered uncovered expenditures.

(c) A subordinated debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the insurance commissioner, may not be considered a liability and shall be recorded as equity.

1 (3) Every certified health plan shall, in determining liabilities,
2 include an amount estimated in the aggregate to provide for unearned
3 premiums and for the payment of claims for health care expenditures
4 that have been incurred, whether reported or unreported, that are
5 unpaid and for which such organization is or may be liable and to
6 provide for the expense of adjustment or settlement of such claims.
7 The claims shall be computed in accordance with rules adopted by
8 the insurance commissioner in consultation with the health services
9 commission.

10 NEW SECTION. **Sec. 438.** FUNDED RESERVE REQUIREMENTS. (1) Each
11 certified health plan obtaining certification from the insurance
12 commissioner under sections 426 through 443 of this act shall provide
13 and maintain a funded reserve of one hundred fifty thousand dollars.
14 The funded reserve shall be deposited with the insurance commissioner
15 or with any organization acceptable to the commissioner in the form of
16 cash, securities eligible for investment under chapter 48.13 RCW,
17 approved surety bond, or any combination of these, and must be equal to
18 or exceed one hundred fifty thousand dollars. The funded reserve shall
19 be established as an assurance that the uncovered expenditures
20 obligations of the certified health plan to the enrolled Washington
21 residents shall be performed.
22 (2) All income from reserves on deposit with the commissioner shall
23 belong to the depositing certified health plan and shall be paid to it
24 as it becomes available.
25 (3) Funded reserves required by this section shall be considered an
26 asset in determining the plan's net worth.

27 NEW SECTION. **Sec. 439.** EXAMINATION OF CERTIFIED HEALTH PLANS,
28 POWERS OF COMMISSIONER, DUTIES OF PLANS, INDEPENDENT AUDIT REPORTS.
29 (1) The insurance commissioner shall make an examination of the
30 operations of a certified health plan as often as the commissioner
31 deems it necessary in order to assure the financial security and health
32 and safety of the enrolled residents. The insurance commissioner shall
33 make an examination of a certified health plan not less than once every
34 three calendar years.
35 (2) Every certified health plan shall submit its books and records
36 relating to its operation for financial condition and market conduct
37 examinations and in every way facilitate them. The quality or

appropriateness of medical services and systems shall be examined by the department of health except that the insurance commissioner may review such areas to the extent that such items impact the financial condition or the market conduct of the certified health plan. For the purpose of the examinations the insurance commissioner may issue subpoenas, administer oaths, and examine the officers and principals of the certified health plans concerning their business.

(3) The insurance commissioner may elect to accept and rely on audit reports made by an independent certified public accountant for the certified health plan in the course of that part of the insurance commissioner's examination covering the same general subject matter as the audit. The commissioner may incorporate the audit report in his or her report of the examination.

(4) Certified health plans shall be equitably assessed to cover the cost of financial condition and market conduct examinations, the costs of adopting rules, and the costs of enforcing the provisions of this chapter. The assessments shall be levied not less frequently than once every twelve months and shall be in an amount expected to fund the examinations, adoption of rules, and enforcement of the provisions of this chapter including a reasonable margin for cost variations. The assessments shall be established by rules adopted by the commissioner in consultation with the health services commission but may not exceed five and one-half cents per month per resident enrolled in the certified health plan. The minimum assessment shall be one thousand dollars. Assessment receipts shall be deposited in the insurance commissioner's regulatory account in the state treasury and shall be used for the purpose of funding the examinations authorized in subsection (1) of this section. Assessments received shall be used to pay a pro rata share of the costs, including overhead of regulating certified health plans. Amounts remaining in the separate account at the end of a biennium shall be applied to reduce the assessments in succeeding biennia.

NEW SECTION. **Sec. 440.** INSOLVENCY--COMMISSIONER'S DUTIES, CONTINUATION OF BENEFITS, ALLOCATION OF COVERAGE. (1) In the event of insolvency of a certified health plan and upon order of the commissioner, all other certified health plans shall offer the enrolled Washington residents of the insolvent certified health plan the opportunity to enroll in a solvent certified health plan. Enrollment

shall be without prejudice for any preexisting condition and shall be continuous provided the resident enrolls in the new certified health plan within thirty days of the date of insolvency and otherwise complies with the certified health plan's managed care procedures within the thirty-day open enrollment period.

(2) The insurance commissioner, in consultation with the health services commission, shall establish guidelines for the equitable distribution of the insolvent certified health plan's enrollees to the remaining certified health plans. The guidelines may include limitations to enrollment based on financial conditions, provider delivery network, administrative capabilities of the certified health plan, and other reasonable measures of the certified health plan's ability to provide benefits to the newly enrolled residents.

(3) Each certified health plan shall have a plan for handling insolvency that allows for continuation of benefits for the duration of the coverage period for which premiums have been paid and continuation of benefits to enrolled Washington residents who are confined on the date of insolvency in an inpatient facility until their discharge or transfer to a new certified health plan as provided in subsection (1) of this section. The plan shall be approved by the insurance commissioner at the time of certification and shall be submitted for review and approval on an annual basis. The commissioner shall approve such a plan if it includes:

(a) Insurance to cover the expenses to be paid for continued benefits after insolvency;

(b) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the certified health plan's insolvency for which premium payment has been made and until the enrolled participant is transferred to a new certified health plan in accordance with subsection (1) of this section. Such extension of coverage shall not obligate the provider of service beyond thirty days following the date of insolvency;

(c) Use of the funded reserve requirements as provided under section 438 of this act;

(d) Acceptable letters of credit or approved surety bonds; or

(e) Other arrangements the insurance commissioner and certified health plan mutually agree are appropriate to assure that benefits are continued.

1 NEW SECTION. **Sec. 441.** FINANCIAL FAILURE, SUPERVISION OF
2 COMMISSIONER--PRIORITY OF DISTRIBUTION OF ASSETS. (1) Any
3 rehabilitation, liquidation, or conservation of a certified health plan
4 shall be deemed to be the rehabilitation, liquidation, or conservation
5 of an insurance company and shall be conducted under the supervision of
6 the insurance commissioner under the law governing the rehabilitation,
7 liquidation, or conservation of insurance companies. The insurance
8 commissioner may apply for an order directing the insurance
9 commissioner to rehabilitate, liquidate, or conserve a certified health
10 plan upon one or more of the grounds set forth in RCW 48.31.030,
11 48.31.050, and 48.31.080. Enrolled residents shall have the same
12 priority in the event of liquidation or rehabilitation as the law
13 provides to policyholders of an insurer.
14 (2) For purposes of determining the priority of distribution of
15 general assets, claims of enrolled residents and their dependents shall
16 have the same priority as established by RCW 48.31.280 for
17 policyholders and their dependents of insurance companies. If an
18 enrolled resident is liable to a provider for services under and
19 covered by a certified health plan, that liability shall have the
20 status of an enrolled resident claim for distribution of general
21 assets.
22 (3) A provider who is obligated by statute or agreement to hold
23 enrolled residents harmless from liability for services provided under
24 and covered by a certified health plan shall have a priority of
25 distribution of the general assets immediately following that of
26 enrolled residents and enrolled residents' dependents as described in
27 this section, and immediately proceeding the priority of distribution
28 described in RCW 48.31.280(2)(e).

29 NEW SECTION. **Sec. 442.** GRIEVANCE PROCEDURE. A certified health
30 plan shall establish and maintain a grievance procedure approved by the
31 commissioner, to provide a reasonable and effective resolution of
32 complaints initiated by enrolled Washington residents concerning any
33 matter relating to the provision of benefits under the uniform benefits
34 package, access to health care services, and quality of services. Each
35 certified health plan shall respond to complaints filed with the
36 insurance commissioner within twenty working days. The insurance
37 commissioner in consultation with the health care commission shall
38 establish standards for grievance procedures and resolution.

1 NEW SECTION. **Sec. 443.** EXEMPTION. The provisions of sections 431
2 through 442 of this act do not apply to any disability insurance
3 company, health care service contractor, or health maintenance
4 organization authorized to do business in Washington.

5 NEW SECTION. **Sec. 444.** ENFORCEMENT AUTHORITY OF COMMISSIONER.
6 For the purposes of chapter . . ., Laws of 1993 (this act), the
7 insurance commissioner shall have the same powers and duties of
8 enforcement as are provided in Title 48 RCW.

9 NEW SECTION. **Sec. 445.** ANNUAL REPORT BY THE INSURANCE
10 COMMISSIONER TO THE HEALTH SERVICES COMMISSION. Beginning January 1,
11 1997, the insurance commissioner shall report annually to the health
12 services commission on the compliance of certified health plans and
13 health insurance purchasing cooperatives with the provisions of chapter
14 . . ., Laws of 1993 (this act). The report shall include information
15 on (1) compliance with chapter . . ., Laws of 1993 (this act) open
16 enrollment and antidiscrimination provisions, (2) financial solvency
17 requirements, (3) the mix of enrollee characteristics within and among
18 plans and groups including age, sex, ethnicity, and any easily
19 obtainable information related to medical risk, (4) the geographic
20 distribution of plans and groups, and (5) other information which the
21 commission may request consistent with the goals of chapter . . ., Laws
22 of 1993 (this act).

23 **F. MANAGED COMPETITION AND LIMITED ANTI-TRUST IMMUNITY**

24 NEW SECTION. **Sec. 446.** MANAGED COMPETITION FINDINGS AND INTENT.
25 (1) The legislature recognizes that competition among health care
26 providers, facilities, payers, and purchasers will yield the best
27 allocation of health care resources, the lowest prices for health care,
28 and the highest quality of health care when there exists a large number
29 of buyers and sellers, easily comparable health care plans and
30 services, minimal barriers to entry and exit into the health care
31 market, and adequate information for buyers and sellers to base
32 purchasing and production decisions. However, the legislature finds
33 that purchasers of health care services and health care coverage do not
34 have adequate information upon which to base purchasing decisions; that
35 health care facilities and providers of health care services face legal

1 and market disincentives to develop economies of scale or to provide
2 the most cost-efficient and efficacious service; that health insurers,
3 contractors, and health maintenance organizations face market
4 disincentives in providing health care coverage to those Washington
5 residents with the most need for health care coverage; and that
6 potential competitors in the provision of health care coverage bear
7 unequal burdens in entering the market for health care coverage.
8 (2) The legislature therefore intends to exempt from state anti-
9 trust laws, and to provide immunity from federal anti-trust laws
10 through the state action doctrine for activities approved under this
11 chapter that might otherwise be constrained by such laws and intends to
12 displace competition in the health care market: To contain the
13 aggregate cost of health care services; to promote the development of
14 comprehensive, integrated, and cost-effective health care delivery
15 systems through cooperative activities among health care providers and
16 facilities; to promote comparability of health care coverage; to
17 improve the cost-effectiveness in providing health care coverage
18 relative to health promotion, disease prevention, and the amelioration
19 or cure of illness; to assure universal access to a publicly
20 determined, uniform package of health care benefits; and to create
21 reasonable equity in the distribution of funds, treatment, and medical
22 risk among purchasers of health care coverage, payers of health care
23 services, providers of health care services, health care facilities,
24 and Washington residents. To these ends, any lawful action taken
25 pursuant to chapter . . ., Laws of 1993 (this act) by any person or
26 entity created or regulated by chapter . . ., Laws of 1993 (this act)
27 are declared to be taken pursuant to state statute and in furtherance
28 of the public purposes of the state of Washington.
29 (3) The legislature does not intend and unless explicitly permitted
30 in accordance with section 447 of this act or under rules adopted
31 pursuant to chapter . . ., Laws of 1993 (this act), does not authorize
32 any person or entity to engage in activities or to conspire to engage
33 in activities that would constitute per se violations of state and
34 federal anti-trust laws including but not limited to conspiracies or
35 agreements:
36 (a) Among competing health care providers not to grant discounts,
37 not to provide services, or to fix the price of their services;
38 (b) Among certified health plans as to the price or level of
39 reimbursement for health care services;

1 (c) Among certified health plans to boycott a group or class of
2 health care service providers;
3 (d) Among purchasers of certified health plan coverage to boycott
4 a particular plan or class of plans;
5 (e) Among certified health plans to divide the market for health
6 care coverage; or
7 (f) Among certified health plans and purchasers to attract or
8 discourage enrollment of any Washington resident or groups of residents
9 in a certified health plan based upon the perceived or actual risk of
10 loss in including such resident or group of residents in a certified
11 health plan or purchasing group.

12 NEW SECTION. **Sec. 447.** COMPETITIVE OVERSIGHT AND ANTI-TRUST
13 IMMUNITY. (1) A certified health plan, health care facility, health
14 care provider, or other person involved in the development, delivery,
15 or marketing of health care or certified health plans may request, in
16 writing, that the attorney general issue an informal opinion as to
17 whether particular conduct is authorized by chapter . . ., Laws of 1993
18 (this act). The attorney general shall issue such opinion within
19 thirty days of receipt of a written request for an opinion or within
20 thirty days of receipt of any additional information requested by the
21 attorney general necessary for rendering an opinion. If the attorney
22 general concludes that such conduct is not authorized by chapter . . .,
23 Laws of 1993 (this act), the person or organization making the request
24 may petition the commission for review and approval of such conduct in
25 accordance with subsection (3) of this section.
26 (2) With the approval of the attorney general, the health services
27 commission:
28 (a) May authorize conduct by a certified health plan, health care
29 facility, health care provider, or any other person that could tend to
30 lessen competition in the relevant market upon a strong showing that
31 the conduct is likely to achieve the policy goals of chapter . . .,
32 Laws of 1993 (this act) and a more competitive alternative is
33 impractical;
34 (b) Shall adopt rules governing conduct among providers, health
35 care facilities, and certified health plans including rules governing
36 provider and facility contracts with certified health plans, rules
37 governing the use of "most favored nation" clauses and exclusive
38 dealing clauses in such contracts, and rules providing that certified

1 health plans in rural areas contract with a sufficient number and type
2 of health care providers and facilities to ensure consumer access to
3 local health care services;
4 (c) Shall adopt rules permitting health care providers within the
5 service area of a plan to collectively negotiate the terms and
6 conditions of contracts with a certified health plan including the
7 ability of providers to meet and communicate for the purposes of these
8 negotiations; and
9 (d) Shall adopt rules governing cooperative activities among health
10 care facilities and providers.
11 (3) A certified health plan, health care facility, health care
12 provider, or any other person involved in the development, delivery,
13 and marketing of health services or certified health plans may file a
14 written petition with the commission requesting approval of conduct
15 that could tend to lessen competition in the relevant market. Such
16 petition shall be filed in a form and manner prescribed by rule of the
17 commission.
18 The commission shall issue a written decision approving or denying
19 a petition filed under this section within ninety days of receipt of a
20 properly completed written petition. The decision shall set forth
21 findings as to benefits and disadvantages and conclusions as to whether
22 the benefits outweigh the disadvantages.
23 (4) In authorizing conduct and adopting rules of conduct under this
24 section, the commission with the advice of the attorney general, shall
25 consider the benefits of such conduct in furthering the goals of health
26 care reform including but not limited to:
27 (a) Enhancement of the quality of health services to consumers;
28 (b) Gains in cost efficiency of health services;
29 (c) Improvements in utilization of health services and equipment;
30 (d) Avoidance of duplication of health services resources; or
31 (e) And as to subsections (b) and (c) of this subsection: (i)
32 Facilitates the exchange of information relating to performance
33 expectations; (ii) simplifies the negotiation of delivery arrangements
34 and relationships; and (iii) reduces the transactions costs on the part
35 of certified health plans and providers in negotiating more cost
36 effective delivery arrangements.
37 These benefits must outweigh disadvantages including and not
38 limited to:

1 (i) Reduced competition among certified health plans, health care
2 providers, or health care facilities;
3 (ii) Adverse impact on quality, availability, or price of health
4 care services to consumers; or
5 (iii) The availability of arrangements less restrictive to
6 competition that achieve the same benefits.
7 (5) Conduct authorized by the commission shall be deemed taken
8 pursuant to state statute and in the furtherance of the public purposes
9 of the state of Washington.
10 (6) With the assistance of the attorney general's office, the
11 commission shall actively supervise any conduct authorized under this
12 section to determine whether such conduct or rules permitting certain
13 conduct should be continued and whether a more competitive alternative
14 is practical. The commission shall periodically review petitioned
15 conduct through, at least, annual progress reports from petitioners,
16 annual or more frequent reviews by the commission that evaluate whether
17 the conduct is consistent with the petition, and whether the benefits
18 continue to outweigh any disadvantages. If the commission determines
19 that the likely benefits of any conduct approved through rule,
20 petition, or otherwise by the commission no longer outweigh the
21 disadvantages attributable to potential reduction in competition, the
22 commission shall order a modification or discontinuance of such
23 conduct. Conduct ordered discontinued by the commission shall no
24 longer be deemed to be taken pursuant to state statute and in the
25 furtherance of the public purposes of the state of Washington.
26 (7) Nothing contained in chapter . . ., Laws of 1993 (this act) is
27 intended to in any way limit the ability of rural hospital districts to
28 enter into cooperative agreements and contracts pursuant to RCW
29 70.44.450 and chapter 39.34 RCW.

30 **G. THE UNIFORM BENEFITS PACKAGE**

31 NEW SECTION. **Sec. 448.** UNIFORM BENEFITS PACKAGE DESIGN. (1) The
32 commission shall define the uniform benefits package, which shall
33 include those health services that, consistent with the goals and
34 intent of chapter . . ., Laws of 1993 (this act), are effective and
35 necessary on a societal basis for the maintenance of the health of
36 citizens of the state, weighed against the need to control state health
37 services expenditures.

(2) The schedule of covered health services shall emphasize proven preventive and primary health care and shall include primary and specialty health services; inpatient and outpatient hospital services; prescription drugs and medications; reproductive services; services necessary for maternity and well-child care, including preventive dental services for children; chemical dependency services; case managed mental health services; short-term skilled nursing facility, home health, and hospice services, subject to preapproval; and other services deemed necessary by the commission. The commission shall determine the specific schedule of health services within the uniform benefits package, including limitations on scope and duration of services. The commission shall consider the recommendations of health services effectiveness panels established pursuant to section 404 of this act in defining the uniform benefits package.

(3) The uniform benefits package shall not limit coverage for preexisting or prior conditions, except that the commission shall establish exclusions for preexisting or prior conditions to the extent necessary to prevent residents from waiting until health services are needed before enrolling in a certified health plan.

(4) The commission shall establish a schedule of enrollee point of service cost-sharing for nonpreventive health services, related to enrollee household income, such that financial considerations are not a barrier to access for low-income persons, but that, for those of means, the uniform benefits package provides for moderate point of service cost-sharing. All point of service cost-sharing and cost control requirements shall apply uniformly to all health care providers providing substantially similar uniform benefits package services. The schedule shall provide for an alternate and lower schedule of cost-sharing applicable to enrollees with household income below the federal poverty level.

(5) The commission shall adopt rules related to coordination of benefits where a resident has duplicate coverage. The rules shall not have the effect of eliminating enrollee premium sharing or point of service cost-sharing. The commission shall endeavor to assure an equitable distribution, among both employers and employees, of the costs of coverage for those households composed of more than one member in the work force.

(6) In determining the uniform benefits package, the commission shall endeavor to seek the opinions of and information from the public.

The commission shall consider the results of official public health assessment and policy development activities including recommendations of the department of health in discharging its responsibilities under this section.

(7) The commission shall submit the following to the legislature by December 1, 1994, and annually thereafter: (a) The uniform benefits package and any changes it may wish to make; (b) an independent actuarial analysis of the cost of the proposed package giving consideration to the factors enumerated in section 406(6) of this act; (c) a small business economic impact statement, to be prepared in consultation with the small business advisory committee, surveying each individual small business to describe the economic impact on their small business of providing the uniform benefits package to employees and dependents; and (d) if the small business economic impact statement indicates a need for assistance to small businesses, recommended mechanisms to offer such assistance. In developing its recommendations, the commission shall evaluate the potential effectiveness of business and occupation tax credits, a small business assistance fund, and any other mechanism deemed appropriate by the commission.

NEW SECTION. **Sec. 449.** SUPPLEMENTAL BENEFIT PACKAGES DESIGN. The commission shall define several supplemental benefits packages, which shall include those health services that, consistent with the goals and intent of chapter . . ., Laws of 1993 (this act), are desirable to expand the available health services defined in the uniform benefits package. Such supplemental benefit packages must be offered only by certified health plans and must be designed in conformance with the procedures and requirements for the design of the uniform benefits package under section 448 of this act.

(1) Such packages may not combine medical and dental services together, but the commission may design complementary packages that include each kind of service and that may be offered together by a certified health plan. A certified health plan that offers a supplemental benefits package containing only dental services is subject to section 427 of this act only in the sale of such package to the Washington state health care authority.

(2) In designing such supplemental benefits packages, the commission shall consider the approach taken by congress and federal

1 agencies in regulating the offering and design of medicare supplemental
2 health insurance policies and the commission shall develop a regulatory
3 method to ensure that pricing of such supplemental benefits packages is
4 consistent with the maximum premium requirements for the uniform
5 benefits package under section 406(6) of this act.

6 NEW SECTION. **Sec. 450.** The legislature may disapprove of the
7 packages developed under sections 448 and 449 of this act and medical
8 risk adjustment mechanisms developed under section 406(8) of this act
9 by an act of law at any time prior to the thirtieth day of the
10 following regular legislative session. If such disapproval action is
11 taken, the commission shall resubmit modified packages to the
12 legislature within fifteen days of the disapproval. If the legislature
13 does not disapprove the packages or modify them by an act of law by the
14 end of that regular session, they are deemed approved.

15 NEW SECTION. **Sec. 451.** LONG-TERM CARE INTEGRATION PLAN. (1) To
16 meet the health needs of the residents of Washington state, it is
17 critical to finance and provide long-term care and support services
18 through an integrated, comprehensive system that promotes human dignity
19 and recognizes the individuality of all functionally disabled persons.
20 This system shall be available, accessible, and responsive to all
21 residents based upon an assessment of their functional disabilities.
22 The governor and the legislature recognize that families, volunteers,
23 and community organizations are essential for the delivery of effective
24 and efficient long-term care and support services, and that this
25 private and public service infrastructure should be supported and
26 strengthened. Further, it is important to provide benefits without
27 requiring family or program beneficiary impoverishment for service
28 eligibility.
29 (2) To realize the need for a strong long-term care system and to
30 carry out the November 30, 1992, final recommendations of the
31 Washington health care commission related to long-term care, the
32 commission shall:
33 (a) Engage in a planning process, in conjunction with an advisory
34 committee appointed for this purpose, for the inclusion of long-term
35 care services in the uniform benefits package established under section
36 448 of this act as soon as practicable, but not later than July 1998;

(b) Include in its planning process consideration of the scope of services to be covered, the cost of and financing of such coverage, the means through which existing long-term care programs and delivery systems can be coordinated and integrated, and the means through which family members can be supported in their role as informal caregivers for their parents, spouses, or other relatives.

(3) The commission shall submit recommendations concerning any necessary statutory changes or modifications of public policy to the governor and the legislature by January 1, 1995.

(4) The departments of health, retirement systems, revenue, social and health services, and veterans' affairs, the offices of financial management, insurance commissioner, and state actuary, along with the health care authority, shall participate in the review of the long-term care needs enumerated in this section and provide necessary supporting documentation and staff expertise as requested by the commission.

(5) The commission shall include in its planning process, the development of two social health maintenance organization long-term care pilot projects. The two pilot projects shall be referred to as the Washington life care pilot projects. Each life care pilot program shall be a single-entry system administered by an individual organization that is responsible for bringing together a full range of medical and long-term care services. The commission, in coordination with the appropriate agencies and departments, shall establish a Washington life care benefits package that shall include the uniform benefits package established in chapter . . ., Laws of 1993 (this act) and long-term care services. The Washington life care benefits package shall include, but not be limited to, the following long-term care services: Case management, intake and assessment, nursing home care, adult family home care, home health and home health aide care, hospice, chore services/homemaker/personal care, adult day care, respite care, and appropriate social services. The pilot project shall develop assessment and case management protocol that emphasize home and community-based care long-term care options.

(a) In designing the pilot projects, the commission shall address the following issues: Costs for the long-term care benefits, a projected case-mix based upon disability, the required federal waiver package, reimbursement, capitation methodology, marketing and enrollment, management information systems, identification of the most appropriate case management models, provider contracts, and the

1 preferred organizational design that will serve as a functioning model
2 for efficiently and effectively transitioning long-term care services
3 into the uniform benefits package established in chapter . . ., Laws of
4 1993 (this act). The commission shall also be responsible for
5 establishing the size of the two membership pools.
6 (b) Each program shall enroll applicants based on their level of
7 functional disability and personal care needs. The distribution of
8 these functional level categories and ethnicity within the enrolled
9 program population shall be representative of their distribution within
10 the community, using the best available data to estimate the community
11 distributions.
12 (c) The two sites selected for the Washington life care pilot
13 program shall be drawn from the largest urban areas and include one
14 site in the eastern part of the state and one site in the western part
15 of the state. The two organizations selected to manage and coordinate
16 the life care services shall have the proven ability to provide
17 ambulatory care, personal care/chore services, dental care, case
18 management and referral services, must be accredited and licensed to
19 provide long-term care for home health services, and may be licensed to
20 provide nursing home care.
21 (d) The report on the development and establishment date of the two
22 social health maintenance organizations shall be submitted to the
23 governor and appropriate committees of the legislature by September 16,
24 1994. If the necessary federal waivers cannot be secured by January 1,
25 1995, the commission may elect to not establish the two pilot programs.

26 NEW SECTION. **Sec. 452.** SUPPLEMENTAL AND ADDITIONAL BENEFITS
27 NEGOTIATION. (1) Nothing in chapter . . ., Laws of 1993 (this act)
28 shall preclude insurers, health care service contractors, health
29 maintenance organizations, or certified health plans from insuring,
30 providing, or contracting for additional benefits not included in the
31 uniform benefits package or in supplemental benefits packages designed
32 by the commission.
33 (2) Nothing in chapter . . ., Laws of 1993 (this act) shall
34 restrict the right of an employer to offer, an employee representative
35 to negotiate for, or an individual to purchase supplemental or
36 additional benefits not included in the uniform benefits package.
37 (3) Nothing in chapter . . ., Laws of 1993 (this act) shall
38 restrict the right of an employer to offer or an employee

1 representative to negotiate for payment of up to one hundred percent of
2 the premium of the lowest priced uniform benefits package available in
3 the geographic area where the employer is located.
4 (4) Pending receipt of necessary federal waivers, nothing in
5 chapter . . ., Laws of 1993 (this act) shall be construed to limit the
6 collective bargaining rights of employee organizations under state or
7 federal law.

8 NEW SECTION. **Sec. 453.** CONSCIENCE OR RELIGION. (1) No certified
9 health plan or health care provider may be required by law or contract
10 in any circumstances to participate in the provision of any uniform
11 benefit if they object to so doing for reason of conscience or
12 religion. No person may be discriminated against in employment or
13 professional privileges because of such objection.
14 (2) The provisions of this section are not intended to result in an
15 enrollee being denied timely access to any service included in the
16 uniform benefits package. Each certified health plan shall:
17 (a) Provide written notice to certified health plan enrollees, upon
18 enrollment with the plan and upon enrollee request thereafter, listing,
19 by provider, services that any provider refuses to perform for reason
20 of conscience or religion;
21 (b) Develop written information describing how an enrollee may
22 directly access, in an expeditious manner, services that a provider
23 refuses to perform; and
24 (c) Ensure that enrollees refused services under this section have
25 prompt access to the information developed pursuant to (b) of this
26 subsection.

27 **H. STATE RESIDENT AND EMPLOYER PARTICIPATION**

28 NEW SECTION. **Sec. 454.** INDIVIDUAL PARTICIPATION. (1) All
29 residents of the state of Washington are required to purchase a uniform
30 benefits package from a certified health plan no later than July 1,
31 1998. This participation requirement shall be waived if imposition of
32 the requirement would constitute a violation of the freedom of religion
33 provisions set forth in the First Amendment, United States Constitution
34 or Article I, section 11 of the state Constitution. Residents of the
35 state of Washington who work in another state for an out-of-state
36 employer shall be deemed to have satisfied the requirements of this

section if they receive health insurance coverage through such employer.

(2) The commission shall monitor the enrollment of individuals into certified health plans and shall make public periodic reports concerning the number of persons enrolled and not enrolled, the reasons why individuals are not enrolled, recommendations to reduce the number of persons not enrolled, and recommendations regarding enforcement of this provision.

NEW SECTION. **Sec. 455.** EMPLOYER PARTICIPATION. (1) The legislature recognizes that small businesses play an essential and increasingly important role in the state's economy. The legislature further recognizes that many of the state's small business owners provide health insurance to their employees through small group policies at a cost that directly affects their profitability. Other small business owners are prevented from providing health benefits to their employees by the lack of access to affordable health insurance coverage. The legislature intends that the provisions of chapter . . ., Laws of 1993 (this act) make health insurance more available and affordable to small businesses in Washington state through strong cost control mechanisms and the option to purchase health benefits through the basic health plan, the Washington state group purchasing association, and health insurance purchasing cooperatives.

(2) In defining the level of mandated employer participation under this section, the commission shall consider the impact of such participation on the financial well-being of the state's employers. In its deliberations, the commission shall evaluate the following:

(a) Whether employers' premium payments should be related to the number of qualified employees the business employs;

(b) Whether different levels of employer premium payments should be applied to employees and dependents;

(c) The profitability of small businesses in Washington state; and

(d) Any other factors deemed necessary by the commission.

(3) On July 1, 1995, every employer employing more than five hundred qualified employees shall:

(a) Offer a choice of the uniform benefits package as provided by at least three available certified health plans, one of which shall be the lowest cost available package within their geographic region, to all qualified employees. The employer shall be required to pay no less

1 than fifty percent and no more than ninety-five percent of the premium
2 cost of the lowest cost available package within their geographic
3 region. On July 1, 1996, all dependents of qualified employees of
4 these firms shall be offered a choice of packages as provided in this
5 section with the employer paying no less than fifty percent and no more
6 than ninety-five percent of the premium of the lowest cost package
7 within their geographic region.
8 (b) For employees who work less than thirty hours during a week or
9 one hundred twenty hours during a calendar month, and their dependents,
10 pay the amount resulting from application of the following formula:
11 The number of hours worked by the employee in a month is multiplied by
12 the amount of a qualified employee's premium, and that amount is then
13 divided by one hundred twenty.
14 (c) If an employee under (b) of this subsection is the dependent of
15 a qualified employee, and is therefore covered as a dependent by the
16 qualified employee's employer, then the employer of the employee under
17 (b) of this subsection shall not be required to participate in the cost
18 of the uniform benefits package for that employee.
19 (d) If an employee working on a seasonal basis is a qualified
20 employee of another employer, and therefore has uniform benefits
21 package coverage through that primary employer, then the seasonal
22 employer of the employee shall not be required to participate in the
23 cost of the uniform benefits package for that employee.
24 (4) By July 1, 1996, every employer employing more than one hundred
25 qualified employees shall:
26 (a) Offer a choice of the uniform benefits package as provided by
27 at least three available certified health plans, one of which shall be
28 the lowest cost available package within their geographic region, to
29 all qualified employees. The employer shall be required to pay no less
30 than fifty percent and no more than ninety-five percent of the premium
31 cost of the lowest cost available package within their geographic
32 region. On July 1, 1997, all dependents of qualified employees in
33 these firms shall be offered a choice of packages as provided in this
34 section with the employer paying no less than fifty percent and no more
35 than ninety-five percent of the premium of the lowest cost package
36 within their geographic region.
37 (b) For employees who work less than thirty hours during a week or
38 one hundred twenty hours during a calendar month, and their dependents,
39 pay the amount resulting from application of the following formula:

1 The number of hours worked by the employee in a month is multiplied by
2 the amount of a qualified employee's premium, and that amount is then
3 divided by one hundred twenty.

4 (c) If an employee under (b) of this subsection is the dependent of
5 a qualified employee, and is therefore covered as a dependent by the
6 qualified employee's employer, then the employer of the employee under
7 (b) of this subsection shall not be required to participate in the cost
8 of the uniform benefits package for that employee.

9 (d) If an employee working on a seasonal basis is a qualified
10 employee of another employer, and therefore has uniform benefits
11 package coverage through that primary employer, then the seasonal
12 employer of the employee shall not be required to participate in the
13 cost of the uniform benefits package for that employee.

14 (5) By July 1, 1997, every employer shall:

15 (a) Offer a choice of the uniform benefits package as provided by
16 at least three available certified health plans, one of which shall be
17 the lowest cost available package within their geographic region, to
18 all qualified employees. The employer shall be required to pay no less
19 than fifty percent and no more than ninety-five percent of the premium
20 cost of the lowest cost available package within their geographic
21 region. On July 1, 1998, all dependents of qualified employees in all
22 firms shall be offered a choice of packages as provided in this section
23 with the employer paying no less than fifty percent and no more than
24 ninety-five percent of the premium of the lowest cost package within
25 their geographic region.

26 (b) For employees who work less than thirty hours during a week or
27 one hundred twenty hours during a calendar month, and their dependents,
28 pay the amount resulting from application of the following formula:
29 The number of hours worked by the employee in a month is multiplied by
30 the amount of a qualified employee's premium, and that amount is then
31 divided by one hundred twenty.

32 (c) If an employee under (b) of this subsection is the dependent of
33 a qualified employee, and is therefore covered as a dependent by the
34 qualified employee's employer, then the employer of the employee under
35 (b) of this subsection shall not be required to participate in the cost
36 of the uniform benefits package for that employee.

37 (d) If an employee working on a seasonal basis is a qualified
38 employee of another employer, and therefore has uniform benefits
39 package coverage through that primary employer, then the seasonal

employer of the employee shall not be required to participate in the cost of the uniform benefits package for that employee.

(6) This employer participation requirement shall be waived if imposition of the requirement would constitute a violation of the freedom of religion provisions of the First Amendment of the United States Constitution or Article I, section 11, of the state Constitution. In such case the employer shall, pursuant to commission rules, set aside an amount equal to the applicable employer contribution level in a manner that would permit his or her employee to fully comply with the requirements of this chapter.

(7) In lieu of offering the uniform benefits package to employees and their dependents through direct contracts with certified health plans, an employer may combine the employer contribution with that of the employee's contribution and enroll in the basic health plan as provided in chapter 70.47 RCW or a health insurance purchasing cooperative established under sections 426 and 427 of this act.

(8) The commission shall submit its employer contribution levels and any changes it may wish to make to the legislature by December 1, 1994, and annually thereafter.

NEW SECTION. **Sec. 456.** SMALL FIRM FINANCIAL ASSISTANCE. (1) Beginning July 1, 1997, firms with fewer than twenty-five workers that face barriers to providing health insurance for their employees may, upon application, be eligible to receive financial assistance with funds set aside from the health services account. Firms with the following characteristics shall be given preference in the distribution of funds: (1) New firms, (2) employers with low average wages, (3) employers with low profits, and (4) firms in economically distressed areas.

(2) All employers in existence on or before July 1, 1997, who meet the criteria set forth in this section, and rules adopted under this section, may apply to the health services commission for assistance. Such employers may not receive premium assistance beyond July 1, 2001. New employers, who come into existence after July 1, 1997, may apply for and receive premium assistance for a limited period of time, as determined by the commission.

(3) The total funds available for small business assistance shall not exceed one hundred million dollars for the biennium beginning July 1, 1997. Thereafter, the amount of total funds available for premium

1 assistance shall be determined by the office of financial management,
2 based on a forecast of inflation, employment, and the number of
3 eligible firms.
4 (4) By July 1, 1997, the health services commission, with
5 assistance from the small business advisory committee established in
6 section 404 of this act, shall develop specific definitions, rules, and
7 procedures governing all aspects of the small business assistance
8 program, including application procedures, thresholds regarding firm
9 size, wages, profits, and age of firm, and rules governing duration of
10 assistance.
11 (5) Final determination of the amount of the premium assistance to
12 be dispensed to an employer shall be made by the commission based on
13 rules, definitions, and procedures developed under this section. If
14 total claims for assistance are above the amount of total funds
15 available for such purposes, the commission shall have the authority to
16 prorate employer claims so that the amount of available funds is not
17 exceeded.
18 (6) The office of financial management, in consultation with the
19 commission, shall establish appropriate criteria for monitoring and
20 evaluating the economic and labor market impacts of the premium
21 assistance program and report its findings to the commission annually
22 through July 1, 2001.

23 NEW SECTION. **Sec. 457.** The department of social and health
24 services shall from July 1, 1993, to July 1, 1998, coordinate a pilot
25 program entitled the Washington long-term care partnership, whereby
26 private insurance and medicaid funds shall be used to finance long-term
27 care. This program must allow for the exclusion of an individual's
28 assets, as approved by the federal health care financing
29 administration, in a determination of the individual's eligibility for
30 medicaid; the amount of any medicaid payment; or any subsequent
31 recovery by the state for a payment for medicaid services to the extent
32 such assets are protected by a long-term care insurance policy or
33 contract governed by chapter 48.84 RCW and meeting the criteria
34 prescribed in this chapter.

35 NEW SECTION. **Sec. 458.** The department of social and health
36 services shall seek approval and a waiver of appropriate federal
37 medicaid regulations to allow the protection of an individual's assets

1 as provided in this chapter. The department shall adopt all rules
2 necessary to implement the Washington long-term care partnership
3 program, which rules shall permit the exclusion of an individual's
4 assets in a determination of medicaid eligibility to the extent that
5 private long-term care insurance provides payment or benefits for
6 services that medicaid would approve or cover for medicaid recipients.

7 NEW SECTION. **Sec. 459.** (1) The insurance commissioner shall adopt
8 rules defining the criteria that long-term care insurance policies must
9 meet to satisfy the requirements of this chapter. The rules shall
10 provide that all long-term care insurance policies purchased for the
11 purposes of this chapter:
12 (a) Be guaranteed renewable;
13 (b) Provide coverage for home and community-based services and
14 nursing home care;
15 (c) Provide automatic inflation protection or similar coverage to
16 protect the policyholder from future increases in the cost of long-term
17 care;
18 (d) Not require prior hospitalization or confinement in a nursing
19 home as a prerequisite to receiving long-term care benefits; and
20 (e) Contain at least a six-month grace period that permits
21 reinstatement of the policy or contract retroactive to the date of
22 termination if the policy or contract holder's nonpayment of premiums
23 arose as a result of a cognitive impairment suffered by the policy or
24 contract holder as certified by a physician.
25 (2) Insurers offering long-term care policies for the purposes of
26 this chapter shall demonstrate to the satisfaction of the insurance
27 commissioner that they:
28 (a) Have procedures to provide notice to each purchaser of the
29 long-term care consumer education program;
30 (b) Offer case management services;
31 (c) Have procedures that provide for the keeping of individual
32 policy records and procedures for the explanation of coverage and
33 benefits identifying those payments or services available under the
34 policy that meet the purposes of this chapter;
35 (d) Agree to provide the insurance commissioner, on or before
36 September 1 of each year, an annual report containing the following
37 information:

(i) The number of policies issued and of the policies issued, that number sorted by issue age;

(ii) To the extent possible, the financial circumstance of the individuals covered by such policies;

(iii) The total number of claims paid; and

(iv) Of the number of claims paid, the number paid for nursing home care, for home care services, and community-based services.

NEW SECTION. **Sec. 460.** The insurance commissioner, in conjunction with the department of social and health services, shall develop a consumer education program designed to educate consumers as to the need for long-term care, methods for financing long-term care, the availability of long-term care insurance, and the availability and eligibility requirements of the asset protection program provided under this chapter.

NEW SECTION. **Sec. 461.** By January 1 of each year, the insurance commissioner, in conjunction with the department of social and health services, shall report to the legislature on the progress of the asset protection program. The report shall include:

(1) The success of the agencies in implementing the program;

(2) The number of insurers offering long-term care policies meeting the criteria for asset protection;

(3) The number, age, and financial circumstances of individuals purchasing long-term care policies meeting the criteria for asset protection;

(4) The number of individuals seeking consumer information services;

(5) The extent and type of benefits paid by insurers offering policies meeting the criteria for asset protection;

(6) Estimates of the impact of the program on present and future medicaid expenditures;

(7) The cost-effectiveness of the program; and

(8) A determination regarding the appropriateness of continuing the program.

I. PUBLIC HEALTH SERVICES IMPROVEMENT PLAN

1 <u>NEW SECTION.</u> **Sec. 462.** A new section is added to chapter 43.70
2 RCW to read as follows:
3 PUBLIC HEALTH SERVICES IMPROVEMENT PLAN. (1) The legislature finds
4 that the public health functions of community assessment, policy
5 development, and assurance of service delivery are essential elements
6 in achieving the objectives of health reform in Washington state. The
7 legislature further finds that the population-based services provided
8 by state and local health departments are cost-effective and are a
9 critical strategy for the long-term containment of health care costs.
10 The legislature further finds that the public health system in the
11 state lacks the capacity to fulfill these functions consistent with the
12 needs of a reformed health care system.
13 (2) The department of health shall develop, in consultation with
14 local health departments and districts, the state board of health, the
15 health services commission, area Indian health service, and other state
16 agencies, health services providers, and citizens concerned about
17 public health, a public health services improvement plan. The plan
18 should provide a detailed accounting of deficits in the core functions
19 of assessment, policy development, assurance of the current public
20 health system, how additional public health funding would be used, and
21 describe the benefits expected from expanded expenditures.
22 (3) The plan shall include:
23 (a) Definition of minimum standards for public health protection
24 through assessment, policy development, and assurances;
25 (i) Enumeration of communities not meeting those standards;
26 (ii) A budget and staffing plan for bringing all communities up to
27 minimum standards;
28 (iii) An analysis of the costs and benefits expected from adopting
29 minimum public health standards for assessment, policy development, and
30 assurances;
31 (b) Recommended strategies and a schedule for improving public
32 health programs throughout the state, including:
33 (i) Strategies for transferring personal health care services from
34 the public health system, into the uniform benefits package where
35 feasible; and
36 (ii) Timing of increased funding for public health services linked
37 to specific objectives for improving public health; and
38 (c) A recommended level of dedicated funding for public health
39 services to be expressed in terms of a percentage of total health

1 service expenditures in the state or a set per person amount; such
2 recommendation shall also include methods to ensure that such funding
3 does not supplant existing federal, state, and local funds received by
4 local health departments, and methods of distributing funds among local
5 health departments.

6 (4) The department shall coordinate this planning process with the
7 study activities required in section 255 of this act.

8 (5) By March 1, 1994, the department shall provide initial
9 recommendations of the public health services improvement plan to the
10 legislature regarding minimum public health standards, and public
11 health programs needed to address urgent needs, such as those cited in
12 subsection (7) of this section.

13 (6) By December 1, 1994, the department shall present the public
14 health services improvement plan to the legislature, with specific
15 recommendations for each element of the plan to be implemented over the
16 period from 1995 through 1997.

17 (7) Thereafter, the department shall update the public health
18 services improvement plan for presentation to the legislature prior to
19 the beginning of a new biennium.

20 (8) Among the specific population-based public health activities to
21 be considered in the public health services improvement plan are:
22 Health data assessment and chronic and infectious disease surveillance;
23 rapid response to outbreaks of communicable disease; efforts to prevent
24 and control specific communicable diseases, such as tuberculosis and
25 acquired immune deficiency syndrome; health education to promote
26 healthy behaviors and to reduce the prevalence of chronic disease, such
27 as those linked to the use of tobacco; access to primary care in
28 coordination with existing community and migrant health clinics and
29 other not for profit health care organizations; programs to ensure
30 children are born as healthy as possible and they receive immunizations
31 and adequate nutrition; efforts to prevent intentional and
32 unintentional injury; programs to ensure the safety of drinking water
33 and food supplies; poison control; trauma services; and other
34 activities that have the potential to improve the health of the
35 population or special populations and reduce the need for or cost of
36 health services.

37 <u>NEW SECTION.</u> **Sec. 463.** A new section is added to chapter 70.170
38 RCW to read as follows:

1 AMERICAN INDIAN HEALTH CARE DELIVERY ELEMENT. Consistent with
2 funds appropriated specifically for this purpose, the department shall
3 establish in conjunction with the area Indian health services system
4 and providers an advisory group comprised of Indian and non-Indian
5 health care facilities and providers to formulate an American Indian
6 health care delivery element for the public health services improvement
7 plan. The element shall include:
8 (1) Recommendations to providers and facilities methods for
9 coordinating and joint venturing with the Indian health services for
10 service delivery;
11 (2) Methods to improve American Indian-specific health programming;
12 and
13 (3) Creation of co-funding recommendations and opportunities for
14 the unmet health services programming needs of American Indians.

15 **J. HEALTH ACCOUNTS**

16 NEW SECTION. **Sec. 464.** HEALTH SERVICES ACCOUNT. The health
17 services account is created in the state treasury. Moneys in the
18 account may be spent only after appropriation. Moneys in the account
19 may be expended only for maintaining and expanding health services
20 access for low-income residents, maintaining and expanding the public
21 health system, maintaining and improving the capacity of the health
22 care system, containing health care costs, and the regulation,
23 planning, and administering of the health care system.

24 NEW SECTION. **Sec. 465.** PUBLIC HEALTH SERVICES ACCOUNT. The
25 public health services account is created in the state treasury.
26 Moneys in the account may be spent only after appropriation. Moneys in
27 the account may be expended only for maintaining and improving the
28 health of Washington residents through the public health system. For
29 purposes of this section, the public health system shall consist of the
30 state board of health, the state department of health, and local health
31 departments and districts.

32 NEW SECTION. **Sec. 466.** HEALTH SYSTEM CAPACITY ACCOUNT. The
33 health system capacity account is created in the state treasury.
34 Moneys in the account may be spent only after appropriation. Moneys in
35 the account may be expended for the following purposes: Health data

1 systems; health systems and public health research; health system
2 regulation; health system planning, development, and administration;
3 and improving the supply and geographic distribution of primary health
4 service providers.

5 NEW SECTION. **Sec. 467.** PERSONAL HEALTH SERVICES ACCOUNT. The
6 personal health services account is created in the treasury. Moneys in
7 the account may be spent only after appropriation. Moneys in the
8 account may be expended for the support of subsidized personal health
9 services for low-income Washington residents.

10 **K. EXCLUSIONS AND STUDIES**

11 NEW SECTION. **Sec. 468.** CODE REVISIONS AND WAIVERS. (1) The
12 commission shall consider the analysis of state and federal laws that
13 would need to be repealed, amended, or waived to implement chapter
14 . . ., Laws of 1993 (this act), and report its recommendations, with
15 proposed revisions to the Revised Code of Washington, to the governor,
16 and appropriate committees of the legislature by January 1, 1994.
17 (2) The governor, in consultation with the commission, shall take
18 the following steps in an effort to receive waivers or exemptions from
19 federal statutes necessary to fully implement chapter . . ., Laws of
20 1993 (this act) to include, but not be limited to:
21 (a) Negotiate with the United States congress and the federal
22 department of health and human services, health care financing
23 administration to obtain a statutory or regulatory waiver of provisions
24 of the medicaid statute, Title XIX of the federal social security act
25 that currently constitute barriers to full implementation of provisions
26 of chapter . . ., Laws of 1993 (this act) related to access to health
27 services for low-income residents of Washington state. Such waivers
28 shall include any waiver needed to implement managed care programs.
29 Waived provisions may include and are not limited to: Categorical
30 eligibility restrictions related to age, disability, blindness, or
31 family structure; income and resource limitations tied to financial
32 eligibility requirements of the federal aid to families with dependent
33 children and supplemental security income programs; administrative
34 requirements regarding single state agencies, choice of providers, and
35 fee for service reimbursement programs; and other limitations on health
36 services provider payment methods.

1 (b) Negotiate with the United States congress and the federal
2 department of health and human services, health care financing
3 administration to obtain a statutory or regulatory waiver of provisions
4 of the medicare statute, Title XVIII of the federal social security act
5 that currently constitute barriers to full implementation of provisions
6 of chapter . . ., Laws of 1993 (this act) related to access to health
7 services for elderly and disabled residents of Washington state. Such
8 waivers shall include any waivers needed to implement managed care
9 programs. Waived provisions include and are not limited to:
10 Beneficiary cost-sharing requirements; restrictions on scope of
11 services; and limitations on health services provider payment methods.
12 (c) Negotiate with the United States congress and the federal
13 department of health and human services to obtain any statutory or
14 regulatory waivers of provisions of the United States public health
15 services act necessary to ensure integration of federally funded
16 community and migrant health clinics and other health services funded
17 through the public health services act into the health services system
18 established pursuant to chapter . . ., Laws of 1993 (this act). The
19 commission shall request in the waiver that funds from these sources
20 continue to be allocated to federally funded community and migrant
21 health clinics to the extent that such clinics' patients are not yet
22 enrolled in certified health plans.
23 (d) Negotiate with the United States Congress to obtain a statutory
24 exemption from provisions of the Employee Retirement Income Security
25 Act that limit the state's ability to enact legislation relating to
26 employee health benefits plans administered by employers, including
27 health benefits plans offered by self-insured employers.
28 (e) Request that the United States Congress amend the Internal
29 Revenue Code to treat employee premium contributions to an employer
30 sponsored health benefit plan as nontaxable income.
31 (3) On or before December 1, 1995, the commission shall report the
32 following to the appropriate committees of the legislature:
33 (a) The status of its efforts to obtain the waivers provided in
34 subsection (2) of this section;
35 (b) The extent to which chapter . . ., Laws of 1993 (this act) can
36 be implemented, given the status of waivers requested or granted; and
37 (c) If a waiver of the Employee Retirement Income Security Act has
38 not been granted and likely will not be granted in the foreseeable
39 future, changes in chapter . . ., Laws of 1993 (this act) necessary to

1 implement a single-sponsor system, or to implement an alternative
2 system that will assure access to care and control health services
3 costs.

4 <u>NEW SECTION.</u> **Sec. 469.** REPORTS OF HEALTH CARE COST CONTROL AND
5 ACCESS COMMISSION. In carrying out its powers and duties under chapter
6 . . ., Laws of 1993 (this act), the design of the uniform benefits
7 package, and the development of guidelines and standards, the
8 commission shall consider the reports of the health care cost control
9 and access commission established under House Concurrent Resolution No.
10 4443 adopted by the legislature in 1990. Nothing in chapter . . .,
11 Laws of 1993 (this act) requires the commission to follow any specific
12 recommendation contained in those reports except as it may also be
13 included in chapter . . ., Laws of 1993 (this act) or other law.

14 <u>NEW SECTION.</u> **Sec. 470.** EVALUATIONS, PLANS, AND STUDIES. (1) By
15 July 1, 1997, the legislative budget committee either directly or by
16 contract shall conduct the following studies:
17 (a) A study to determine whether the administrative structure of
18 the Washington health services commission as set forth in section 403
19 of this act should be continued. The study shall analyze the structure
20 as set forth in chapter . . ., Laws of 1993 (this act), a single
21 administering-agency model, and at least one other salient
22 organizational model, and recommend a structure that would be most
23 efficient and effective;
24 (b) A study to determine the desirability and feasibility of
25 consolidating the following programs, services, and funding sources
26 into the delivery and financing of uniform benefits package services
27 through certified health plans:
28 (i) State and federal veterans' health services;
29 (ii) Civilian health and medical program of the uniformed services
30 (CHAMPUS) of the federal department of defense and other federal
31 agencies; and
32 (iii) Federal employee health benefits.
33 (2) The legislative budget committee shall evaluate the
34 implementation of the provisions of chapter . . ., Laws of 1993 (this
35 act). The study shall determine to what extent chapter . . ., Laws of
36 1993 (this act) has been implemented consistent with the principles and
37 elements set forth in chapter . . ., Laws of 1993 (this act) and shall

1 report its findings to the governor and appropriate committees of the
2 legislature by July 1, 2003.

3 NEW SECTION. **Sec. 471.** FINANCIAL AND ACCOUNTING STRUCTURE OF
4 STATE PURCHASED HEALTH CARE. The commission, the office of financial
5 management, and the legislative evaluation and accountability program
6 committee shall jointly review the financial and accounting structure
7 of all current state-purchased health care programs and any new
8 programs established in chapter . . ., Laws of 1993 (this act). They
9 shall report to the legislature on or before December 1, 1994, with
10 recommendations on how to structure a state-purchased health services
11 budget that: (1) Meets federal and state audit requirements; (2)
12 exercises adequate fiscal and programmatic control; (3) provides
13 management and organizational accountability and control; and (4)
14 provides continuity with historical health services expenditure data.

15 NEW SECTION. **Sec. 472.** EVALUATION OF REFORM EFFORT. The office
16 of financial management may undertake or facilitate evaluations of
17 health care reform, including analysis of fiscal and economic impacts,
18 the effectiveness of managed care and managed competition, and effects
19 of reform on access and quality of service.

20 NEW SECTION. **Sec. 473.** COORDINATION OF CERTIFIED HEALTH PLANS AND
21 OTHER INSURANCE. (1) On or before December 1, 1994, the legislative
22 budget committee, whether directly or by contract, shall conduct a
23 study related to coordination of certified health plans and other
24 property and casualty insurance products. The goal of the study shall
25 be to determine methods for containing costs of health services paid
26 for through coverage underwritten by property and casualty insurers.
27 (2) The study shall address methods to integrate coverage sold by
28 property and casualty insurance companies that covers medical and
29 hospital expenses with coverage provided through certified health
30 plans. In conducting the study, the legislative budget committee shall
31 evaluate at least the following options:
32 (a) Requiring all property and casualty insurance coverage of
33 health services to be provided through managed care systems rather than
34 through fee for service or indemnification plans;
35 (b) Prohibiting certified health plans from recovering from
36 property and casualty insurance companies amounts that the plan has

1 expended for health services even if coverage for such services is
2 available under property and casualty insurance policies;
3 (c) Requiring persons injured as a result of an accident, however
4 caused, to obtain health services through a certified health plan, even
5 if coverage for health services is available under a property and
6 casualty insurance policy;
7 (d) Requiring property and casualty insurance companies to reduce
8 premium rates for all coverage duplicated by a certified health plan to
9 the extent that a certified health plan is denied subrogation rights
10 against the property and casualty insurer;
11 (e) Prohibiting litigation by any person to recover amounts paid
12 for health services available under a certified health plan, except in
13 limited circumstances such as product liability or other areas of
14 negligence where the negligent party would benefit from such a system
15 without contributing to the costs of providing coverage under certified
16 health plans; and
17 (f) Limiting property and casualty insurance companies' sale of
18 coverage that would duplicate coverage provided by certified health
19 plans.

20 NEW SECTION. **Sec. 474.** A new section is added to chapter 70.170
21 RCW to read as follows:
22 HOSPITAL REGULATION STUDY. The department, through a competitive
23 bidding process restricted to those with suitable expertise to conduct
24 such a study, shall contract for an examination of local, state, and
25 federal regulations that apply to hospitals and shall report to the
26 health care policy committees of the legislature by July 1, 1994, on
27 the following:
28 (1) An inventory of health and safety regulations that apply to
29 hospitals;
30 (2) A description of the costs to local, state, and federal
31 agencies for operating the regulatory programs;
32 (3) An estimate of the costs to hospitals to comply with the
33 regulations;
34 (4) A description of whether regulatory functions are duplicated
35 among different regulatory programs;
36 (5) An analysis of the effectiveness of regulatory programs in
37 meeting their safety and health objectives;

1 (6) An analysis of hospital charity care requirements under RCW
2 70.170.060 and their relevance under the health care reforms created
3 under chapter . . ., Laws of 1993 (this act);
4 (7) Recommendations on elimination or consolidation of unnecessary
5 or duplicative regulatory activities that would not result in a
6 reduction in the health and safety objectives.

7 NEW SECTION. **Sec. 475.** NURSING HOME DOCUMENTATION STUDY. The
8 department of social and health services aging and adult services
9 administration shall, to the extent that resources are available,
10 review all federal and state laws, and departmental rules that require
11 health care providers in nursing homes to submit documentation. The
12 departmental review shall be conducted to determine what documentation
13 or protocols are redundant and can be modified or eliminated without
14 jeopardizing the health and safety of residents or violating federal
15 regulations. The review shall result in an itemized evaluation of the
16 number of forms requiring physician's review and signature together
17 with a citation of their origin. In addition, the department shall
18 review and suggest efficiencies that could be realized through the
19 development of standardized physicians' protocols for repetitive but
20 nonlifethreatening conditions, such as but not limited to, skin tears,
21 early stage decubiti, bowel and bladder care, and other common and
22 predictable nursing home patient conditions. Whenever possible, source
23 documentation should be enabled to allow multiple attestations to be
24 consolidated into a single document. The department shall conduct this
25 review in coordination with different nursing home care constituent
26 groups and professions, including but not limited to, a gerontologist
27 to be selected by the Washington state medical association and the
28 Washington osteopathic medical association, a nurse to be selected by
29 the Washington state nurses association and other employee
30 organizations representing nurses, one representative from each of the
31 two largest nursing home associations, and a representative of a
32 nursing home residency advocacy group to be selected by the department.
33 The department shall make appropriate regulatory changes, or recommend
34 appropriate regulatory changes to the appropriate regulatory agency,
35 resulting from this review and report its actions and any statutory
36 changes needed to further the goal of regulatory simplification to the
37 chair of the house of representatives health care committee and the

1 chair of the senate health and human services committee by December 12,
2 1994.

3 NEW SECTION. **Sec. 476.** CERTIFIED HEALTH PLAN LICENSING STUDY.
4 The insurance commissioner shall undertake a study of the feasibility
5 and benefits of developing a single licensing category for certified
6 health plans that would replace current statues licensing disability
7 insurers, health care service contractors, and health maintenance
8 organizations. The commissioner shall report his or her findings and
9 recommendations to the legislature by January 1, 1994. In conducting
10 such study, the commissioner shall:
11 (1) Consider standards for the regulation and inclusion of
12 preferred provider organizations, independent practice associations,
13 and independent physician organizations under such new certified health
14 plan statute;
15 (2) Review existing capital and reserve statutes governing
16 insurers, contractors, and health maintenance organizations to
17 determine the appropriate level of capital and reserve for licensing of
18 certified health plans to protect consumers while encouraging
19 competition in the certified health plan market from new entrants into
20 the market;
21 (3) Review existing rate regulation of disability insurance
22 policies, health care service contracts, and health maintenance
23 agreements and propose a uniform approach for regulation of rates that
24 balances the need of certified health plans to freely compete and the
25 need to protect consumers from inadequate, excessive, or unfairly
26 discriminatory rates;
27 (4) Consider regulatory methods to ensure the adequate provision of
28 and contracting with health care facilities and providers by certified
29 health plans to meet the health care needs of enrollees of certified
30 health plans;
31 (5) Consider the need to modify existing insurance statutes and
32 regulations to govern the integration, development, and marketing of
33 health care coverage that would supplement the uniform benefits
34 package; and
35 (6) Consult with health care service contractors, health
36 maintenance organizations, disability insurance companies, and other
37 health care service providers who would be affected by such changes.

1 NEW SECTION. **Sec. 477.** CRIME VICTIMS' COMPENSATION MEDICAL
2 BENEFITS. (1) On or before January 1, 1995, the department of labor
3 and industries in coordination with the commission, shall complete a
4 study related to the medical services component of the crime victims'
5 compensation program of the department of labor and industries. The
6 goal of the study shall be to determine whether and how the medical
7 services component of the crime victims' compensation program can be
8 modified to provide appropriate medical services to crime victims in a
9 more cost-effective manner. In conducting the study, consideration
10 shall be given to at least the following factors: Required benefit
11 design, necessary statutory changes, and the use of managed care to
12 provide services to crime victims. The study shall evaluate at least
13 the following options:
14 (a) Whether the medical services component of the crime victims'
15 compensation program should be maintained within the department of
16 labor and industries, and its purchasing and other practices modified
17 to control costs and increase efficacy of health services provided to
18 crime victims;
19 (b) Whether the medical services component of the crime victims'
20 compensation program should be administered by the health care
21 authority as the state health care purchasing agent;
22 (c) Whether the medical services component of the crime victims'
23 compensation program should be included in the services offered by
24 certified health plans.
25 (2) The department of labor and industries shall present the
26 recommendations to the governor and the appropriate committees of the
27 legislature by January 1, 1995.

28 **L. WORKERS' COMPENSATION**

29 NEW SECTION. **Sec. 478.** WORKERS' COMPENSATION MEDICAL BENEFITS.
30 On or before December 1, 1994, the health services commission, in
31 coordination with the department of labor and industries and the
32 workers' compensation advisory committee, shall complete a study
33 related to the medical services component of the workers' compensation
34 program of the department of labor and industries. The goal of the
35 study is to determine whether and how the medical services component of
36 the workers' compensation program can be modified to provide
37 appropriate medical services to injured workers in a more cost-

effective manner. In conducting the study, consideration shall be given to at least the following factors: Workers' choice of health care providers, twenty-four hour coverage, the relationship between rehabilitation and medical services, and the quasi-judicial system that overlays treatment. The study shall evaluate at least the following options:

(1) Whether the medical services component of the workers' compensation program should be maintained within the department of labor and industries, and its purchasing and other practices modified to control costs and increase efficacy of health services provided to injured workers;

(2) Whether the medical services component of the workers' compensation program should be administered by the health care authority as the state health services purchasing agent, pursuant to section 225 of this act. Any recommendation proposing that the state health services agent purchase injured workers' medical services shall assure that the uniform benefits package will provide benefits that are medically necessary under the workers' compensation program in 1993, including payment for medical determinations of disability under Title 51 RCW, and consider issues presented by twenty-four hour coverage and the use of managed care to provide medical services to injured workers;

(3) Whether the medical services component of the workers' compensation program should be included in the services offered by certified health plans through employer sponsorship as provided in chapter . . ., Laws of 1993 (this act). Any recommendation proposing the inclusion of workers' compensation medical services in the services offered by certified health plans shall assure that (a) no less than ninety-seven percent of state residents have access to the uniform benefits package as required in chapter . . ., Laws of 1993 (this act), (b) the uniform benefits package provides benefits that are medically necessary under the workers' compensation program in 1993, including payment for medical determinations of disability under Title 51 RCW, (c) time-loss benefits and rehabilitative services will not be reduced as a result of the transfer, and (d) the employees' share of the workers' compensation medical aid fund contribution will be returned to employees as increased wages.

M. MISCELLANEOUS

1 <u>NEW SECTION.</u> **Sec. 479.** SHORT TITLE. This act may be known and
2 cited as the Washington health services act of 1993.

3 **Sec. 480.** RCW 42.17.2401 and 1991 c 200 s 404 are each amended to
4 read as follows:
5 EXECUTIVE STATE OFFICERS. For the purposes of RCW 42.17.240, the
6 term "executive state officer" includes:
7 (1) The chief administrative law judge, the director of
8 agriculture, the administrator of the office of marine safety, the
9 administrator of the Washington basic health plan, the director of the
10 department of services for the blind, the director of the state system
11 of community <u>and technical</u> colleges, the director of community
12 development, the secretary of corrections, the director of ecology, the
13 commissioner of employment security, the chairman of the energy
14 facility site evaluation council, the director of the energy office,
15 the secretary of the state finance committee, the director of financial
16 management, the director of fisheries, the executive secretary of the
17 forest practices appeals board, the director of the gambling
18 commission, the director of general administration, the secretary of
19 health, the administrator of the Washington state health care
20 authority, the executive secretary of the health care facilities
21 authority, the executive secretary of the higher education facilities
22 authority, the director of the higher education personnel board, the
23 executive secretary of the horse racing commission, the executive
24 secretary of the human rights commission, the executive secretary of
25 the indeterminate sentence review board, the director of the department
26 of information services, the director of the interagency committee for
27 outdoor recreation, the executive director of the state investment
28 board, the director of labor and industries, the director of licensing,
29 the director of the lottery commission, the director of the office of
30 minority and women's business enterprises, the director of parks and
31 recreation, the director of personnel, the executive director of the
32 public disclosure commission, the director of retirement systems, the
33 director of revenue, the secretary of social and health services, the
34 chief of the Washington state patrol, the executive secretary of the
35 board of tax appeals, the director of trade and economic development,
36 the secretary of transportation, the secretary of the utilities and
37 transportation commission, the director of veterans affairs, the
38 director of wildlife, the president of each of the regional and state

universities and the president of The Evergreen State College, each district and each campus president of each state community college;

(2) Each professional staff member of the office of the governor;

(3) Each professional staff member of the legislature; and

(4) Central Washington University board of trustees, board of trustees of each community college, each member of the state board for community and technical colleges ((~~education~~)), state convention and trade center board of directors, committee for deferred compensation, Eastern Washington University board of trustees, Washington economic development finance authority, The Evergreen State College board of trustees, forest practices appeals board, forest practices board, gambling commission, Washington health care facilities authority, each member of the Washington health services commission, higher education coordinating board, higher education facilities authority, higher education personnel board, horse racing commission, state housing finance commission, human rights commission, indeterminate sentence review board, board of industrial insurance appeals, information services board, interagency committee for outdoor recreation, state investment board, liquor control board, lottery commission, marine oversight board, oil and gas conservation committee, Pacific Northwest electric power and conservation planning council, parks and recreation commission, personnel appeals board, personnel board, board of pilotage ((~~[commissioners]~~)) commissioners, pollution control hearings board, public disclosure commission, public pension commission, shorelines hearing board, ((~~state~~)) public employees' benefits board, board of tax appeals, transportation commission, University of Washington board of regents, utilities and transportation commission, Washington state maritime commission, Washington public power supply system executive board, Washington State University board of regents, Western Washington University board of trustees, and wildlife commission.

Sec. 481. RCW 43.20.050 and 1992 c 34 s 4 are each amended to read as follows:

STATE BOARD OF HEALTH--PUBLIC HEALTH POLICY. (1) The state board of health shall provide a forum for the development of public health policy in Washington state. It is authorized to recommend to the secretary means for obtaining appropriate citizen and professional involvement in all public health policy formulation and other matters related to the powers and duties of the department. It is further

empowered to hold hearings and explore ways to improve the health status of the citizenry.

(a) At least every five years, the state board shall convene regional forums to gather citizen input on public health issues.

(b) Every two years, in coordination with the development of the state biennial budget, the state board shall prepare the state public health report that outlines the health priorities of the ensuing biennium. The report shall:

(i) Consider the citizen input gathered at the ((~~health~~)) forums;

(ii) Be developed with the assistance of local health departments;

(iii) Be based on the best available information collected and reviewed according to RCW 43.70.050 and recommendations from the council;

(iv) Be developed with the input of state health care agencies. At least the following directors of state agencies shall provide timely recommendations to the state board on suggested health priorities for the ensuing biennium: The secretary of social and health services, the health care authority administrator, the insurance commissioner, the superintendent of public instruction, the director of labor and industries, the director of ecology, and the director of agriculture;

(v) Be used by state health care agency administrators in preparing proposed agency budgets and executive request legislation;

(vi) Be submitted by the state board to the governor by ((~~June~~)) January 1 of each even-numbered year for adoption by the governor. The governor, no later than ((~~September~~)) March 1 of that year, shall approve, modify, or disapprove the state public health report.

(c) In fulfilling its responsibilities under this subsection, the state board ((~~shall~~)) may create ad hoc committees or other such committees of limited duration as necessary. ((~~Membership should include legislators, providers, consumers, bioethicists, medical economics experts, legal experts, purchasers, and insurers, as necessary.~~))

(2) In order to protect public health, the state board of health shall:

(a) Adopt rules necessary to assure safe and reliable public drinking water and to protect the public health. Such rules shall establish requirements regarding:

1 (i) The design and construction of public water system facilities,
2 including proper sizing of pipes and storage for the number and type of
3 customers;
4 (ii) Drinking water quality standards, monitoring requirements, and
5 laboratory certification requirements;
6 (iii) Public water system management and reporting requirements;
7 (iv) Public water system planning and emergency response
8 requirements;
9 (v) Public water system operation and maintenance requirements;
10 (vi) Water quality, reliability, and management of existing but
11 inadequate public water systems; and
12 (vii) Quality standards for the source or supply, or both source
13 and supply, of water for bottled water plants.
14 (b) Adopt rules and standards for prevention, control, and
15 abatement of health hazards and nuisances related to the disposal of
16 wastes, solid and liquid, including but not limited to sewage, garbage,
17 refuse, and other environmental contaminants; adopt standards and
18 procedures governing the design, construction, and operation of sewage,
19 garbage, refuse and other solid waste collection, treatment, and
20 disposal facilities;
21 (c) Adopt rules controlling public health related to environmental
22 conditions including but not limited to heating, lighting, ventilation,
23 sanitary facilities, cleanliness and space in all types of public
24 facilities including but not limited to food service establishments,
25 schools, institutions, recreational facilities and transient
26 accommodations and in places of work;
27 (d) Adopt rules for the imposition and use of isolation and
28 quarantine;
29 (e) Adopt rules for the prevention and control of infectious and
30 noninfectious diseases, including food and vector borne illness, and
31 rules governing the receipt and conveyance of remains of deceased
32 persons, and such other sanitary matters as admit of and may best be
33 controlled by universal rule; and
34 (f) Adopt rules for accessing existing data bases for the purposes
35 of performing health related research.
36 (3) The state board may delegate any of its rule-adopting authority
37 to the secretary and rescind such delegated authority.
38 (4) All local boards of health, health authorities and officials,
39 officers of state institutions, police officers, sheriffs, constables,

1 and all other officers and employees of the state, or any county, city,
2 or township thereof, shall enforce all rules adopted by the state board
3 of health. In the event of failure or refusal on the part of any
4 member of such boards or any other official or person mentioned in this
5 section to so act, he shall be subject to a fine of not less than fifty
6 dollars, upon first conviction, and not less than one hundred dollars
7 upon second conviction.

8 (5) The state board may advise the secretary on health policy
9 issues pertaining to the department of health and the state.

10 NEW SECTION. **Sec. 482.** REPEAL--DENTISTRY--SOLICITATION. RCW
11 18.32.675 and 1935 c 112 s 19 are each repealed.

12 NEW SECTION. **Sec. 483.** SEVERABILITY. If any provision of this
13 act or its application to any person or circumstance is held invalid,
14 the remainder of the act or the application of the provision to other
15 persons or circumstances is not affected.

16 NEW SECTION. **Sec. 484.** SAVINGS CLAUSE. The enactment of this act
17 does not have the effect of terminating, or in any way modifying, any
18 obligation or any liability, civil or criminal, which was already in
19 existence on the effective date of this act.

20 NEW SECTION. **Sec. 485.** CAPTIONS. Captions used in this act do
21 not constitute any part of the law.

22 NEW SECTION. **Sec. 486.** CODIFICATION. (1) Sections 401 through
23 407, 409, 424, 426 through 428, and 446 through 456 of this act shall
24 constitute a new chapter in Title 43 RCW.

25 (2) Sections 425 and 429 through 445 of this act shall constitute
26 a new chapter in Title 48 RCW.

27 (3) Sections 457 through 461 of this act shall constitute a new
28 chapter in Title 48 RCW.

29 NEW SECTION. **Sec. 487.** RESERVATION OF LEGISLATIVE AUTHORITY. The
30 legislature reserves the right to amend or repeal all or any part of
31 this act at any time and there shall be no vested private right of any
32 kind against such amendment or repeal. All the rights, privileges, or
33 immunities conferred by this act or any acts done pursuant thereto

1 shall exist subject to the power of the legislature to amend or repeal
2 this act at any time.

3 NEW SECTION. **Sec. 488.** EFFECTIVE DATE CLAUSE. This act is
4 necessary for the immediate preservation of the public peace, health,
5 or safety, or support of the state government and its existing public
6 institutions, and shall take effect July 1, 1993, except for:
7 (1) Sections 231 through 254 of this act, which shall take effect
8 July 1, 1994; and
9 (2) Sections 301 through 303 of this act, which shall take effect
10 January 1, 1996."

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