E2SSB 5304 - CONF REPT
By Conference Committee

ADOPTED AS AMENDED BY H2650 - 4/23/93

Strike everything after the enacting clause and insert the following:

"TABLE OF CONTENTS

PART I. FINDINGS, GOALS, AND INTENT

NEW SECTION. **Sec. 101.** FINDINGS. The legislature finds that our health and financial security are jeopardized by our ever increasing demand for health care and by current health insurance and health system practices. Current health system practices encourage public demand for unneeded, ineffective, and sometimes dangerous health treatments. These practices often result in unaffordable cost increases that far exceed ordinary inflation for essential care. Current total health care expenditure rates should be sufficient to provide access to essential health care interventions to all within a reformed, efficient system.

The legislature finds that too many of our state's residents are without health insurance, that each year many individuals and families are forced into poverty because of serious illness, and that many must leave gainful employment to be eligible for publicly funded medical services. Additionally, thousands of citizens are at risk of losing adequate health insurance, have had insurance canceled recently, or cannot afford to renew existing coverage.

The legislature finds that businesses find it difficult to pay for health insurance and remain competitive in a global economy, and that individuals, the poor, and small businesses bear an inequitable health insurance burden.

The legislature finds that persons of color have significantly higher rates of mortality and poor health outcomes, and substantially lower numbers and percentages of persons covered by health insurance than the general population. It is intended that chapter . . ., Laws of 1993 (this act) make provisions to address the special health care needs of these racial and ethnic populations in order to improve their health status.

The legislature finds that uncontrolled demand and expenditures for health care are eroding the ability of families, businesses, communities, and governments to invest in other enterprises that promote health, maintain independence, and ensure continued economic welfare. Housing, nutrition, education, and the environment are all diminished as we invest ever increasing shares of wealth in health care treatments.

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

NEW SECTION. **Sec. 102.** LEGISLATIVE INTENT AND GOALS. (1) The legislature intends that state government policy stabilize health services costs, assure access to essential services for all residents, actively address the health care needs of persons of color, improve the public's health, and reduce unwarranted health services costs to preserve the viability of nonhealth care businesses.

(2) The legislature intends that:

(a) Total health services costs be stabilized and kept within rates of increase similar to the rates of personal income growth within a publicly regulated, private marketplace that preserves personal choice;

(b) State residents be enrolled in the certified health plan of their choice that meets state standards regarding affordability, accessibility, cost-effectiveness, and clinical efficaciousness;

(c) State residents be able to choose health services from the full range of health care providers, as defined in section 402(12) of this act, in a manner consistent with good health services management, quality assurance, and cost effectiveness;

(d) Individuals and businesses have the option to purchase any health services they may choose in addition to those included in the uniform benefits package or supplemental benefits;

(e) All state residents, businesses, employees, and government participate in payment for health services, with total costs to individuals on a sliding scale based on income to encourage efficient and appropriate utilization of services;

(f) These goals be accomplished within a reformed system using private service providers and facilities in a way that allows consumers to choose among competing plans operating within budget limits and other regulations that promote the public good; and

(g) A policy of coordinating the delivery, purchase, and provision of health services among the federal, state, local, and tribal governments be encouraged and accomplished by chapter . . ., Laws of 1993 (this act).

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

PART II. EARLY IMPLEMENTATION MEASURES

A. BASIC HEALTH PLAN EXPANSION

NEW SECTION. **Sec. 201.** A new section is added to chapter 70.47 RCW to read as follows:

TRANSFER OF POWER AND DUTIES TO WASHINGTON STATE HEALTH CARE AUTHORITY. The powers, duties, and functions of the Washington basic health plan are hereby transferred to the Washington state health care authority. All references to the administrator of the Washington basic health plan in the Revised Code of Washington shall be construed to mean the administrator of the Washington state health care authority.

NEW SECTION. **Sec. 202.** TRANSFER OF RECORDS, EQUIPMENT, FUNDS. All reports, documents, surveys, books, records, files, papers, or written material in the possession of the Washington basic health plan shall be delivered to the custody of the Washington state health care authority. All cabinets, furniture, office equipment, motor vehicles, and other tangible property used by the Washington basic health plan shall be made available to the Washington state health care authority. All funds, credits, or other assets held by the Washington basic health plan shall be assigned to the Washington state health care authority.

Any appropriations made to the Washington basic health plan shall, on the effective date of this section, be transferred and credited to the Washington state health care authority. At no time may those funds in the basic health plan trust account, any funds appropriated for the subsidy of any enrollees, or any premium payments or other sums made or received on behalf of any enrollees in the basic health plan be commingled with any appropriated funds designated or intended for the purposes of providing health care coverage to any state or other public employees.

Whenever any question arises as to the transfer of any personnel, funds, books, documents, records, papers, files, equipment, or other tangible property used or held in the exercise of the powers and the performance of the duties and functions transferred, the director of financial management shall make a determination as to the proper allocation and certify the same to the state agencies concerned.

NEW SECTION. **Sec. 203.** TRANSFER OF EMPLOYEES. All employees of the Washington basic health plan are transferred to the jurisdiction of

the Washington state health care authority. All employees classified under chapter 41.06 RCW, the state civil service law, are assigned to the Washington state health care authority to perform their usual duties upon the same terms as formerly, without any loss of rights, subject to any action that may be appropriate thereafter in accordance with the laws and rules governing state civil service.

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

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

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

NEW SECTION. **Sec. 207.** COLLECTIVE BARGAINING. Nothing contained in sections 201 through 206 of this act may be construed to alter any existing collective bargaining unit or the provisions of any existing collective bargaining agreement until the agreement has expired or until the bargaining unit has been modified by action of the personnel 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~~)) 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 so long as such purchase does not result in a lower standard of coverage for employees.

(c) The legislature intends that, to the extent of available funds, the program be available throughout Washington state to subsidized and nonsubsidized enrollees. It is also the intent of the legislature to enroll subsidized enrollees first, to the maximum extent feasible.

(d) 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, 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 the administrator determines at the time of application does not have health insurance more comprehensive than that offered by the plan, and 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 the administrator determines at the time of application does not have health insurance more comprehensive than that offered by 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 449 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 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 endeavor to make the copayments structure of the plan consistent with enrollee point of service cost-sharing levels adopted by the Washington health services commission, giving consideration to funding available to the plan.

(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 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 business owner pay at least fifty percent of the nonsubsidized premium cost of the plan on behalf of each employee enrolled in the plan. Enrollment is limited to those not eligible for medicare 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~~)) funding, assistance for rural ((~~health activities that endeavor to develop needed health care services in rural parts of the state~~)) residents, underserved populations, and persons of color.

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; 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: (a) By October 1, 1995, all employees of school districts. Between October 1, 1994, and September 30, 1995, "employee" includes employees of those school districts for whom the authority has undertaken the purchase of insurance benefits. The transition to insurance benefits purchasing by the authority may not disrupt existing insurance contracts between school district employees and insurers. However, except to the extent provided in RCW 28A.400.200, any such contract that provides for health insurance benefits coverage after October 1, 1995, shall be void as of that date if the contract was entered into, renewed, or extended after July 1, 1993. Prior to October 1, 1994, "employee" includes 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; (b) 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~~)); (c) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, 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 have an administrator appointed by the governor, with the consent of the senate. The administrator shall serve at the pleasure of the governor. The administrator may employ up to seven staff members, who shall be exempt from chapter 41.06 RCW, and any additional staff members as are necessary to administer this chapter. The primary duties of the authority shall be to administer state employees' insurance benefits ((~~and to~~)), study state-purchased health care programs in order to maximize cost containment in these programs while ensuring access to quality health care, and implement state initiatives, joint purchasing strategies, and techniques for efficient administration that have potential application to all state-purchased health services. The authority's duties include, but are not limited to, the following:

((~~(1)~~)) (a) To administer a health care benefit program for employees as specifically authorized in RCW 41.05.065 and in accordance with the methods described in RCW 41.05.075, 41.05.140, and other provisions of this chapter;

((~~(2)~~)) (b) To analyze state-purchased health care programs and to explore options for cost containment and delivery alternatives for those programs that are consistent with the purposes of those programs, including, but not limited to:

((~~(a)~~)) (i) Creation of economic incentives for the persons for whom the state purchases health care to appropriately utilize and purchase health care services, including the development of flexible benefit plans to offset increases in individual financial responsibility;

((~~(b)~~)) (ii) Utilization of provider arrangements that encourage cost containment ((~~and ensure access to quality care~~)), including but not limited to prepaid delivery systems, utilization review, and prospective payment methods, and that ensure access to quality care, including assuring reasonable access to local providers, especially for employees residing in rural areas;

((~~(c)~~)) (iii) Coordination of state agency efforts to purchase drugs effectively as provided in RCW 70.14.050;

((~~(d)~~)) (iv) Development of recommendations and methods for purchasing medical equipment and supporting services on a volume discount basis; and

((~~(e)~~)) (v) Development of data systems to obtain utilization data from state-purchased health care programs in order to identify cost centers, utilization patterns, provider and hospital practice patterns, and procedure costs, utilizing the information obtained pursuant to RCW 41.05.031;

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

Sec. 217. RCW 41.05.055 and 1989 c 324 s 1 are each amended to read as follows:

PUBLIC EMPLOYEES' BENEFITS BOARD--SCHOOL DISTRICT EMPLOYEES. (1) The ((~~state~~)) public employees' benefits board is created within the authority. The function of the board is to design and approve insurance benefit plans for state employees and school district employees.

(2) Effective January 1, 1995, the board shall be composed of ((~~seven~~)) nine members appointed by the governor as follows:

(a) ((~~Three~~)) Two representatives of state employees, ((~~one of whom shall represent an employee association certified as exclusive representative of at least one bargaining unit of classified employees,~~)) one of whom shall represent an employee union certified as exclusive representative of at least one bargaining unit of classified employees, and one of whom is retired, is covered by a program under the jurisdiction of the board, and represents an organized group of retired public employees;

(b) Two representatives of school district employees, one of whom shall represent an association of school employees and one of whom is retired, and represents an organized group of retired school employees;

((~~Three~~)) (c) Four members with experience in health benefit management and cost containment; and

((~~(c)~~)) (d) The administrator.

Prior to January 1, 1995, the composition of the public employees benefits board shall reflect its composition on January 1, 1993.

(3) The governor shall appoint the initial members of the board to 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, employee eligibility criteria related to the number of hours worked and the benefits provided to employees shall be substantially equivalent to the state employees' health benefits plan and eligibility criteria 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.

(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.

NEW SECTION. **Sec. 221.** A new section is added to chapter 41.05 RCW to read as follows:

MEDICARE SUPPLEMENTAL BENEFITS. The administrator, in consultation with the public employees' benefits board, shall design a self-insured medicare supplemental insurance plan for retired and disabled employees eligible for medicare. For the purpose of determining the appropriate scope of the self-funded medicare supplemental plan, the administrator shall consider the differences in the scope of health services available under the uniform benefits package and the medicare program. The proposed plan shall be submitted to appropriate committees of the legislature by December 1, 1993.

NEW SECTION. **Sec. 222.** A new section is added to chapter 41.05 RCW to read as follows:

MEDICARE SUPPLEMENTAL BENEFITS. Notwithstanding any other provisions of this title or rules or procedures adopted by the authority, the authority shall make available to retired or disabled employees who are eligible for medicare at least two medicare supplemental insurance policies that conform to the requirements of chapter 48.66 RCW. One policy shall include coverage for prescription drugs. The policies shall be chosen in consultation with the public employees' benefits board. These policies shall be made available to retired or disabled employees, or employees of county, municipal, or other political subdivisions eligible for coverage available under the authority. All offerings shall be made available not later than January 1, 1994.

NEW SECTION. **Sec. 223.** A new section is added to chapter 41.05 RCW to read as follows:

MEDICARE SUPPLEMENTAL BENEFITS. If a waiver of the medicare statute, Title XVIII of the federal social security act, sufficient to meet the requirements of chapter . . ., Laws of 1993 (this act) is not granted on or before January 1, 1995, the medicare supplemental insurance policies authorized under section 222 of this act shall be made available to any resident of the state eligible for medicare benefits. Except for those retired state or school district employees eligible to purchase medicare supplemental benefits through the authority, persons purchasing a medicare supplemental insurance policy under this section shall be required to pay the full cost of any such policy.

Sec. 224. RCW 47.64.270 and 1988 c 107 s 21 are each amended to read as follows:

FERRY EMPLOYEES--ENROLLMENT IN CERTIFIED HEALTH PLANS. Until December 31, 1996, absent a collective bargaining agreement to the contrary, the department of transportation shall provide contributions to insurance and health care plans for ferry system employees and dependents, as determined by the state health care authority, under chapter 41.05 RCW((.)); and the ferry system management and employee organizations may collectively bargain for other insurance and health care plans, and employer contributions may exceed that of other state

agencies as provided in RCW 41.05.050, subject to RCW 47.64.180. On January 1, 1997, ferry employees shall enroll in certified health plans under the provisions of chapter . . ., Laws of 1993 (this act). To the 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. 225. 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. 226. 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, effective on and after October 1, 1995, 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 extracurricular activities, for those students whose families, by reason of their low income, would have difficulty paying the entire amount of such insurance premiums. The district board shall adopt regulations for waiving or reducing the insurance coverage requirements for low-income students in order to assure such students are not prohibited from participating in extracurricular interschool activities.

(4) All contracts for insurance or protection written to take advantage of the provisions of this section shall provide that the beneficiaries of such contracts may utilize on an equal participation basis the services of those practitioners licensed pursuant to chapters 18.22, 18.25, 18.53, 18.57, and 18.71 RCW.

C. CONSOLIDATED STATE HEALTH CARE PURCHASING AGENT

NEW SECTION. **Sec. 227.** A new section is added to Title 43 RCW to read as follows:

STATE HEALTH SERVICES AGENT. (1) The health care authority is hereby designated as the single state agent for purchasing health services.

(2) On and after July 1, 1995, at least the following state-purchased health services programs shall be merged into a single, community-rated risk pool: The basic health plan; health benefits for employees of school districts; and health benefits for state employees. Until that date, in purchasing health services, the health care authority shall maintain separate risk pools for each of the programs in this subsection. The administrator may develop mechanisms to ensure that the cost of comparable benefits packages does not vary widely across the risk pools. At the earliest opportunity the governor shall seek necessary federal waivers and state legislation to place the medical and acute care components of the medical assistance program, the limited casualty program, and the medical care services program of the department of social and health services in this single risk pool. Long-term care services that are provided under the medical assistance program shall not be placed in the single risk pool until such services have been added to the uniform benefits package. On or before January

1, 1997, 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 449 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 consistent with the provisions of chapter ..., Laws of 1993 (this act), 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 under the provisions of chapter ..., Laws of 1993 (this act);

(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.

NEW SECTION. **Sec. 228.** 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 coordinating and enhancing the health care purchasing power of the groups identified in subsection (2) of this section. The purchasing association shall be administered by the administrator.

(2) The following organizations or entities may seek the approval of the administrator for membership in the purchasing association:

(a) Private nonprofit human services provider organizations under contract with state agencies, on behalf of their employees and their employees' spouses and dependent children;

(b) Individuals providing in-home long-term care services to persons whose care is financed in whole or in part through the medical assistance personal care or community options program entry system program as provided in chapter 74.09 RCW, or the chore services program, as provided in chapter 74.08 RCW, on behalf of themselves and their spouses and dependent children;

(c) Owners and operators of child day care centers and family child care homes licensed under chapter 74.15 RCW and of preschool or other child care programs exempted from licensing under chapter 74.15 RCW on behalf of themselves and their employees and employees' spouses and dependent children; and

(d) Foster parents contracting with the department of social and health services under chapter 74.13 RCW and licensed under chapter 74.15 RCW on behalf of themselves and their spouses and dependent children.

(3) In administering the purchasing association, the administrator shall:

(a) Negotiate and enter into contracts on behalf of the purchasing association's members in conjunction with its contracting and purchasing activities for employee benefits plans under RCW 41.05.075. In negotiating and contracting with insuring entities on behalf of employees and purchasing association members, two distinct pools shall be maintained.

(b) Review and approve or deny applications from entities seeking membership in the purchasing association:

(i) The administrator may require all or the substantial majority of the employees of the organizations or entities listed in subsection (2) of this section to enroll in the purchasing association.

(ii) The administrator shall require, that as a condition of membership in the purchasing association, an entity or organization listed in subsection (2) of this section that employs individuals pay at least fifty percent of the cost of the health insurance coverage for each employee enrolled in the purchasing association.

(iii) In offering and administering the purchasing association, the administrator may not discriminate against individuals or groups based on age, gender, geographic area, industry, or medical history.

(4) On and after July 1, 1995, the uniform benefits package and schedule of premiums and point of service cost-sharing adopted and from time to time revised by the health services commission pursuant to chapter . . ., Laws of 1993 (this act) shall be applicable to the association.

(5) The administrator shall adopt preexisting condition coverage provisions for the association as provided in sections 283 through 286 of this act.

(6) Premiums charged to purchasing association members shall include the authority's reasonable administrative and marketing costs. Purchasing association members may not receive any subsidy from the state for the purchase of health insurance coverage through the association.

(7)(a) The Washington state group purchasing association account is established in the custody of the state treasurer, to be used by the administrator for the deposit of premium payments from individuals and entities described in subsection (2) of this section, and for payment of premiums for benefit contracts entered into on behalf of the purchasing association's participants and operating expenses incurred by the authority in the administration of benefit contracts under this section. Moneys from the account shall be disbursed by the state treasurer by warrants on vouchers duly authorized by the administrator.

(b) Disbursements from the account are not subject to appropriations, but shall be subject to the allotment procedure provided under chapter 43.88 RCW.

NEW SECTION. **Sec. 229.** A new section is added to chapter 41.05 RCW to read as follows:

MARKETING PLAN. The administrator shall develop a marketing plan for the basic health plan and the Washington state group purchasing association. The plan shall be targeted to individuals and entities eligible to enroll in the two programs and provide clear and understandable explanations of the programs and enrollment procedures. The plan also shall incorporate special efforts to reach communities and people of color.

NEW SECTION. **Sec. 230.** WASHINGTON STATE GROUP PURCHASING ASSOCIATION--REPEAL. The following acts or parts of acts, as now existing or hereafter amended, are each repealed, effective June 30, 1998:

(1) RCW 41.05.___ and 1993 c ___ s 228 (section 228 of this act); and

(2) RCW 41.05.___ and 1993 c ___ s 229 (section 229 of this act).

Sec. 231. RCW 74.09.055 and 1982 c 201 s 19 are each amended to read as follows:

The department is authorized to establish copayment, deductible, or coinsurance requirements for recipients of any medical programs defined in RCW 74.09.010 ((~~but shall not establish copayment, deductible or coinsurance requirements for legend drugs as defined in RCW 69.41.210, unless required by federal law~~)).

NEW SECTION. **Sec. 232.** TRANSFER OF AUTHORITY TO PURCHASE SERVICES FROM COMMUNITY HEALTH CENTERS. (1) State general funds appropriated to the department of health for the purposes of funding community health centers to provide primary health and dental care services, migrant health services, and maternity health care services shall be transferred to the state health care authority. Any related administrative funds expended by the department of health for this purpose shall also be transferred to the health care authority. The health care authority shall exclusively expend these funds through contracts with community health centers to provide primary health and dental care services, migrant health services, and maternity health care services. The administrator of the health care authority shall establish requirements necessary to assure community health centers provide quality health care services that are appropriate and effective and are delivered in a cost-efficient manner. The administrator shall further assure that community health centers have appropriate referral arrangements for acute care and medical specialty services not provided by the community health centers.

(2) To further the intent of chapter . . ., Laws of 1993 (this act), the health care authority, in consultation with the department of health, shall evaluate the organization and operation of the federal and state-funded community health centers and other not-for-profit health care organizations and propose recommendations to the health

services commission and the health policy committees of the legislature by November 30, 1994, that identify changes to permit community health centers and other not-for-profit health care organizations to form certified health plans or other innovative health care delivery arrangements that help ensure access to primary health care services consistent with the purposes of chapter . . ., Laws of 1993 (this act).

(3) The authority, in consultation with the department of health, shall work with community and migrant health clinics and other providers of care to underserved populations, to ensure that the number of people of color and underserved people receiving access to managed care is expanded in proportion to need, based upon demographic data.

D. HEALTH CARE PROVIDER CONFLICT OF INTEREST STANDARDS

Sec. 233. 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. 234. 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. 235. 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. 236. 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. 237.** 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. 238. 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. 239. 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 237 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. 240. 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 chapters 70.05 and 70.46 RCW ((~~and RCW 70.46.020 through 70.46.090~~)).

Sec. 241. 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 chapters 70.05 and 70.46 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 chapters 70.05 and 70.46 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 chapters 70.05 and 70.46 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. 242. 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. 243. 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. 244. 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. 245. 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. 246. 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. 247. 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. 248. 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. 249. 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. 250. 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. 251. 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((~~: PROVIDED, That~~)). A<u></u>ny county((~~, city or town~~)) which withdraws from membership in said health district shall immediately establish a health department or provide health services which shall meet the standards for health services promulgated by the state board of health((~~: PROVIDED FURTHER, That~~)). N<u></u>o local health department ((~~shall~~)) <u>may</u> be deemed to provide adequate public health services unless there is at least one full time professionally trained and qualified physician as set forth in RCW 70.05.050.

Sec. 252. RCW 70.46.120 and 1963 c 121 s 1 are each amended to read as follows:

FEES MAY BE CHARGED. In addition to all other powers and duties, health districts shall have the power to charge fees in connection with the issuance or renewal of a license or permit required by law: PROVIDED, That the fees charged shall not exceed the actual cost involved in issuing or renewing the license or permit((~~: PROVIDED FURTHER, That no fees shall be charged pursuant to this section within the corporate limits of any city or town which prior to the enactment of this section charged fees in connection with the issuance or renewal of a license or permit pursuant to city or town ordinance and where said city or town makes a direct contribution to said health district, unless such city or town expressly consents thereto~~)).

Sec. 253. RCW 82.44.110 and 1991 c 199 s 221 are each amended to read as follows:

DISPOSITION OF MOTOR VEHICLE EXCISE TAX REVENUE--PUBLIC HEALTH. The county auditor shall regularly, when remitting license fee receipts, pay over and account to the director of licensing for the excise taxes collected under the provisions of this chapter. The director shall forthwith transmit the excise taxes to the state treasurer.

(1) The state treasurer shall deposit the excise taxes collected under RCW 82.44.020(1) as follows:

(a) 1.60 percent into the motor vehicle fund to defray administrative and other expenses incurred by the department in the collection of the excise tax.

(b) 8.15 percent into the Puget Sound capital construction account in the motor vehicle fund.

(c) 4.07 percent into the Puget Sound ferry operations account in the motor vehicle fund.

(d) ((~~8.83~~)) 5.88 percent into the general fund to be distributed under RCW 82.44.155.

(e) 4.75 percent into the municipal sales and use tax equalization account in the general fund created in RCW 82.14.210.

(f) 1.60 percent into the county sales and use tax equalization account in the general fund created in RCW 82.14.200.

(g) 62.6440 percent into the general fund through June 30, 1993, 57.6440 percent into the general fund beginning July 1, 1993, and 66 percent into the general fund beginning January 1, 1994.

(h) 5 percent into the transportation fund created in RCW 82.44.180 beginning July 1, 1993.

(i) 5.9686 percent into the county criminal justice assistance account created in RCW 82.14.310 through December 31, 1993.

(j) 1.1937 percent into the municipal criminal justice assistance account for distribution under RCW 82.14.320 through December 31, 1993.

(k) 1.1937 percent into the municipal criminal justice assistance account for distribution under RCW 82.14.330 through December 31, 1993.

(l) 2.95 percent into the general fund to be distributed by the state treasurer to county health departments to be used exclusively for public health. The state treasurer shall distribute these funds proportionately among the counties based on population as determined by the most recent United States census.

(2) The state treasurer shall deposit the excise taxes collected under RCW 82.44.020(2) into the transportation fund.

(3) The state treasurer shall deposit the excise tax imposed by RCW 82.44.020(3) into the air pollution control account created by RCW 70.94.015.

Sec. 254. RCW 82.44.155 and 1991 c 199 s 223 are each amended to read as follows:

MOTOR VEHICLE EXCISE TAX DISTRIBUTION TO CITIES AND TOWNS. When distributions are made under RCW 82.44.150, the state treasurer shall apportion and distribute the motor vehicle excise taxes deposited into the general fund under RCW 82.44.110((~~(4)~~))(1)(d) to the cities and towns ratably on the basis of population as last determined by the office of financial management. When so apportioned, the amount 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. 255. 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. 256.** 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. 257.** 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. 258.** 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 234 through 257 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 health care services when needed, and other matters as the three associations agree are of substance in the implementation of sections 234 through 257 of this act. This study shall be coordinated with the public health services improvement planning process set forth in section 467 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 March 1, 1994.

F. DATA COLLECTION

Sec. 259. RCW 70.170.100 and 1990 c 269 s 12 are each amended to read as follows:

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

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

~~(3)~~)) In designing the state-wide ((~~hospital~~)) health care data system and any data plans, the department shall identify ((~~hospital~~)) health care data elements relating to ((~~both hospital finances~~)) health care costs, the quality of health care services, the outcomes of health care services, and ((~~the~~)) use of ((~~services by patients~~)) health care by consumers. Data elements ((~~relating to hospital finances~~)) shall be reported ((~~by hospitals~~)) as the 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. 260. 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. 261.** A new section is added to chapter 70.170 RCW to read as follows:

CONFIDENTIALITY OF DATA. (1) 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: (a) Records obtained, reviewed by, or on file that contain information concerning medical treatment of individuals shall be exempt from public inspection and copying; and (b) 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.

(2) 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 that may, in any manner, identify individual persons.

(3) Data collected pursuant to sections 262 and 263 of this act shall be used solely for the health care reform provisions of chapter ..., Laws of 1993 (this act). The department shall ensure that the enrollee identifier used will employ the highest available standards for accuracy and uniqueness.

(4) Nothing in this section shall impede an enrollee’s access to her or his health care records as provided in chapter 70.02 RCW.

NEW SECTION. **Sec. 262.** 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 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 benefits 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 date of birth, sex, and ethnicity; (b) provider identifier; (c) diagnosis; (d) health care services or procedures provided; (e) provider charges, if any; and (f) amount paid. The department shall establish by rule confidentiality standards to safeguard the information from inappropriate use or release.

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

NEW SECTION. **Sec. 263.** A new section is added to chapter 70.170 RCW to read as follows:

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

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

NEW SECTION. **Sec. 264.** 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. 265.** 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 charges and may specifically review them. Hospitals are also directed to study methods for making daily charges available to prescribing physicians through the use of interactive software and/or computerized information thereby allowing physicians and other health care providers to review not only the costs of present and past services but also future contemplated costs for additional diagnostic studies and therapeutic medications.

NEW SECTION. **Sec. 266.** A new section is added to chapter 18.68 RCW to read as follows:

SPIRALING COSTS--PRESCRIPTION MEDICATIONS. The legislature finds that the spiraling costs of health care continue to surmount efforts to contain them, increasing at approximately twice the inflationary rate. One of the fastest growing segments of the health care expenditure involves prescription medications. By making physicians and other

health care providers with prescriptive authority more aware of the cost consequences of health care treatments for consumers, these providers may be inclined to exercise more restraint in providing only the most relevant and cost-beneficial drug and medication treatments. The requirement of the pharmacy to inform physicians and other health care providers of the charges of prescription drugs and medications 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.

NEW SECTION. **Sec. 267.** A new section is added to chapter 18.68 RCW to read as follows:

COST OF PRESCRIPTIVE MEDICATIONS. The registered or licensed pharmacist of this chapter shall establish and maintain a procedure for disclosing to physicians and other health care providers with prescriptive authority information detailed by prescriber, of the cost and dispensation of all prescriptive medications prescribed by him or her for his or her patients on request. These charges should be made available on at least a quarterly basis for all requested patients and should include medication, dosage, number dispensed, and the cost of the prescription. Pharmacies may provide this information in a summary form for each prescribing physician for all patients rather than as individually itemized reports. All efforts should be made to utilize the existing computerized records and software to provide this information in the least costly format.

NEW SECTION. **Sec. 268.** A new section is added to chapter 18.51 RCW to read as follows:

SPIRALING COSTS--NURSING HOMES. (1) The legislature finds that the spiraling costs of nursing home care continue to surmount efforts to contain them, increasing at approximately twice the inflationary rate. The causes of this phenomenon are complex. By making nursing home facilities and care providers more aware of the cost consequences of care services for consumers, these providers may be inclined to exercise more restraint in providing only the most relevant and cost-beneficial services and care, with a potential for reducing the utilization of those services. The requirement of the nursing home to

inform physicians, consumers, and other care providers of the charges of the services that they order may have a positive effect on containing health costs.

(2) All nursing home administrators in facilities licensed under this chapter shall be required to develop and maintain a written procedure for disclosing patient charges to attending physicians with admitting privileges. The nursing home administrator shall have the capability to provide an itemized list of the charges for all health care services that may be ordered by a physician. The information shall be made available on request of consumers, or the physicians or other appropriate health care providers responsible for prescribing care.

H. HEALTH PROFESSIONAL SHORTAGES

NEW SECTION. **Sec. 269.** LEGISLATIVE INTENT. The legislature finds that the successful implementation of health care reform will depend on 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. 270. 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 to increase the number of persons of color in the health professions. Such strategies shall incorporate, to the extent possible, federal and state assistance programs for health career development, including those for American Indians, economically disadvantaged persons, physically challenged persons, and persons of color.

(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. 271. 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. 272.** A new section is added to chapter 41.05 RCW to read as follows:

MULTICULTURAL HEALTH CARE TECHNICAL ASSISTANCE PROGRAM. (1) Consistent with funds appropriated specifically for this purpose, the authority shall provide matching grants to support community-based multicultural health care technical assistance programs. The purpose of the programs shall be to promote technical assistance through community and migrant health clinics and other appropriate health care providers who serve underserved populations 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. 273. 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~~)) and avoid duplication with similar federal programs and with the Washington rural health system project as authorized under chapter 70.175 RCW to consolidate administrative duties and reduce costs.

NEW SECTION. **Sec. 274.** A new section is added to chapter 70.185 RCW to read as follows:

STUDENT POSITIONS. (1) The department may develop a mechanism for underserved rural or urban communities to contract with education and training programs for student positions above the full time equivalent lids. The goal of this program is to provide additional capacity, educating students who will practice in underserved communities.

(2) Eligible education and training programs are those programs approved by the department that lead to eligibility for a credential as a credentialed health care professional. Eligible professions are those licensed under chapters 18.36A, 18.57, 18.57A, 18.71, and 18.71A RCW and advanced registered nurse practitioners and certified nurse midwives licensed under chapter 18.88 RCW, and may include other providers identified as needed in the health personnel resource plan.

(3) Students participating in the community contracted educational positions shall meet all applicable educational program requirements and provide assurances, acceptable to the community, that they will practice in the sponsoring community following completion of education and necessary licensure.

(4) Participants in the program incur an obligation to repay any contracted funds with interest set by state law, unless they serve at least three years in the sponsoring community.

(5) The department may provide funds to communities for use in contracting.

NEW SECTION. **Sec. 275.** A new section is added to chapter 70.185 RCW to read as follows:

AREA HEALTH EDUCATION CENTERS. The secretary may establish and contract with area health education centers in the eastern and western parts of the state. Consistent with the recruitment and retention objectives of this chapter, the centers shall provide or facilitate the provision of health professional educational and continuing education programs that strengthen the delivery of primary health care services in rural and medically underserved urban areas of the state. The center shall assist in the development and operation of health personnel recruitment and retention programs that are consistent with activities authorized under this chapter. The centers shall further provide technical expertise in the development of well managed health care delivery systems in rural Washington consistent with the goals and objectives of chapter . . ., Laws of 1993 (this act).

Sec. 276. 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. 277. 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 provider, including continuing education requirements;

(2) The participating ((~~physician~~)) primary 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 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 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 provider for services provided by the ((~~physician~~)) primary 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 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. 278.** 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 physicians. Currently, only a small proportion of medical school graduates are Washington residents who serve as primary care practitioners in certain parts of this state.

NEW SECTION. **Sec. 279.** MEDICAL SCHOOL PRIMARY CARE PHYSICIAN SHORTAGE PLAN DEVELOPMENT. (1) The University of Washington shall prepare a primary care shortage plan that accomplishes the following:

(a) Identifies specific activities that the school of medicine shall pursue to increase the number of Washington residents serving as primary care physicians in rural and medically underserved areas of the state, including establishing a goal that assures that no less than fifty percent of medical school graduates who are Washington state residents at the time of matriculation will enter into primary care residencies, to the extent possible, in Washington state by the year 2000;

(b) Assures that the school of medicine shall establish among its highest training priorities the distribution of its primary care physician graduates from the school and associated postgraduate residency programs into rural and medically underserved areas;

(c) Establishes the goal of assuring that the annual number of graduates from the family practice residency network entering rural or medically underserved practice shall be increased by forty percent over a baseline period from 1988 through 1990 by 1995;

(d) Establishes a further goal to make operational at least two additional family practice residency programs within Washington state in geographic areas identified by the plan as underserved in family practice by 1997. The geographic areas identified by the plan as being underserved by family practice physicians shall be consistent with any

such similar designations as may be made in the health personnel research plan as authorized under chapter 28B.125 RCW;

(e) Establishes, with the cooperation of existing community and migrant health clinics in rural or medically underserved areas of the state, three family practice residency training tracks. Furthermore, the primary care shortage plan shall provide that one of these training tracks shall be a joint American osteopathic association and American medical association approved training site coordinated with an accredited college of osteopathic medicine with extensive experience in training primary care physicians for the western United States. Such a proposed joint accredited training track will have at least fifty 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. 280.** 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. 281.** 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. 282. 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 maintenance agreement which provides benefits for hospital, medical, or surgical expenses shall be delivered or issued for delivery in this state ((~~after September 8, 1975~~)) which contains any provision whereby the insurer, contractor, or health maintenance organization may reduce or refuse to pay such benefits otherwise payable thereunder solely on account of the existence of similar benefits provided under any ((~~individual~~)) disability insurance policy, ((~~or under any individual~~)) health care service contract, or health maintenance agreement.

(2) No individual or group disability insurance policy, health care service contract, or health maintenance agreement providing hospital, medical or surgical expense benefits and which contains a provision for the reduction of benefits otherwise payable or available thereunder on the basis of other existing coverages, shall provide that such reduction will operate to reduce total benefits payable below an amount equal to one hundred percent of total allowable expenses exclusive of copayments, deductibles, and other similar cost-sharing arrangements.

(3) The commissioner shall by rule establish guidelines for the application of this section, including:

(a) The procedures by which persons ((~~insured~~)) covered under such policies, contracts, and agreements are to be made aware of the existence of such a provision;

(b) The benefits which may be subject to such a provision;

(c) The effect of such a provision on the benefits provided;

(d) Establishment of the order of benefit determination; ((~~and~~))

(e) Exceptions necessary to preserve policy, contract, or agreement requirements for use of particular health care facilities or providers; and

(f) Reasonable claim administration procedures to expedite claim payments and prevent duplication of payments or benefits under such a provision((~~: PROVIDED, HOWEVER, That any group disability insurance policy which is issued as part of an employee insurance benefit program authorized by RCW 41.05.025(3) may exclude all or part of any deductible amounts from the definition of total allowable expenses for purposes of coordination of benefits within the plan and between such plan and other applicable group coverages: AND PROVIDED FURTHER, That any group disability insurance policy providing coverage for persons in this state may exclude all or part of any deductible amounts required by a group disability insurance policy from the definition of total 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. 283.** 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. 284.** A new section is added to chapter 48.21 RCW to read as follows:

GROUP DISABILITY INSURERS--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. 285.** A new section is added to chapter 48.44 RCW to read as follows:

HEALTH CARE SERVICE CONTRACTORS--PREEXISTING CONDITIONS EXCLUSIONS AND LIMITATIONS. (1) After January 1, 1994, every health care service contractor, except limited health care service contractors as defined under RCW 48.44.035, 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 contract 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. 286.** A new section is added to chapter 48.46 RCW to read as follows:

HEALTH MAINTENANCE ORGANIZATIONS--PREEXISTING CONDITIONS EXCLUSIONS AND LIMITATIONS. (1) After January 1, 1994, every health maintenance organization 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 agreement 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.

Sec. 287. RCW 48.30.300 and 1975-’76 2nd ex.s. c 119 s 7 are each amended to read as follows:

UNFAIR PRACTICES. Notwithstanding any provision contained in Title 48 RCW to the contrary:

(1) 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. Subject to the provisions of

subsection (2) of this section these 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.

(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:

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

(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

(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. 288.** 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 that 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. 289.** 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. 290. 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. 291. 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. 292.** 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. 293.** 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. 294.** A new section is added to chapter 48.01 RCW to read as follows:

CERTIFIED HEALTH PLAN PROVISIONS--APPLICATION. Whenever the provisions of this title conflict with the provisions of chapter . . ., Laws of 1993 (this act), chapter . . ., Laws of 1993 (this act) shall control.

Sec. 295. 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. 296. 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

(f) Disclosure of any financial interests held by officers and directors in any providers associated with the health maintenance organization or any provider of the health maintenance organization.

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

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

(5) No person shall knowingly file with any public official or knowingly make, publish, or disseminate any financial statement of a health maintenance organization which does not accurately state the health maintenance organization's financial condition.

PART III. TAXES

NEW SECTION. **Sec. 301.** A new section is added to chapter 48.14 RCW to read as follows:

TAX ON PREMIUMS AND PREPAYMENTS. (1) As used in this section, "taxpayer" means a health maintenance organization, as defined in RCW 48.46.020, a health care service contractor, as defined in RCW 48.44.010, or a certified health plan certified under section 434 of this act.

(2) Each taxpayer shall pay a tax on or before the first day of March of each year to the state treasurer through the insurance commissioner's office. The tax shall be equal to the total amount of all premiums and prepayments for health care services received by the taxpayer during the preceding calendar year multiplied by the rate of two percent.

(3) Taxpayers shall prepay their tax obligations under this section. The minimum amount of the prepayments shall be percentages of the taxpayer's tax obligation for the preceding calendar year recomputed using the rate in effect for the current year. For the prepayment of taxes due during the first calendar year, the minimum amount of the prepayments shall be percentages of the taxpayer's tax obligation that would have been due had the tax been in effect during 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 469 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 434 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:

TAX ON HOSPITALS OPERATED AS NONPROFIT CORPORATIONS. (1) Upon every person engaging within this state in the business of buying wheat, oats, dry peas, dry beans, lentils, triticale, corn, rye and barley, but not including any manufactured or processed products thereof, and selling the same at wholesale; the tax imposed shall be equal to the gross proceeds derived from such sales multiplied by the rate of one one-hundredth of one percent.

(2) Upon every person engaging within this state in the business of manufacturing wheat into flour, barley into pearl barley, soybeans into soybean oil, or sunflower seeds into sunflower oil; as to such persons the amount of tax with respect to such business shall be equal to the value of the flour, pearl barley, or oil manufactured, multiplied by the rate of one-eighth of one percent.

(3) Upon every person engaging within this state in the business of splitting or processing dried peas; as to such persons the amount of tax with respect to such business shall be equal to the value of the peas split or processed, multiplied by the rate of one-quarter of one percent.

(4) Upon every person engaging within this state in the business of manufacturing seafood products which remain in a raw, raw frozen, or raw salted state at the completion of the manufacturing by that person; as to such persons the amount of tax with respect to such business shall be equal to the value of the products manufactured, multiplied by the rate of one-eighth of one percent.

(5) Upon every person engaging within this state in the business of manufacturing by canning, preserving, freezing or dehydrating fresh fruits and vegetables; as to such persons the amount of tax with respect to such business shall be equal to the value of the products canned, preserved, frozen or dehydrated multiplied by the rate of three-tenths of one percent.

(6) Upon every nonprofit corporation and nonprofit association engaging within this state in research and development, as to such corporations and associations, the amount of tax with respect to such activities shall be equal to the gross income derived from such activities multiplied by the rate of forty-four one-hundredths of one percent.

(7) Upon every person engaging within this state in the business of slaughtering, breaking and/or processing perishable meat products and/or selling the same at wholesale only and not at retail; as to such persons the tax imposed shall be equal to the gross proceeds derived from such sales multiplied by the rate of twenty-five one-hundredths of one percent through June 30, 1986, and one-eighth of one percent thereafter.

(8) Upon every person engaging within this state in the business of making sales, at retail or wholesale, of nuclear fuel assemblies manufactured by that person, as to such persons the amount of tax with

respect to such business shall be equal to the gross proceeds of sales of the assemblies multiplied by the rate of twenty-five one-hundredths of one percent.

(9) Upon every person engaging within this state in the business of manufacturing nuclear fuel assemblies, as to such persons the amount of tax with respect to such business shall be equal to the value of the products manufactured multiplied by the rate of twenty-five one-hundredths of one percent.

(10) Upon every person engaging within this state in the business of acting as a travel agent; as to such persons the amount of the tax with respect to such activities shall be equal to the gross income derived from such activities multiplied by the rate of twenty-five one-hundredths of one percent.

(11) Upon every person engaging within this state in business as an international steamship agent, international customs house broker, international freight forwarder, vessel and/or cargo charter broker in foreign commerce, and/or international air cargo agent; as to such persons the amount of the tax with respect to only international activities shall be equal to the gross income derived from such activities multiplied by the rate of thirty-three one-hundredths of one percent.

(12) Upon every person engaging within this state in the business of stevedoring and associated activities pertinent to the movement of goods and commodities in waterborne interstate or foreign commerce; as to such persons the amount of tax with respect to such business shall be equal to the gross proceeds derived from such activities multiplied by the rate of thirty-three one hundredths of one percent. Persons subject to taxation under this subsection shall be exempt from payment of taxes imposed by chapter 82.16 RCW for that portion of their business subject to taxation under this subsection. Stevedoring and associated activities pertinent to the conduct of goods and commodities in waterborne interstate or foreign commerce are defined as all activities of a labor, service or transportation nature whereby cargo may be loaded or unloaded to or from vessels or barges, passing over, onto or under a wharf, pier, or similar structure; cargo may be moved to a warehouse or similar holding or storage yard or area to await further movement in import or export or may move to a consolidation freight station and be stuffed, unstuffed, containerized, separated or otherwise segregated or aggregated for delivery or loaded on any mode

of transportation for delivery to its consignee. Specific activities included in this definition are: Wharfage, handling, loading, unloading, moving of cargo to a convenient place of delivery to the consignee or a convenient place for further movement to export mode; documentation services in connection with the receipt, delivery, checking, care, custody and control of cargo required in the transfer of cargo; imported automobile handling prior to delivery to consignee; terminal stevedoring and incidental vessel services, including but not limited to plugging and unplugging refrigerator service to containers, trailers, and other refrigerated cargo receptacles, and securing ship hatch covers.

(13) Upon every person engaging within this state in the business of disposing of low-level waste, as defined in RCW 43.145.010; as to such persons the amount of the tax with respect to such business shall be equal to the gross income of the business, excluding any fees imposed under chapter 43.200 RCW, multiplied by the rate of fifteen percent.

(a) The rate specified in this subsection shall be reduced to ten percent on May 20, 1991.

(b) The rate specified in this subsection shall be further reduced to five percent on January 1, 1992.

(c) The rate specified in this subsection shall be further reduced to three percent on July 1, 1993.

If the gross income of the taxpayer is attributable to activities both within and without this state, the gross income attributable to this state shall be determined in accordance with the methods of apportionment required under RCW 82.04.460.

(14) Upon every person engaging within this state as an insurance agent, insurance broker, or insurance solicitor licensed under chapter 48.17 RCW; as to such persons, the amount of the tax with respect to such licensed activities shall be equal to the gross income of such 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 seventy-five one-hundredths 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 469 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--BUSINESS AND OCCUPATION TAX 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 469 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 469 of this act.

Sec. 310. RCW 82.08.150 and 1989 c 271 s 503 are each amended to read as follows:

TAX ON SPIRITS. (1) There is levied and shall be collected a tax upon each retail sale of spirits, or strong beer in the original package at the rate of fifteen percent of the selling price. The tax imposed in this subsection shall apply to all such sales including

sales by the Washington state liquor stores and agencies, but excluding sales to class H licensees.

(2) There is levied and shall be collected a tax upon each sale of spirits, or strong beer in the original package at the rate of ten percent of the selling price on sales by Washington state liquor stores and agencies to class H licensees.

(3) There is levied and shall be collected an additional tax upon each retail sale of spirits in the original package at the rate of one dollar and seventy-two cents per liter. The additional tax imposed in this subsection shall apply to all such sales including sales by Washington state liquor stores and agencies, and including sales to class H licensees.

(4) An additional tax is imposed equal to ((~~the rate specified in RCW 82.02.030~~)) fourteen percent multiplied by the taxes payable under subsections (1), (2), and (3) of this section.

(5) Until July 1, 1995, an additional tax is imposed upon each retail sale of spirits in the original package at the rate of seven cents per liter. The additional tax imposed in this subsection shall apply to all such sales including sales by Washington state liquor stores and agencies, and including sales to class H licensees. 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.

(6)(a) An additional tax is imposed upon retail sale of spirits in the original package at the rate of one and seven-tenths percent of the selling price through June 30, 1995, two and six-tenths percent of the selling price for the period July 1, 1995, through June 30, 1997, and three and four-tenths of the selling price thereafter. This additional tax applies to all such sales including sales by Washington state liquor stores and agencies, but excluding sales to class H licensees.

(b) An additional tax is imposed upon retail sale of spirits in the original package at the rate of one and one-tenth percent of the selling price through June 30, 1995, one and seven-tenths percent of the selling price for the period July 1, 1995, through June 30, 1997, and two and three-tenths of the selling price thereafter. This additional tax applies to all such sales to class H licensees.

(c) An additional tax is imposed upon each retail sale of spirits in the original package at the rate of twenty cents per liter through June 30, 1995, thirty cents per liter for the period July 1, 1995,

through June 30, 1997, and forty-one cents per liter thereafter. This additional tax applies to all such sales including sales by Washington state liquor stores and agencies, and including sales to class H licensees.

(d) All revenues collected during any month from additional taxes under this subsection shall be deposited in the health services account created under section 469 of this act by the twenty-fifth day of the following month.

(7) The tax imposed in RCW 82.08.020((~~, as now or hereafter amended,~~)) shall not apply to sales of spirits or strong beer in the original package.

((~~(7)~~)) (8) The taxes imposed in this section shall be paid by the buyer to the seller, and each seller shall collect from the buyer the full amount of the tax payable in respect to each taxable sale under this section. The taxes required by this section to be collected by the seller shall be stated separately from the selling price and for purposes of determining the tax due from the buyer to the seller, it shall be conclusively presumed that the selling price quoted in any price list does not include the taxes imposed by this section.

((~~(8)~~)) (9) As used in this section, the terms, "spirits," "strong beer," and "package" shall have the meaning ascribed to them in chapter 66.04 RCW.

Sec. 311. 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 469 of this act.

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

Sec. 312. 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~~)).

PART IV. HEALTH SYSTEM REFORM

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

NEW SECTION. **Sec. 402.** DEFINITIONS. In this chapter, unless the context otherwise requires:

(1) "Certified health plan" or "plan" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, a health maintenance organization as defined in RCW 48.46.020, or an entity certified in accordance with sections 433 through 443 of this act.

(2) "Chair" means the presiding officer of the Washington health services commission.

(3) "Commission" or "health services commission" means the Washington health services commission.

(4) "Community rate" means the rating method used to establish the premium for the uniform benefits package adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region and family size as determined by the commission.

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

(6) "Employee" means a resident who is in the employment of an employer, as defined by chapter 50.04 RCW.

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

(8) "Enrollee point of service cost-sharing" means amounts paid to certified health plans directly providing services, health care providers, or health care facilities by enrollees for receipt of specific uniform benefits package services, and may include copayments, coinsurance, or deductibles, that together must be actuarially equivalent across plans and within overall limits established by the commission.

(9) "Enrollee premium sharing" means that portion of the premium that is paid by enrollees or their family members.

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

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

(12) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW and chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

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

(13) "Health insurance purchasing cooperative" or "cooperative" means a member-owned and governed nonprofit organization certified in accordance with sections 425 and 426 of this act.

(14) "Long-term care" means institutional, residential, outpatient, or community-based services that meet the individual needs of persons of all ages who are limited in their functional capacities or have disabilities and require assistance with performing two or more activities of daily living for an extended or indefinite period of time. These services include case management, protective supervision, in-home care, nursing services, convalescent, custodial, chronic, and terminally ill care.

(15) "Major capital expenditure" means any project or expenditure for capital construction, renovations, or acquisition, including medical technological equipment, as defined by the commission, costing more than one million dollars.

(16) "Managed care" means an integrated system of insurance, financing, and health services delivery functions that: (a) Assumes financial risk for delivery of health services and uses a defined network of providers; or (b) assumes financial risk for delivery of health services and promotes the efficient delivery of health services through provider assumption of some financial risk including capitation, prospective payment, resource-based relative value scales, fee schedules, or similar method of limiting payments to health care providers.

(17) "Maximum enrollee financial participation" means the income-related total annual payments that may be required of an enrollee per family who chooses one of the three lowest priced uniform benefits packages offered by plans in a geographic region including both premium sharing and enrollee point of service cost-sharing.

(18) "Persons of color" means Asians/Pacific Islanders, African, Hispanic, and Native Americans.

(19) "Premium" means all sums charged, received, or deposited by a certified health plan as consideration for a uniform benefits package or the continuance of a uniform benefits package. Any assessment, or any "membership," "policy," "contract," "service," or similar fee or charge made by the certified health plan in consideration for the uniform benefits package is deemed part of the premium. "Premium"

shall not include amounts paid as enrollee point of service cost-sharing.

(20) "Qualified employee" means an employee who is employed at least thirty hours during a week or one hundred twenty hours during a calendar month.

(21) "Registered employer health plan" means a health plan established by a private employer of more than seven thousand active employees in this state solely for the benefit of such employees and their dependents and that meets the requirements of section 430 of this act. Nothing contained in this subsection shall be deemed to preclude the plan from providing benefits to retirees of the employer.

(22) "Supplemental benefits" means those appropriate and effective health services that are not included in the uniform benefits package or that expand the type or level of health services available under the uniform benefits package and that are offered to all residents in accordance with the provisions of sections 452 and 453 of this act.

(23) "Technology" means the drugs, devices, equipment, and medical or surgical procedures used in the delivery of health services, and the organizational or supportive systems within which such services are provided. It also means sophisticated and complicated machinery developed as a result of ongoing research in the basic biological and physical sciences, clinical medicine, electronics, and computer sciences, as well as specialized professionals, medical equipment, procedures, and chemical formulations used for both diagnostic and therapeutic purposes.

(24) "Uniform benefits package" or "package" means those appropriate and effective health services, defined by the commission under section 449 of this act, that must be offered to all Washington residents through certified health plans.

(25) "Washington resident" or "resident" means a person who intends to reside in the state permanently or indefinitely and who did not move to Washington for the primary purpose of securing health services under sections 427 through 466 of this act. "Washington resident" also includes people and their accompanying family members who are residing in the state for the purpose of engaging in employment for at least one month, who did not enter the state for the primary purpose of obtaining health services. The confinement of a person in a nursing home, hospital, or other medical institution in the state shall not by itself be sufficient to qualify such person as a resident.

A. THE WASHINGTON HEALTH SERVICES COMMISSION

NEW SECTION. **Sec. 403.** CREATION OF COMMISSION--MEMBERSHIP--TERMS OF OFFICE--VACANCIES--SALARIES. (1) There is created an agency of state government to be known as the Washington health services commission. The commission shall consist of five members reflecting ethnic and racial diversity, appointed by the governor, with the consent of the senate. One member shall be designated by the governor as chair and shall serve at the pleasure of the governor. The insurance commissioner shall serve as an additional nonvoting member. Of the initial members, one shall be appointed to a term of three years, two shall be appointed to a term of four years, and two shall be appointed to a term of five years. Thereafter, members shall be appointed to five-year terms. Vacancies shall be filled by appointment for the remainder of the unexpired term of the position being vacated.

(2) Members of the commission shall have no pecuniary interest in any business subject to regulation by the commission and shall be subject to chapter 42.18 RCW, the executive branch conflict of interest act.

(3) Members of the commission shall occupy their positions on a full-time basis and are exempt from the provisions of chapter 41.06 RCW. Commission members and the professional commission staff are subject to the public disclosure provisions of chapter 42.17 RCW. Members shall be paid a salary to be fixed by the governor in accordance with RCW 43.03.040. A majority of the members of the commission constitutes a quorum for the conduct of business.

NEW SECTION. **Sec. 404.** ADVISORY COMMITTEES. (1)(a) The chair shall appoint an advisory committee with balanced representation from consumers, business, government, labor, certified health plans, practicing health care providers, health care facilities, and health services researchers reflecting ethnic and racial diversity. In addition, the chair may appoint special committees for specified periods of time.

(b) The chair shall also appoint a five-member health services effectiveness committee whose members possess a breadth of experience and knowledge in the treatment, research, and public and private funding of health care services. The committee shall meet at the call of the chair. The health services effectiveness committee shall advise

the commission on: (i) Those health services that may be determined by the commission to be appropriate and effective; (ii) use of technology and practice indicators; (iii) the uniform benefits package; and (iv) rules that insurers and certified health plans must use to determine whether a procedure, treatment, drug, or other health service is no longer experimental or investigative.

(c) The commission shall also appoint a small business advisory committee composed of seven owners of businesses with twenty-five or fewer full-time equivalent employees' reflecting ethnic and racial diversity, to assist the commission in development of the small business economic impact statement and the small business assistance program, as provided in sections 450 and 466 of this act.

(d) The commission shall also appoint an organized labor advisory committee composed of seven representatives of employee organizations representing employees of public or private employers. The committee shall assist the commission in conducting the evaluation of Taft-Hartley health care trusts and self-insured employee health benefits plans, as provided in section 406(26) of this act, and shall advise the commission on issues related to the impact of chapter . . ., Laws of 1993 (this act) on negotiated health benefits agreements and other employee health benefits plans.

(2) Members of committees and panels shall serve without compensation for their services but shall be reimbursed for their expenses while attending meetings on behalf of the commission in accordance with RCW 43.03.050 and 43.03.060.

NEW SECTION. **Sec. 405.** POWERS AND DUTIES OF THE CHAIR. The chair shall be the chief administrative officer and the appointing authority of the commission and has the following powers and duties:

(1) Direct and supervise the commission's administrative and technical activities in accordance with the provisions of this chapter and rules and policies adopted by the commission;

(2) Employ personnel of the commission in accordance with chapter 41.06 RCW, and prescribe their duties. With the approval of a majority of the commission, the chair may appoint persons to administer any entity established pursuant to subsection (8) of this section, and up to seven additional employees all of whom shall be exempt from the provisions of chapter 41.06 RCW;

(3) Enter into contracts on behalf of the commission;

(4) Accept and expend gifts, donations, grants, and other funds received by the commission;

(5) Delegate administrative functions of the commission to employees of the commission as the chair deems necessary to ensure efficient administration;

(6) Subject to approval of the commission, appoint advisory committees and undertake studies, research, and analysis necessary to support activities of the commission;

(7) Preside at meetings of the commission;

(8) Consistent with policies and rules established by the commission, establish such administrative divisions, offices, or programs as are necessary to carry out the purposes of chapter . . ., Laws of 1993 (this act); and

(9) Perform such other administrative and technical duties as are consistent with chapter . . ., Laws of 1993 (this act) and the rules and policies of the commission.

NEW SECTION. **Sec. 406.** POWERS AND DUTIES OF THE COMMISSION. The commission has the following powers and duties:

(1) Ensure that all residents of Washington state are enrolled in a certified health plan to receive the uniform benefits package, regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment, or economic status.

(2) Endeavor to ensure that all residents of Washington state have access to appropriate, timely, confidential, and effective health services, and monitor the degree of access to such services. If the commission finds that individuals or populations lack access to certified health plan services, the commission shall:

(a) Authorize appropriate state agencies, local health departments, community or migrant health clinics, public hospital districts, or other nonprofit health service entities to take actions necessary to assure such access. This includes authority to contract for or directly deliver services described within the uniform benefits package to special populations; or

(b) Notify appropriate certified health plans and the insurance commissioner of such findings. The commission shall adopt by rule standards by which the insurance commissioner may, in such event, require certified health plans in closest proximity to such individuals

and populations to extend their catchment areas to those individuals and populations and offer them enrollment.

(3) Adopt necessary rules in accordance with chapter 34.05 RCW to carry out the purposes of chapter . . ., Laws of 1993 (this act). An initial set of draft rules establishing at least the commission's organization structure, the uniform benefits package, and standards for certified health plan certification, must be submitted in draft form to appropriate committees of the legislature by December 1, 1994.

(4) Establish and modify as necessary, in consultation with the state board of health and the department of health, and coordination with the planning process set forth in section 467 of this act a uniform set of health services based on the recommendations of the health care cost control and access commission established under House Concurrent Resolution No. 4443 adopted by the legislature in 1990.

(5) Establish and modify as necessary the uniform benefits package as provided in section 449 of this act, which shall be offered to enrollees of a certified health plan. The benefit package shall be provided at no more than the maximum premium specified in subsection (6) of this section.

(6)(a) Establish for each year a community-rated maximum premium for the uniform benefits package that shall operate to control overall health care costs. The maximum premium cost of the uniform benefits package in the base year 1995 shall be established upon an actuarial determination of the costs of providing the uniform benefits package and such other cost impacts as may be deemed relevant by the commission. Beginning in 1996, the growth rate of the premium cost of the uniform benefits package for each certified health plan shall be allowed to increase by a rate no greater than the average growth rate in the cost of the package between 1990 and 1993 as actuarially determined, reduced by two percentage points per year until the growth rate is no greater than the five-year rolling average of growth in Washington per capita personal income, as determined by the office of financial management.

(b) In establishing the community-rated maximum premium under this subsection, the commission shall develop a composite rate for employees that provides nominal, if any, variance between the rate for individual employees and employees with dependents to minimize any economic incentive to an employer to discriminate between prospective employees based upon whether or not they have dependents for whom coverage would

be required. Nothing in this subsection (6)(b) shall preclude the commission from evaluating other methodologies for establishing the community-rated maximum premium and recommending an alternative methodology to the legislature.

(c) If the commission adds or deletes services or benefits to the uniform benefits package in subsequent years, it may increase or decrease the maximum premium to reflect the actual cost experience of a broad sample of providers of that service in the state, considering the factors enumerated in (a) of this subsection and adjusted actuarially. The addition of services or benefits shall not result in a redetermination of the entire cost of the uniform benefits package.

(d) The level of state expenditures for the uniform benefits package shall be limited to the appropriation of funds specifically for this purpose.

(7) Determine the need for medical risk adjustment mechanisms to minimize financial incentives for certified health plans to enroll individuals who present lower health risks and avoid enrolling individuals who present higher health risks, and to minimize financial incentives for employer hiring practices that discriminate against individuals who present higher health risks. In the design of medical risk distribution mechanisms under this subsection, the commission shall (a) balance the benefits of price competition with the need to protect certified health plans from any unsustainable negative effects of adverse selection; (b) consider the development of a system that creates a risk profile of each certified health plan's enrollee population that does not create disincentives for a plan to control benefit utilization, that requires contributions from plans that enjoy a low-risk enrollee population to plans that have a high-risk enrollee population, and that does not permit an adjustment of the premium charged for the uniform benefits package or supplemental coverage based upon either receipt or contribution of assessments; and (c) consider whether registered employer health plans should be included in any medical risk adjustment mechanism. Proposed medical risk adjustment mechanisms shall be submitted to the legislature as provided in section 454 of this act.

(8) Design a mechanism to assure minors have access to confidential health care services as currently provided in RCW 70.24.110 and 71.34.030.

(9) Monitor the actual growth in total annual health services costs.

(10) 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.

(11) 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 and shall report to the legislature regarding major capital expenditures on at least an annual basis. The Washington health care facilities authority and the commission shall develop standards jointly 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.

(12) Establish maximum enrollee financial participation levels. The levels shall be related to enrollee household income.

(13) For health services provided under the uniform benefits package and supplemental benefits, 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, health care facilities, 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.

(14) Propose 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.

(15) Propose other guidelines to certified health plans for utilization management, use of technology and methods of payment, such as diagnosis-related groups and a resource-based relative value scale. Such guidelines shall be voluntary and shall be designed to promote improved management of care, and provide incentives for improved efficiency and effectiveness within the delivery system.

(16) Adopt standards and oversee and develop policy for personal health data and information system as provided in chapter 70.170 RCW.

(17) Adopt standards that prevent conflict of interest by health care providers as provided in section 408 of this act.

(18) At the appropriate juncture and in the fullness of time, consider the extent to which medical research and health professions training activities should be included within the health service system set forth in this chapter . . ., Laws of 1993 (this act).

(19) Evaluate and monitor the extent to which racial and ethnic minorities have access and to receive health services within the state, and develop strategies to address barriers to access.

(20) Develop standards for the certification process to certify health plans and employer health plans to provide the uniform benefits package, according to the provisions for certified health plans and registered employer health plans under chapter . . ., Laws of 1993 (this act).

(21) Develop rules for implementation of individual and employer participation under sections 463 and 464 of this act specifically applicable to persons who work in this state but do not live in the state or persons who live in this state but work outside of the state. The rules shall be designed so that these persons receive coverage and financial requirements that are comparable to that received by persons who both live and work in the state.

(22) After receiving advice from the health services effectiveness committee, adopt rules that must be used by certified health plans, disability insurers, health care service contractors, and health maintenance organizations to determine whether a procedure, treatment, drug, or other health service is no longer experimental or investigative.

(23) Establish a process for purchase of uniform benefits package services by enrollees when they are out-of-state.

(24) Develop recommendations to the legislature as to whether state and school district employees, on whose behalf health benefits are or

will be purchased by the health care authority pursuant to chapter 41.05 RCW, should have the option to purchase health benefits through health insurance purchasing cooperatives on and after July 1, 1997. In developing its recommendations, the commission shall consider:

(a) The impact of state or school district employees purchasing through health insurance purchasing cooperatives on the ability of the 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 provide benefits to certain individuals in the state; review the federal laws under which these trusts are organized; and make appropriate recommendations to the governor and the legislature on or before December 1, 1994, as to whether these trusts should be brought under the provisions of chapter . . ., Laws of 1993 (this act) when it is fully implemented, and if the commission recommends inclusion of the trusts, how to implement such inclusion.

(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 unsubsidized and 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 evidence established by independent actuarial analysis, if the commission finds that the economic viability of a significant number of the state's certified health plans is seriously threatened, the commission may increase the maximum premium to the extent mandated by the Constitution, and must immediately thereafter submit to the legislature a proposal for a new formula for adjusting the maximum premium, which must be enacted into law by a sixty percent vote of each house of the legislature.

NEW SECTION. **Sec. 408.** A new section is added to chapter 18.130 RCW to read as follows:

CONFLICT OF INTEREST STANDARDS. The Washington health services commission established by section 403 of this act, in consultation with the secretary of health, and the health care disciplinary authorities under RCW 18.130.040(2)(b), shall establish standards and monetary penalties in rule prohibiting provider investments and referrals that present a conflict of interest resulting from inappropriate financial gain for the provider or his or her immediate family. These standards are not intended to inhibit the efficient operation of managed health care systems or certified health plans. The commission shall report to the health policy committees of the senate and house of representatives by December 1, 1994, on the development of the standards and any recommended statutory changes necessary to implement the standards.

NEW SECTION. **Sec. 409.** CONTINUOUS QUALITY IMPROVEMENT AND TOTAL QUALITY MANAGEMENT. To ensure the highest quality health services at the lowest total cost, the commission shall establish a total quality management system of continuous quality improvement. Such endeavor shall be based upon the recognized quality science for continuous quality improvement. The commission shall impanel a committee composed of persons from the private sector and related sciences who have broad knowledge and successful experiences in continuous quality improvement

and total quality management applications. It shall be the responsibility of the committee to develop standards for a Washington state health services supplier certification process and recommend such standards to the commission for review and adoption. Once adopted, the commission shall establish a schedule, with full compliance no later than July 1, 1996, whereby all health service providers and health service facilities shall be certified prior to providing uniform benefits package services.

B. PRACTICE INDICATORS

NEW SECTION. **Sec. 410.** A new section is added to chapter 43.70 RCW to read as follows:

PRACTICE INDICATORS. The department of health shall consult with health care providers and facilities, purchasers, health professional regulatory authorities under RCW 18.130.040, appropriate research and clinical experts, and consumers of health care services to identify specific practice areas where practice indicators and risk management protocols have been developed, including those that have been demonstrated to be effective among persons of color. Practice indicators shall be based upon expert consensus and best available scientific evidence. The department shall:

(1) Develop a definition of expert consensus and best available scientific evidence so that practice indicators can serve as a standard for excellence in the provision of health care services.

(2) Establish a process to identify and evaluate practice indicators and risk management protocols as they are developed by the appropriate professional, scientific, and clinical communities.

(3) Recommend the use of practice indicators and risk management protocols in quality assurance, utilization review, or provider payment to the health services commission.

C. HEALTH CARE LIABILITY REFORMS

Sec. 411. RCW 43.70.320 and 1991 sp.s. c 13 s 18 are each amended to read as follows:

HEALTH PROFESSIONS ACCOUNT. (1) There is created in the state treasury an account to be known as the health professions account. All fees received by the department for health professions licenses,

registration, certifications, renewals, or examinations and the civil penalties assessed and collected by the department under RCW 18.130.190 shall be forwarded to the state treasurer who shall credit such moneys to the health professions account.

(2) All expenses incurred in carrying out the health professions 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 449 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) Each quality improvement committee shall, on at least a semiannual basis, report to the governing board of the hospital in which the committee is located. The report shall review the quality improvement activities conducted by the committee, and any actions taken as a result of those activities.

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

((~~(5)~~)) (6) 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)~~)) (7) 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.

(6) Hospitals shall be granted access to information held by the medical disciplinary board and the board of osteopathic medicine and surgery pertinent to decisions of the hospital regarding credentialing and recredentialing of practitioners.

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

NEW SECTION. **Sec. 417.** A new section is added to chapter 43.70 RCW to read as follows:

COORDINATED QUALITY IMPROVEMENT PROGRAM. (1)(a) Health care institutions and medical facilities, other than hospitals, that are licensed by the department, professional societies or organizations, and certified health plans approved pursuant to section 428 of this act may 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 as set forth in RCW 70.41.200.

(b) All such programs shall comply with the requirements of RCW 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the institution, facility, professional societies or organizations, or certified health plan, unless an alternative quality improvement program substantially equivalent to RCW 70.41.200(1)(a) is developed. All such programs, whether complying with the requirement set forth in RCW 70.41.200(1)(a) or in the form of an alternative program, must be approved by the department before the discovery limitations provided in subsections (3) and (4) of this section shall apply. In reviewing plans submitted by

licensed entities that are associated with physicians' offices, the department shall ensure that the discovery limitations of this section are applied only to information and documents related specifically to quality improvement activities undertaken by the licensed entity.

(2) Health care provider groups of ten or more providers may 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 as set forth in RCW 70.41.200. All such programs shall comply with the requirements of RCW 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the health care provider group. 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;

(b) Appropriate limits on the amount or manner of compensation of mediators;

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

(d) 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;

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

(f) 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

(g) 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.

NEW SECTION. **Sec. 423.** A new section is added to chapter 7.70 RCW to read as follows:

MANDATORY MEDIATION OF HEALTH CARE MALPRACTICE CLAIMS. A cause of action that has been mediated as provided in section 419 of this act shall be exempt from any superior court civil rules mandating arbitration of civil actions or participation in settlement conferences prior to trial.

Sec. 424. 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 against whom judgment has been entered 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, then, 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

NEW SECTION. **Sec. 425.** HEALTH INSURANCE PURCHASING COOPERATIVES--DESIGNATION OF REGIONS BY COMMISSION, INFORMATION SYSTEMS, MINIMUM STANDARDS, AND RULES. (1) The commission shall designate four geographic regions within the state in which health insurance purchasing cooperatives may operate, based upon population, assuming that each cooperative must serve no less than one hundred fifty thousand persons; geographic factors; market conditions; and other factors deemed appropriate by the commission. The commission shall designate one health insurance purchasing cooperative per region.

(2) In coordination with the commission and consistent with the provisions of chapter 70.170 RCW, the department of health shall establish an information clearinghouse for the collection and dissemination of information necessary for the efficient operation of cooperatives, including the establishment of a risk profile information system related to certified health plan enrollees that would permit the equitable distribution of losses among plans in accordance with section 406(7) of this act.

(3) Every health insurance purchasing cooperative shall:

(a) Admit all individuals, employers, or other groups wishing to participate in the cooperative;

(b) Make available for purchase by cooperative members every health care program offered by every certified health plan operating within the cooperative's region;

(c) Be operated as a member-governed and owned, nonprofit cooperative in which no certified health plan, health maintenance organization, health care service contractor, independent practice association, independent physician organization, or any individual with a pecuniary interest in any such organization, shall have any pecuniary interest in or management control of the cooperative;

(d) Provide for centralized enrollment and premium collection and distribution among certified health plans; and

(e) Serve as an ombudsman for its members to resolve inquiries, complaints, or other concerns with certified health plans.

(4) Every health insurance purchasing cooperative shall assist 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. 426.** 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. 427.** CERTIFIED HEALTH PLANS--CERTIFICATION REQUIRED--PENALTY. (1) On and after July 1, 1995, no person or entity in this state shall provide the uniform benefits package and supplemental benefits as defined in section 402 of this act without being certified as a certified health plan by the insurance commissioner.

(2) On and after July 1, 1995, no certified health plan may offer less than the uniform benefits package to residents of this state and no registered employer health plan may provide less than the uniform benefits package to its employees and their dependents.

NEW SECTION. **Sec. 428.** HEALTH PLAN CERTIFICATION STANDARDS. A certified health plan shall:

(1) Provide the benefits included in the uniform benefits package to enrolled Washington residents for a prepaid per capita community-rated premium not to exceed the maximum premium established by the commission and provide such benefits through managed care in accordance with rules adopted by the commission;

(2) Offer supplemental benefits to enrolled Washington residents for a prepaid per capita community-rated premium and provide such benefits through managed care in accordance with rules adopted by the commission;

(3) Accept for enrollment any state resident within the plan's service area and provide or assure the provision of all services within

the uniform benefits package and offer supplemental benefits regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The insurance commissioner may grant a temporary exemption from this subsection, if, upon application by a certified health plan, the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a certified health plan is required to continue enrollment of additional eligible individuals;

(4) If the plan provides benefits through contracts with, ownership of, or management of health care facilities and contracts with or employs health care providers, demonstrate to the satisfaction of the insurance commissioner in consultation with the department of health and the commission that its facilities and personnel are adequate to provide the benefits prescribed in the uniform benefits package and offer supplemental benefits to enrolled Washington residents, and that it is financially capable of providing such residents with, or has made adequate contractual arrangements with health care providers and facilities to provide enrollees with such benefits;

(5) Comply with portability of benefits requirements prescribed by the commission;

(6) Comply with administrative rules prescribed by the commission, the insurance commissioner, and other state agencies governing certified health plans;

(7) Provide all enrollees with instruction and informational materials to increase individual and family awareness of injury and illness prevention; encourage assumption of personal responsibility for protecting personal health; and stimulate discussion about the use and limits of medical care in improving the health of individuals and communities;

(8) Disclose to enrollees the charity care requirements under chapter 70.170 RCW;

(9) Include in all of its contracts with health care providers and health care facilities a provision prohibiting such providers and facilities from billing enrollees for any amounts in excess of applicable enrollee point of service cost-sharing obligations for services included in the uniform benefits package and supplemental benefits;

(10) Include in all of its contracts issued for uniform benefits package and supplemental benefits coverage a subrogation provision that allows the certified health plan to recover the costs of uniform benefits package and supplemental benefits services incurred to care for an enrollee injured by a negligent third party. The costs recovered shall be limited to:

(a) If the certified health plan has not intervened in the action by an injured enrollee against a negligent third party, then the amount of costs the certified health plan can recover shall be limited to the excess remaining after the enrollee has been fully compensated for his or her loss minus a proportionate share of the enrollee's costs and fees in bringing the action. The proportionate share shall be determined by:

(i) The fees and costs approved by the court in which the action was initiated; or

(ii) The written agreement between the attorney and client that established fees and costs when fees and costs are not addressed by the court.

When fees and costs have been approved by a court, after notice to the certified health plan, the certified health plan shall have the right to be heard on the matter of attorneys' fees and costs or its proportionate share;

(b) If the certified health plan has intervened in the action by an injured enrollee against a negligent third party, then the amount of costs the certified health plan can recover shall be the excess remaining after the enrollee has been fully compensated for his or her loss or the amount of the plan's incurred costs, whichever is less;

(11) Establish and maintain a grievance procedure approved by the commissioner, to provide a reasonable and effective resolution of complaints initiated by enrollees concerning any matter relating to the provision of benefits under the uniform benefits package and supplemental benefits, access to health care services, and quality of services. Each certified health plan shall respond to complaints filed with the insurance commissioner within fifteen working days. The insurance commissioner in consultation with the commission shall establish standards for resolution of grievances;

(12) Comply with the provisions of chapter 48.30 RCW prohibiting unfair and deceptive acts and practices to the extent such provisions are not specifically modified or superseded by the provisions of

chapter . . ., Laws of 1993 (this act) and be prohibited from offering or supplying incentives that would have the effect of avoiding the requirements of subsection (3) of this section;

(13) Have culturally sensitive health promotion programs that include approaches that are specifically effective for persons of color and accommodating to different cultural value systems, gender, and age;

(14) Permit every category of health care provider to provide health services or care for conditions included in the uniform benefits package to the extent that:

(a) The provision of such health services or care is within the health care providers' permitted scope of practice; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of health services;

(ii) Management and administrative procedures; and

(iii) Provision of cost-effective and clinically efficacious health services;

(15) 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 with guidelines adopted by the commission, those that have been clearly drawn to be exclusionary within a health care catchment area;

(16) Annually report the names and addresses of all officers, directors, or trustees of the certified health plan during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals;

(17) Annually report the number of residents enrolled and terminated during the previous year. Additional information regarding the enrollment and termination pattern for a certified health plan may be required by the commissioner to determine compliance with the open enrollment and free access requirements of chapter..., Laws of 1993 (this act); and

(18) Disclose any financial interests held by officers and directors in any facilities associated with or operated by the certified health plan.

NEW SECTION. **Sec. 429.** LIMITED CERTIFIED HEALTH PLAN FOR DENTAL SERVICES. (1) For the purposes of this section "limited certified dental plan" or "dental plan" means a limited health service contractor governed by RCW 48.44.035 offering dental care services only and that complies with all certified health plan requirements for managed care, community rating, portability, and nondiscrimination as provided in section 428 of this act.

(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 dental care 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.

NEW SECTION. **Sec. 430.** REGISTERED EMPLOYER HEALTH PLANS. Consistent with the provisions of section 464 of this act, a registered employer health plan shall:

(1) Register with the insurance commissioner by filing its plan of management and operation including but not limited to information required by the commissioner sufficient for a determination by the commissioner that such plan meets the requirements of this section and any rules adopted by the health services commission and the insurance commissioner pertaining to such plans.

(2) Provide the benefits included in the uniform benefits package to employees and their dependents for a prepaid, community-rated premium not to exceed the maximum premium established by the commission and provide such benefits through managed care in accordance with rules adopted by the commission.

(3) Offer supplemental benefits to employees and their dependents for a prepaid, community-rated premium and provide such benefits through managed care in accordance with rules adopted by the commission. Benefits offered by such plan need not comply with the provisions of sections 452 and 453 of this act.

(4) Provide or assure the provision of all services within the uniform benefits package and offer supplemental benefits regardless of age, sex, family structure, ethnicity, race, health condition,

socioeconomic status, or other condition or situation, or the provisions of RCW 49.60.174(2).

(5) If the plan provides benefits through contracts with, ownership of, or management of health care facilities and contracts with or employs health care providers, demonstrate to the satisfaction of the insurance commissioner in consultation with the department of health and the commission that its facilities and personnel are adequate to provide the uniform benefits package and any supplemental benefits or has made adequate contractual arrangements with health care providers and facilities to provide employees and their dependents with such benefits.

(6) Comply with portability of benefits requirements prescribed by the commission for registered employer health plans.

(7) Comply with administrative rules prescribed by the commission, the insurance commissioner, and other state agencies governing registered employer health plans.

(8) Provide all employees and their dependents enrolled in the plan with instruction and informational materials to increase individual and family awareness of injury and illness prevention; encourage assumption of personal responsibility for protecting personal health; and stimulate discussion about the use and limits of medical care in improving the health of individuals and communities.

(9) Include in all of its contracts with health care providers and health care facilities a provision prohibiting such providers and facilities from billing employees and their dependents enrolled in the plan for any amounts in excess of applicable enrollee point of service, cost-sharing obligations for services included in the uniform benefits package and supplemental benefits.

(10) Include in all of its contracts issued for uniform benefits package and supplemental benefits coverage a subrogation provision that allows the plan to recover the costs of uniform benefits package and supplemental benefit services incurred to care for a plan enrollee injured by a negligent third party. The costs recovered shall be limited to:

(a) If the plan has not intervened in the action by an injured plan enrollee against a negligent third party, then the amount of costs the plan can recover shall be limited to the excess remaining after the plan enrollee has been fully compensated for his or her loss minus a

proportionate share of the enrollee's costs and fees in bringing the action. The proportionate share shall be determined by:

(i) The fees and costs approved by the court in which the action was initiated; or

(ii) The written agreement between the attorney and client that established fees and costs when fees and costs are not addressed by the court.

When fees and costs have been approved by a court, after notice to the plan, the plan shall have the right to be heard on the matter of attorneys' fees and costs or its proportionate share;

(b) If the plan has intervened in the action by an injured enrollee against a negligent third party, then the amount of costs the plan can recover shall be the excess remaining after the enrollee has been fully compensated for his or her loss or the amount of the plan's incurred costs, whichever is less.

(11) Establish and maintain a grievance procedure approved by the insurance commissioner, to provide a reasonable and effective resolution of complaints initiated by plan enrollees concerning any matter relating to the provision of benefits under the uniform benefits package and supplemental benefits, access to health care services, and quality of services. Each plan shall respond to complaints filed with the insurance commissioner within fifteen working days. The insurance commissioner in consultation with the commission shall establish standards for resolution of grievances by enrollees of registered employer health plans.

(12) Have culturally sensitive health promotion programs that include approaches that are specifically effective for persons of color and accommodating to different cultural value systems, gender, and age.

(13) Permit every category of health care provider to provide health services or care for conditions included in the uniform benefits package to the extent that:

(a) The provision of such health services or care is within the health care providers' permitted scope of practice; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of health services;

(ii) Management and administrative procedures; and

(iii) Provision of cost-effective and clinically efficacious health services.

(14) Pay to the state treasurer a tax equivalent to the tax applied to taxpayers under section 301 of this act in accordance with rules adopted by the department of revenue.

(15) File their uniform benefits package and supplemental benefits with the insurance commissioner who may disapprove and order a modification of such package or benefits if such package or benefits fail to meet any standards or rules adopted by the commission pertaining to maximum premiums, enrollee financial participation, point of service cost-sharing, benefit design, or health service delivery.

(16) Comply with and shall be subject to sections 431, 447, and 448 of this act.

(17) Pay an annual fee to the insurance commissioner's office in an amount established by rule of the commissioner necessary for the performance of the commissioner's responsibilities under this section consistent with and subject to the collection, depositing, and spending provisions applicable to fees collected pursuant to RCW 48.02.190.

(18) File an annual report with the commissioner containing such information as the commissioner may require to determine compliance with this section.

(19) In addition to any other penalties prescribed by law, be subject to the penalties contained in section 432 of this act for violations of this section.

NEW SECTION. **Sec. 431.** 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 of the legislature that the health services commission in developing rules in accordance with this section and the attorney general in monitoring the level of competition in the various geographic markets, balance the need for cost-effective and quality delivery of health services with the need for inclusion of both individual health care providers and categories of health care providers in managed care programs developed by certified health plans.

(2) All licensed health care providers licensed by the state, irrespective of the type or kind of practice, should be afforded the

opportunity for inclusion in certified health plans consistent with the goals of health care reform.

The health services commission shall adopt rules requiring certified health plans to publish general criteria for the plan's selection or termination of health care providers. Such rules shall not require the disclosure of criteria deemed by the plan to be of a proprietary or competitive nature that would hurt the plan's ability to compete or to manage health services. Disclosure of criteria is proprietary or anticompetitive if revealing the criteria would have the tendency to cause health care providers to alter their practice pattern in a manner that would harm efforts to contain health care costs and is proprietary if revealing the criteria would cause the plan's competitors to obtain valuable business information.

If a certified health plan uses unpublished criteria to judge the quality and cost-effectiveness of a health care provider's practice under any specific program within the plan, the plan may not reject or terminate the provider participating in that program based upon such criteria until the provider has been informed of the criteria that his or her practice fails to meet and is given a reasonable opportunity to conform to such criteria.

(3)(a) Whenever a determination is made under (b) of this subsection that a plan's share of the market reaches a point where the plan's exclusion of health care providers from a program of the plan would result in the substantial inability of providers to continue their practice thereby unreasonably restricting consumer access to needed health services, the certified health plan must allow all providers within the affected market to participate in the programs of the certified health plan. All such providers must meet the published criteria and requirements of the programs.

(b) The attorney general with the assistance of the insurance commissioner shall periodically analyze the market power of certified health plans to determine when the market share of any program of a certified health plan reaches a point where the plan's exclusion of health service providers from a program of the plan would result in the substantial inability of providers to continue their practice thereby unreasonably restricting consumer access to needed health services. In analyzing the market power of a certified health plan, the attorney general shall consider:

(i) The ease with which providers may obtain contracts with other plans;

(ii) The amount of the private pay and government employer business that is controlled by the certified health plan taking into account the selling of its provider network to self-insured employer plans;

(iii) The difficulty in establishing new competing plans in the relevant geographic market; and

(iv) The sufficiency of the number or type of providers under contract with the plan available to meet the needs of plan enrollees.

Notwithstanding the provisions of this subsection, if the certified health plan demonstrates to the satisfaction of the attorney general and the health services commission that health service utilization data and similar information shows that the inclusion of additional health service providers would substantially lessen the plan's ability to control health care costs and that the plan's procedures for selection of providers are not improperly exclusive of providers, the plan need not include additional providers within the plan's program.

(4) The health services commission shall adopt rules for the resolution of disputes between providers and certified health plans including disputes regarding the decision of a plan not to include the services of a provider.

(5) Nothing contained in this section shall be construed to require a plan to allow or continue the participation of a provider if the plan is a federally qualified health maintenance organization and the participation of the provider or providers would prevent the health maintenance organization from operating as a health maintenance organization in accordance with 42 U.S.C. Sec. 300e.

NEW SECTION. **Sec. 432.** CERTIFIED HEALTH PLANS--REGISTRATION 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. 433.** 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 438 of this act and the funding reserve requirements set forth in section 439 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. 434.** 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;

(2) The applicant has demonstrated the intent and ability to assure that the health services will be provided in a manner to assure both their availability and accessibility;

(3) The organization is financially responsible and may be reasonably expected to meet its obligations to its enrolled participants. In making this determination, the commissioner shall consider among other relevant factors:

(a) Any agreements with a casualty insurer, a government agency, or any other organization paying or insuring payment for health care services;

(b) Any agreements with providers for the provision of health care services; and

(c) Any arrangements for liability and malpractice insurance coverage.

(4) The procedures for offering health care services are reasonable and equitable; and

(5) Procedures have been established to:

(a) Monitor the quality of care provided by the certified health plan including standards and guidelines provided by the health services commission and other appropriate state agencies;

(b) Operate internal peer review mechanisms; and

(c) Resolve complaints and grievances in accordance with section 443 of this act and rules established by the insurance commissioner in consultation with the commission.

NEW SECTION. **Sec. 435.** PREMIUMS AND ENROLLEE PAYMENT AMOUNTS--FILING OF PREMIUMS AND ENROLLEE PAYMENT AMOUNTS--ADDITIONAL CHARGES PROHIBITED. (1) The insurance commissioner shall verify that the certified health plan and its providers are charging no more than the maximum premiums and enrollee financial participation amounts during the course of financial and market conduct examinations or more frequently if justified in the opinion of the insurance commissioner or upon request by the health services commission.

(2) The certified health plans shall file the premium schedules including employer contributions, enrollee premium sharing, and enrollee point of service cost sharing amounts with the insurance commissioner, within thirty days of establishment by the health services commission.

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

NEW SECTION. **Sec. 436.** ANNUAL STATEMENT FILING--CONTENTS--PENALTY FOR FAILURE TO FILE--ACCURACY REQUIRED. (1) Every certified health plan shall annually not later than March 1 of the calendar year, file

with the insurance commissioner a statement verified by at least two of its principal officers showing its financial condition as of December 31 of the preceding year.

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

(a) A financial statement of the certified health plan, 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 certified health plan benefit packages;

(ii) Expenditures to all categories of health care facilities, providers, and organizations with which the plan has contracted to fulfill obligations to enrolled residents arising out of the uniform benefits package and other approved supplemental benefit 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) A report of the names and addresses of all officers, directors, or trustees of the certified health plan during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals;

(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 provide to the health services commission 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. 437.** 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. 438.** 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.

(3) Every certified health plan shall, in determining liabilities, include an amount estimated in the aggregate to provide for unearned premiums and for the payment of claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which such organization is or may be liable and to provide for the expense of adjustment or settlement of such claims.

The claims shall be computed in accordance with rules adopted by the insurance commissioner in consultation with the health services commission.

NEW SECTION. **Sec. 439.** FUNDED RESERVE REQUIREMENTS. (1) Each certified health plan obtaining certification from the insurance commissioner under sections 427 through 444 of this act shall provide and maintain a funded reserve of one hundred fifty thousand dollars. The funded reserve shall be deposited with the insurance commissioner or with any organization acceptable to the commissioner in the form of cash, securities eligible for investment under chapter 48.13 RCW, approved surety bond, or any combination of these, and must be equal to or exceed one hundred fifty thousand dollars. The funded reserve shall be established as an assurance that the uncovered expenditures obligations of the certified health plan to the enrolled Washington residents shall be performed.

(2) All income from reserves on deposit with the commissioner shall belong to the depositing certified health plan and shall be paid to it as it becomes available.

(3) Funded reserves required by this section shall be considered an asset in determining the plan's net worth.

NEW SECTION. **Sec. 440.** EXAMINATION OF CERTIFIED HEALTH PLANS, POWERS OF COMMISSIONER, DUTIES OF PLANS, INDEPENDENT AUDIT REPORTS. (1) The insurance commissioner shall make an examination of the operations of a certified health plan as often as the commissioner deems it necessary in order to assure the financial security and health and safety of the enrolled residents. The insurance commissioner shall make an examination of a certified health plan not less than once every three calendar years.

(2) Every certified health plan shall submit its books and records relating to its operation for financial condition and market conduct examinations and in every way facilitate them. The quality or appropriateness of health 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. 441.** 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 439 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.

NEW SECTION. **Sec. 442.** FINANCIAL FAILURE, SUPERVISION OF COMMISSIONER--PRIORITY OF DISTRIBUTION OF ASSETS. (1) Any rehabilitation, liquidation, or conservation of a certified health plan shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the insurance commissioner under the law governing the rehabilitation, liquidation, or conservation of insurance companies. The insurance commissioner may apply for an order directing the insurance commissioner to rehabilitate, liquidate, or conserve a certified health plan upon one or more of the grounds set forth in RCW 48.31.030, 48.31.050, and 48.31.080. Enrolled residents shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) For purposes of determining the priority of distribution of general assets, claims of enrolled residents and their dependents shall have the same priority as established by RCW 48.31.280 for policyholders and their dependents of insurance companies. If an enrolled resident is liable to a provider for services under and covered by a certified health plan, that liability shall have the status of an enrolled resident claim for distribution of general assets.

(3) A provider who is obligated by statute or agreement to hold enrolled residents harmless from liability for services provided under and covered by a certified health plan shall have a priority of distribution of the general assets immediately following that of enrolled residents and enrolled residents' dependents as described in this section, and immediately proceeding the priority of distribution described in RCW 48.31.280(2)(e).

NEW SECTION. **Sec. 443.** GRIEVANCE PROCEDURE. A certified health plan shall establish and maintain a grievance procedure approved by the commissioner, to provide a reasonable and effective resolution of complaints initiated by enrolled Washington residents concerning any matter relating to the provision of benefits under the uniform benefits package, access to health care services, and quality of services. Each certified health plan shall respond to complaints filed with the insurance commissioner within twenty working days. The insurance commissioner in consultation with the health services commission shall establish standards for grievance procedures and resolution.

NEW SECTION. **Sec. 444.** EXEMPTION. The provisions of sections 433 through 443 of this act do not apply to any disability insurance company, health care service contractor, or health maintenance organization authorized to do business in Washington.

NEW SECTION. **Sec. 445.** ENFORCEMENT AUTHORITY OF COMMISSIONER. For the purposes of chapter . . ., Laws of 1993 (this act), the insurance commissioner shall have the same powers and duties of enforcement as are provided in Title 48 RCW.

NEW SECTION. **Sec. 446.** ANNUAL REPORT BY THE INSURANCE COMMISSIONER TO THE HEALTH SERVICES COMMISSION. Beginning January 1, 1997, the insurance commissioner shall report annually to the health services commission on the compliance of certified health plans and health insurance purchasing cooperatives with the provisions of chapter . . ., Laws of 1993 (this act). The report shall include information on (1) compliance with chapter . . ., Laws of 1993 (this act) open enrollment and antidiscrimination provisions, (2) financial solvency requirements, (3) the mix of enrollee characteristics within and among plans and groups including age, sex, ethnicity, and any easily

obtainable information related to medical risk, (4) the geographic distribution of plans and groups, and (5) other information that the commission may request consistent with the goals of chapter . . ., Laws of 1993 (this act).

F. MANAGED COMPETITION AND LIMITED ANTI-TRUST IMMUNITY

NEW SECTION. **Sec. 447.** MANAGED COMPETITION FINDINGS AND INTENT. (1) The legislature recognizes that competition among health care providers, facilities, payers, and purchasers will yield the best allocation of health care resources, the lowest prices for health care, and the highest quality of health care when there exists a large number of buyers and sellers, easily comparable health care plans and services, minimal barriers to entry and exit into the health care market, and adequate information for buyers and sellers to base purchasing and production decisions. However, the legislature finds that purchasers of health care services and health care coverage do not have adequate information upon which to base purchasing decisions; that health care facilities and providers of health care services face legal and market disincentives to develop economies of scale or to provide the most cost-efficient and efficacious service; that health insurers, contractors, and health maintenance organizations face market disincentives in providing health care coverage to those Washington residents with the most need for health care coverage; and that potential competitors in the provision of health care coverage bear unequal burdens in entering the market for health care coverage.

(2) The legislature therefore intends to exempt from state anti-trust laws, and to provide immunity from federal anti-trust laws through the state action doctrine for activities approved under this chapter that might otherwise be constrained by such laws and intends to displace competition in the health care market: To contain the aggregate cost of health care services; to promote the development of comprehensive, integrated, and cost-effective health care delivery systems through cooperative activities among health care providers and facilities; to promote comparability of health care coverage; to improve the cost-effectiveness in providing health care coverage relative to health promotion, disease prevention, and the amelioration or cure of illness; to assure universal access to a publicly determined, uniform package of health care benefits; and to create

reasonable equity in the distribution of funds, treatment, and medical risk among purchasers of health care coverage, payers of health care services, providers of health care services, health care facilities, and Washington residents. To these ends, any lawful action taken pursuant to chapter . . ., Laws of 1993 (this act) by any person or entity created or regulated by chapter . . ., Laws of 1993 (this act) are declared to be taken pursuant to state statute and in furtherance of the public purposes of the state of Washington.

(3) The legislature does not intend and unless explicitly permitted in accordance with section 448 of this act or under rules adopted pursuant to chapter . . ., Laws of 1993 (this act), does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state and federal anti-trust laws including but not limited to conspiracies or agreements:

(a) Among competing health care providers not to grant discounts, not to provide services, or to fix the price of their services;

(b) Among certified health plans as to the price or level of reimbursement for health care services;

(c) Among certified health plans to boycott a group or class of health care service providers;

(d) Among purchasers of certified health plan coverage to boycott a particular plan or class of plans;

(e) Among certified health plans to divide the market for health care coverage; or

(f) Among certified health plans and purchasers to attract or discourage enrollment of any Washington resident or groups of residents in a certified health plan based upon the perceived or actual risk of loss in including such resident or group of residents in a certified health plan or purchasing group.

NEW SECTION. **Sec. 448.** COMPETITIVE OVERSIGHT AND ANTI-TRUST IMMUNITY. (1) A certified health plan, health care facility, health care provider, or other person involved in the development, delivery, or marketing of health care or certified health plans may request, in writing, that the commission obtain an informal opinion from the attorney general as to whether particular conduct is authorized by chapter . . ., Laws of 1993 (this act). The attorney general shall issue such opinion within thirty days of receipt of a written request

for an opinion or within thirty days of receipt of any additional information requested by the attorney general necessary for rendering an opinion unless extended by the attorney general for good cause shown. If the attorney general concludes that such conduct is not authorized by chapter . . ., Laws of 1993 (this act), the person or organization making the request may petition the commission for review and approval of such conduct in accordance with subsection (3) of this section.

(2) After obtaining the written opinion of the attorney general and consistent with such opinion, the health services commission:

(a) May authorize conduct by a certified health plan, health care facility, health care provider, or any other person that could tend to lessen competition in the relevant market upon a strong showing that the conduct is likely to achieve the policy goals of chapter . . ., Laws of 1993 (this act) and a more competitive alternative is impractical;

(b) Shall adopt rules governing conduct among providers, health care facilities, and certified health plans including rules governing provider and facility contracts with certified health plans, rules governing the use of "most favored nation" clauses and exclusive dealing clauses in such contracts, and rules providing that certified health plans in rural areas contract with a sufficient number and type of health care providers and facilities to ensure consumer access to local health care services;

(c) Shall adopt rules permitting health care providers within the service area of a plan to collectively negotiate the terms and conditions of contracts with a certified health plan including the ability of providers to meet and communicate for the purposes of these negotiations; and

(d) Shall adopt rules governing cooperative activities among health care facilities and providers.

(3) A certified health plan, health care facility, health care provider, or any other person involved in the development, delivery, and marketing of health services or certified health plans may file a written petition with the commission requesting approval of conduct that could tend to lessen competition in the relevant market. Such petition shall be filed in a form and manner prescribed by rule of the commission.

The commission shall issue a written decision approving or denying a petition filed under this section within ninety days of receipt of a properly completed written petition unless extended by the commission for good cause shown. The decision shall set forth findings as to benefits and disadvantages and conclusions as to whether the benefits outweigh the disadvantages.

(4) In authorizing conduct and adopting rules of conduct under this section, the commission with the advice of the attorney general, shall consider the benefits of such conduct in furthering the goals of health care reform including but not limited to:

(a) Enhancement of the quality of health services to consumers;

(b) Gains in cost efficiency of health services;

(c) Improvements in utilization of health services and equipment;

(d) Avoidance of duplication of health services resources; or

(e) And as to subsections (b) and (c) of this subsection: (i) Facilitates the exchange of information relating to performance expectations; (ii) simplifies the negotiation of delivery arrangements and relationships; and (iii) reduces the transactions costs on the part of certified health plans and providers in negotiating more cost effective delivery arrangements.

These benefits must outweigh disadvantages including and not limited to:

(i) Reduced competition among certified health plans, health care providers, or health care facilities;

(ii) Adverse impact on quality, availability, or price of health care services to consumers; or

(iii) The availability of arrangements less restrictive to competition that achieve the same benefits.

(5) Conduct authorized by the commission shall be deemed taken pursuant to state statute and in the furtherance of the public purposes of the state of Washington.

(6) With the assistance of the attorney general’s office, the commission shall actively supervise any conduct authorized under this section to determine whether such conduct or rules permitting certain conduct should be continued and whether a more competitive alternative is practical. The commission shall periodically review petitioned conduct through, at least, annual progress reports from petitioners, annual or more frequent reviews by the commission that evaluate whether the conduct is consistent with the petition, and whether the benefits

continue to outweigh any disadvantages. If the commission determines that the likely benefits of any conduct approved through rule, petition, or otherwise by the commission no longer outweigh the disadvantages attributable to potential reduction in competition, the commission shall order a modification or discontinuance of such conduct. Conduct ordered discontinued by the commission shall no longer be deemed to be taken pursuant to state statute and in the furtherance of the public purposes of the state of Washington.

(7) Nothing contained in chapter . . ., Laws of 1993 (this act) is intended to in any way limit the ability of rural hospital districts to enter into cooperative agreements and contracts pursuant to RCW 70.44.450 and chapter 39.34 RCW.

G. THE UNIFORM BENEFITS PACKAGE

NEW SECTION. **Sec. 449.** UNIFORM BENEFITS PACKAGE DESIGN. (1) The commission shall define the uniform benefits package, which shall include those health services that, consistent with the goals and intent of chapter . . ., Laws of 1993 (this act), are effective and necessary on a societal basis for the maintenance of the health of citizens of the state, weighed against the need to control state health services expenditures.

(2) The schedule of covered health services shall emphasize proven preventive and primary health care and shall be composed of the following essential health services: (a) Primary and specialty health services; (b) inpatient and outpatient hospital services; (c) prescription drugs and medications; (d) reproductive services; (e) services necessary for maternity and well-child care, including preventive dental services for children; and (f) case-managed chemical dependency, mental health, short-term skilled nursing facility, home health, and hospice services, to the extent that such services reduce inappropriate utilization of more intensive or less efficacious medical services. The commission shall determine the specific schedule of health services within the uniform benefits package, including limitations on scope and duration of services. The schedule shall be the benefit and actuarial equivalent of the schedule of benefits offered by the basic health plan on January 1, 1993, including any additions that may result from the inclusion of the services listed in (c) through (f) of this subsection. 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 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 and premium payments. The rules shall not have the effect of eliminating enrollee financial participation. 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 by December 1 of the year preceding any year in which the commission proposes to significantly modify the uniform benefits package: (a) The uniform benefits package; and (b) an independent actuarial analysis of the cost of the proposed package, giving consideration to the factors considered under section 406(6) of this act. The commission shall not modify the services included in the uniform benefits package before January 1, 1999.

NEW SECTION. **Sec. 450.** SMALL BUSINESS ECONOMIC IMPACT STATEMENT. (1) In conjunction with submission of the uniform benefits package as provided in section 449(7) of this act, the commission also shall submit a small business economic impact statement, prepared in consultation with the small business advisory committee. The impact statement shall address the economic impact on businesses with twenty-five or fewer full-time equivalent employees of participating in the cost of the uniform benefits package for their employees and employees' dependents. As an aid in preparing the small business economic impact statement, the commission shall conduct a survey of a statistically valid sample of small businesses.

(2) If the small business economic impact statement indicates a need to address the economic consequences of mandating employer participation in the cost of uniform benefits package coverage for employees and their dependents, the commission shall submit proposed strategies to address such consequences. Strategies may include: The level of employer participation in uniform benefits package costs; coverage of dependents; application of the uniform benefits package as the minimum benefits package offered to employees or dependents; and any other strategies deemed appropriate by the commission.

NEW SECTION. **Sec. 451.** HOUSEHOLD INCOME ANALYSIS. In conjunction with submission of the uniform benefits package as provided in section 449(7) of this act, the commission shall submit an analysis of the impact of employee premium contributions on individuals with household income of less than two hundred percent of the federal poverty level. The analysis shall include estimates of the cost of varying levels of premium subsidies for these individuals and their families.

NEW SECTION. **Sec. 452.** CERTIFIED HEALTH PLAN BENEFIT PACKAGES--OFFERING, FILING, AND APPROVAL OF FORMS. No uniform benefits package or supplemental benefits may be offered, delivered, or issued for delivery to any person in this state unless it otherwise complies with chapter . . ., Laws of 1993 (this act), and complies with the following:

(1) All certified health plan forms for uniform and supplemental benefits issued by the plan to enrollees and such other marketing documents purporting to describe the plan's benefits shall comply with the minimum standards the commissioner deems reasonable and necessary

to carry out the purposes and provisions of this chapter and consistent with health services commission standards. The plan's forms and documents shall fully inform enrollees of the health services to which they are entitled, and shall fully disclose any limitations, exclusions, rights, responsibilities, and duties required of either the enrollee or the certified health plan. No form or document may be issued, delivered, or issued for delivery unless it has been filed with and approved by the commissioner.

(2) Every form or document filing containing a certification, in a manner approved by the commissioner, by either the chief executive officer of the plan or by an actuary who is a member of the American academy of actuaries, attesting that the filing complies with Title 48 RCW, Title 284 WAC, and this chapter, may be used by such certified health plan immediately after filing with the commissioner. The commissioner may order a plan to cease using a certified form or document upon the grounds set forth in subsection (6) of this section.

(3) Every filing that does not contain a certification pursuant to subsection (2) of this section shall be made not less than thirty days in advance of any such issuance, delivery, or use. At the expiration of such thirty days the form or document filed shall be deemed approved unless affirmatively approved or disapproved by the commissioner within the thirty-day period. The commissioner may extend by not more than an additional fifteen days the period within which the commissioner may review such filing, by notifying the plan of the extension before expiration of the initial thirty-day period. At the expiration of any extension period and in the absence of prior affirmative approval or disapproval, any such form or document shall be deemed approved. The commissioner may withdraw approval at any time for cause. By approval of any filing for immediate use, the commissioner may waive any unexpired portion of the initial thirty-day waiting period.

(4) Whenever the commissioner disapproves a filing or withdraws a previous approval, the commissioner shall state the grounds for disapproval.

(5) The commissioner may exempt from the requirements of this section any plan document or form that, in the commissioner's opinion, may not practicably be applied to, or the filing and approval of which are, in the commissioner's opinion, not desirable or necessary for the protection of the public.

(6) The commissioner shall disapprove any form or document or shall withdraw any previous approval, only:

(a) If it is in any respect in violation of or does not comply with Title 48 RCW, Title 284 WAC, and this chapter, or any applicable order of the commissioner;

(b) If it does not comply with any controlling filing previously made and approved;

(c) If it contains or incorporates by reference any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions that unreasonably or deceptively affect the health services purported to be offered or provided;

(d) If it has any title, heading, or other indication of its provisions that is misleading;

(e) If purchase of health services under the form or document is being solicited by deceptive advertising; or

(f) If the health service benefits provided in the form or document are unreasonable in relation to the premium charged.

NEW SECTION. **Sec. 453.** UNIFORM AND SUPPLEMENTAL BENEFITS--RATES--FILING AND APPROVAL. (1) Premium rates for uniform benefits package and supplemental benefits shall not be excessive or inadequate, and shall not discriminate in a manner prohibited by section 428(3) of this act. Premium rates, enrollee point of service cost-sharing, or maximum enrollee financial participation amounts for a uniform benefits package may not exceed the limits established by the health services commission in accordance with section 406 of this act. Premium rates for uniform benefits package and supplemental benefits shall be developed on a community-rated basis as determined by the health services commission.

(2) Prior to using, every certified health plan shall file with the commissioner its enrollee point of service, cost-sharing amounts, enrollee financial participation amounts, rates, its rating plan, and any other information used to determine the specific premium to be charged any enrollee and every modification of any of the foregoing.

(3) Every such filing shall indicate the type and extent of the health services contemplated and must be accompanied by sufficient information to permit the commissioner to determine whether it meets the requirements of this chapter. A plan shall offer in support of any filing:

(a) Any historical data and actuarial projections used to establish the rate filed;

(b) An exhibit detailing the major elements of operating expense for the types of health services affected by the filing;

(c) An explanation of how investment income has been taken into account in the proposed rates;

(d) Any other information that the plan deems relevant; and

(e) Any other information that the commissioner requires by rule.

(4) If a plan has insufficient loss experience to support its proposed rates, it may submit loss experience for similar exposures of other plans within the state.

(5) Every filing shall state its proposed effective date.

(6) Actuarial formulas, statistics, and assumptions submitted in support of a rate or form filing by a plan or submitted to the commissioner at the commissioner’s request shall be withheld from public inspection in order to preserve trade secrets or prevent unfair competition.

(7) No plan may make or issue a benefits package except in accordance with its filing then in effect.

(8) The commissioner shall review a filing as soon as reasonably possible after made, to determine whether it meets the requirements of this section.

(9)(a) No filing may become effective within thirty days after the date of filing with the commissioner, which period may be extended by the commissioner for an additional period not to exceed fifteen days if the commissioner gives notice within such waiting period to the plan that the commissioner needs additional time to consider the filing.

(b) A filing shall be deemed to meet the requirements of this section unless disapproved by the commissioner within the waiting period or any extension period.

(c) If within the waiting or any extension period, the commissioner finds that a filing does not meet the requirements of this section, the commissioner shall disapprove the filing, shall notify the plan of the grounds for disapproval, and shall prohibit the use of the disapproved filing.

(10) If at any time after the applicable review period provided in this section, the commissioner finds that a filing does not meet the requirements of this section, the commissioner shall, after notice and hearing, issue an order specifying in what respect the commissioner

finds that such filing fails to meet the requirements of this section, and stating when, within a reasonable period thereafter, the filings shall be deemed no longer effective.

The order shall not affect any benefits package made or issued prior to the expiration of the period set forth in the order.

NEW SECTION. **Sec. 454.** The legislature may disapprove of the uniform benefits package developed under section 449 of this act and medical risk adjustment mechanisms developed under section 406(7) of this act by an act of law at any time prior to the thirtieth day of the following regular legislative session. If such disapproval action is taken, the commission shall resubmit a modified package to the legislature within fifteen days of the disapproval. If the legislature does not disapprove or modify the package by an act of law by the end of that regular session, the package is deemed approved.

NEW SECTION. **Sec. 455.** SUPPLEMENTAL AND ADDITIONAL BENEFITS NEGOTIATION. (1) Nothing in chapter . . ., Laws of 1993 (this act) shall preclude insurers, health care service contractors, health maintenance organizations, or certified health plans from insuring, providing, or contracting for benefits not included in the uniform benefits package or in supplemental benefits.

(2) Nothing in chapter . . ., Laws of 1993 (this act) shall restrict the right of an employer to offer, an employee representative to negotiate for, or an individual to purchase supplemental or additional benefits not included in the uniform benefits package.

(3) Nothing in chapter . . ., Laws of 1993 (this act) shall restrict the right of an employer to offer or an employee representative to negotiate for payment of up to one hundred percent of the premium of the lowest priced uniform benefits package available in the geographic area where the employer is located.

(4) Nothing in chapter . . ., Laws of 1993 (this act) shall be construed to affect the collective bargaining rights of employee organizations to the extent that federal law specifically restricts the ability of states to limit collective bargaining rights of employee organizations.

(5) After July 1, 1999, no property or casualty insurance policy issued in this state may provide first-party coverage for health services to the extent that such services are provided under a uniform

benefits package covering the resident to whom such property or casualty insurance policy is issued.

NEW SECTION. **Sec. 456.** CONSCIENCE OR RELIGION. (1) No certified health plan or health care provider may be required by law or contract in any circumstances to participate in the provision of any uniform benefit if they object to so doing for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objection.

(2) The provisions of this section are not intended to result in an enrollee being denied timely access to any service included in the uniform benefits package. Each certified health plan shall:

(a) Provide written notice to certified health plan enrollees, upon enrollment with the plan and upon enrollee request thereafter, listing, by provider, services that any provider refuses to perform for reason of conscience or religion;

(b) Develop written information describing how an enrollee may directly access, in an expeditious manner, services that a provider refuses to perform; and

(c) Ensure that enrollees refused services under this section have prompt access to the information developed pursuant to (b) of this subsection.

NEW SECTION. **Sec. 457.** LONG-TERM CARE INTEGRATION PLAN. (1) To meet the health needs of the residents of Washington state, it is critical to finance and provide long-term care and support services through an integrated, comprehensive system that promotes human dignity and recognizes the individuality of all functionally disabled persons. This system shall be available, accessible, and responsive to all residents based upon an assessment of their functional disabilities. The governor and the legislature recognize that families, volunteers, and community organizations are essential for the delivery of effective and efficient long-term care and support services, and that this private and public service infrastructure should be supported and strengthened. Further, it is important to provide benefits without requiring family or program beneficiary impoverishment for service eligibility.

(2) To realize the need for a strong long-term care system and to carry out the November 30, 1992, final recommendations of the

Washington health care cost control and access commission, established under House Concurrent Resolution No. 4443 adopted by the legislature in 1990, related to long-term care, the commission shall:

(a) Engage in a planning process, in conjunction with an advisory committee appointed for this purpose, for the inclusion of long-term care services in the uniform benefits package established under section 449 of this act by July 1999;

(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 preferred organizational design that will serve as a functioning model for efficiently and effectively transitioning long-term care services into the uniform benefits package established in chapter . . ., Laws of 1993 (this act). The commission shall also be responsible for establishing the size of the two membership pools.

(b) Each program shall enroll applicants based on their level of functional disability and personal care needs. The distribution of these functional level categories and ethnicity within the enrolled program population shall be representative of their distribution within the community, using the best available data to estimate the community distributions.

(c) The two sites selected for the Washington life care pilot program shall be drawn from the largest urban areas and include one site in the eastern part of the state and one site in the western part of the state. The two organizations selected to manage and coordinate the life care services shall have the proven ability to provide ambulatory care, personal care/chore services, dental care, case management and referral services, must be accredited and licensed to provide long-term care for home health services, and may be licensed to provide nursing home care.

(d) The report on the development and establishment date of the two social health maintenance organizations shall be submitted to the governor and appropriate committees of the legislature by September 16, 1994. If the necessary federal waivers cannot be secured by January 1, 1995, the commission may elect to not establish the two pilot programs.

NEW SECTION. **Sec. 458.** WASHINGTON LONG-TERM CARE PARTNERSHIP. The department of social and health services shall from July 1, 1993, to July 1, 1998, coordinate a pilot program entitled the Washington long-term care partnership, whereby private insurance and medicaid funds shall be used to finance long-term care. This program must allow

for the exclusion of an individual's assets, as approved by the federal health care financing administration, in a determination of the individual's eligibility for medicaid; the amount of any medicaid payment; or any subsequent recovery by the state for a payment for medicaid services to the extent such assets are protected by a long-term care insurance policy or contract governed by chapter 48.84 RCW and meeting the criteria prescribed in this chapter.

NEW SECTION. **Sec. 459.** WASHINGTON LONG-TERM CARE PARTNERSHIP. The department of social and health services shall seek approval and a waiver of appropriate federal medicaid regulations to allow the protection of an individual's assets as provided in this chapter. The department shall adopt all rules necessary to implement the Washington long-term care partnership program, which rules shall permit the exclusion of an individual's assets in a determination of medicaid eligibility to the extent that private long-term care insurance provides payment or benefits for services that medicaid would approve or cover for medicaid recipients.

NEW SECTION. **Sec. 460.** WASHINGTON LONG-TERM CARE PARTNERSHIP. (1) The insurance commissioner shall adopt rules defining the criteria that long-term care insurance policies must meet to satisfy the requirements of this chapter. The rules shall provide that all long-term care insurance policies purchased for the purposes of this chapter:

(a) Be guaranteed renewable;

(b) Provide coverage for home and community-based services and nursing home care;

(c) Provide automatic inflation protection or similar coverage to protect the policyholder from future increases in the cost of long-term care;

(d) Not require prior hospitalization or confinement in a nursing home as a prerequisite to receiving long-term care benefits; and

(e) Contain at least a six-month grace period that permits reinstatement of the policy or contract retroactive to the date of termination if the policy or contract holder's nonpayment of premiums arose as a result of a cognitive impairment suffered by the policy or contract holder as certified by a physician.

(2) Insurers offering long-term care policies for the purposes of this chapter shall demonstrate to the satisfaction of the insurance commissioner that they:

(a) Have procedures to provide notice to each purchaser of the long-term care consumer education program;

(b) Offer case management services;

(c) Have procedures that provide for the keeping of individual policy records and procedures for the explanation of coverage and benefits identifying those payments or services available under the policy that meet the purposes of this chapter;

(d) Agree to provide the insurance commissioner, on or before September 1 of each year, an annual report containing the following 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. 461.** WASHINGTON LONG-TERM CARE PARTNERSHIP. 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. 462.** WASHINGTON LONG-TERM CARE PARTNERSHIP. 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.

H. STATE RESIDENT AND EMPLOYER PARTICIPATION

NEW SECTION. **Sec. 463.** INDIVIDUAL PARTICIPATION. (1) All residents of the state of Washington are required to purchase a uniform benefits package from a certified health plan no later than July 1, 1999. This participation requirement shall be waived if imposition of the requirement would constitute a violation of the freedom of religion provisions set forth in the First Amendment, United States Constitution or Article I, section 11 of the state Constitution. Residents of the state of Washington who work in another state for an out-of-state 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. 464.** 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) 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, and for employers who have established a registered employer health plan, one of which may be its own registered employer health plan, to all qualified employees. The employer shall be required to pay no less than fifty percent of the premium cost of the lowest cost available package within their geographic region. On July 1, 1996, all dependents of qualified employees of these firms shall be offered a choice of packages as provided in this section with the employer paying no less than fifty percent of the premium of the lowest cost package within their geographic region.

(b) For employees who work fewer than thirty hours during a week or one hundred twenty hours during a calendar month, three hundred sixty hours during a calendar quarter or one thousand four hundred forty hours during a calendar year, and their dependents, pay, for the period of time adopted by the employer under this subsection, the amount resulting from application of the following formula: The number of hours worked by the employee in a month is multiplied by the amount of a qualified employee's premium, and that amount is then divided by one hundred twenty.

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

(d) If an employee working on a seasonal basis is a qualified employee of another employer, and therefore has uniform benefits 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.

(3) By July 1, 1996, every employer employing more than one 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 than fifty percent of the premium cost of the lowest cost available package within their geographic region. On July 1, 1997, all dependents of qualified employees in these firms shall be offered a choice of packages as provided in this section with the employer paying no less than fifty percent of the premium of the lowest cost package within their geographic region.

(b) For employees who work fewer than thirty hours during a week or one hundred twenty hours during a calendar month, three hundred sixty hours during a calendar quarter or one thousand four hundred forty hours during a calendar year, and their dependents, pay, for the period of time adopted by the employer under this subsection, the amount resulting from application of the following formula: The number of hours worked by the employee in a month is multiplied by the amount of a qualified employee’s premium, and that amount is then divided by one hundred twenty.

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

(d) If an employee working on a seasonal basis is a qualified employee of another employer, and therefore has uniform benefits 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.

(4) By July 1, 1997, every employer 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 than fifty percent of the premium cost of the lowest cost available

package within their geographic region. On July 1, 1999, all dependents of qualified employees in all firms shall be offered a choice of packages as provided in this section with the employer paying no less than fifty percent of the premium of the lowest cost package within their geographic region.

(b) For employees who work fewer than thirty hours during a week or one hundred twenty hours during a calendar month, three hundred sixty hours during a calendar quarter or one thousand four hundred forty hours during a calendar year, and their dependents, pay, for the period of time adopted by the employer under this subsection, the amount resulting from application of the following formula: The number of hours worked by the employee in a month is multiplied by the amount of a qualified employee's premium, and that amount is then divided by one hundred twenty.

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

(d) If an employee working on a seasonal basis is a qualified employee of another employer, and therefore has uniform benefits 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.

(5) 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.

(6) 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 425 and 426 of this act.

NEW SECTION. **Sec. 465.** DEPOSITORY. (1) The health care authority shall establish a depository where payments under section 464 of this act can be made and held in safekeeping for the benefit of employees working less than the number of hours worked by a qualified employee.

(2) The authority shall adopt appropriate rules for operation of the depository, in consultation with representatives of employees and employers, especially those that are seasonal or employ large numbers of part-time workers. The rules shall address the means through which payments will be properly deposited to the credit of employees and the means through which employees can access payments made on their behalf. On and after July 1, 1995, payments deposited by employers on behalf of employees may be used by employees only for purchase of the uniform benefits package. Prior to July 1, 1995, payments may be used for purchase of any health insurance coverage.

NEW SECTION. **Sec. 466.** 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: (a) New firms, (b) employers with low average wages, (c) employers with low profits, and (d) 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 fifty million dollars for the biennium beginning July 1, 1997. Thereafter, the amount of total funds available for premium assistance shall be determined by the office of financial management, based on a forecast of inflation, employment, and the number of eligible firms.

(4) By July 1, 1997, the health services commission, with assistance from the small business advisory committee established in section 404 of this act, shall develop specific definitions, rules, and procedures governing all aspects of the small business assistance program, including application procedures, thresholds regarding firm size, wages, profits, and age of firm, and rules governing duration of assistance.

(5) Final determination of the amount of the premium assistance to be dispensed to an employer shall be made by the commission based on rules, definitions, and procedures developed under this section. If total claims for assistance are above the amount of total funds available for such purposes, the commission shall have the authority to prorate employer claims so that the amount of available funds is not exceeded.

(6) The office of financial management, in consultation with the commission, shall establish appropriate criteria for monitoring and evaluating the economic and labor market impacts of the premium assistance program and report its findings to the commission annually through July 1, 2001.

I. PUBLIC HEALTH SERVICES IMPROVEMENT PLAN

NEW SECTION. **Sec. 467.** A new section is added to chapter 43.70 RCW to read as follows:

PUBLIC HEALTH SERVICES IMPROVEMENT PLAN. (1) The legislature finds that the public health functions of community assessment, policy development, and assurance of service delivery are essential elements in achieving the objectives of health reform in Washington state. The legislature further finds that the population-based services provided by state and local health departments are cost-effective and are a critical strategy for the long-term containment of health care costs. The legislature further finds that the public health system in the state lacks the capacity to fulfill these functions consistent with the needs of a reformed health care system.

(2) The department of health shall develop, in consultation with local health departments and districts, the state board of health, the health services commission, area Indian health service, and other state agencies, health services providers, and citizens concerned about public health, a public health services improvement plan. The plan

shall provide a detailed accounting of deficits in the core functions of assessment, policy development, assurance of the current public health system, how additional public health funding would be used, and describe the benefits expected from expanded expenditures.

(3) The plan shall include:

(a) Definition of minimum standards for public health protection through assessment, policy development, and assurances;

(i) Enumeration of communities not meeting those standards;

(ii) A budget and staffing plan for bringing all communities up to minimum standards;

(iii) An analysis of the costs and benefits expected from adopting minimum public health standards for assessment, policy development, and assurances;

(b) Recommended strategies and a schedule for improving public health programs throughout the state, including:

(i) Strategies for transferring personal health care services from the public health system, into the uniform benefits package where feasible; and

(ii) Timing of increased funding for public health services linked to specific objectives for improving public health; and

(c) A recommended level of dedicated funding for public health services to be expressed in terms of a percentage of total health service expenditures in the state or a set per person amount; such recommendation shall also include methods to ensure that such funding does not supplant existing federal, state, and local funds received by local health departments, and methods of distributing funds among local health departments.

(4) The department shall coordinate this planning process with the study activities required in section 258 of this act.

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

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

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

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

NEW SECTION. **Sec. 468.** A new section is added to chapter 41.05 RCW to read as follows:

AMERICAN INDIAN HEALTH CARE DELIVERY PLAN. Consistent with funds appropriated specifically for this purpose, the authority shall establish in conjunction with the area Indian health services system and providers an advisory group comprised of Indian and non-Indian health care facilities and providers to formulate an American Indian health care delivery plan. The plan shall include:

(1) Recommendations to providers and facilities methods for coordinating and joint venturing with the Indian health services for service delivery;

(2) Methods to improve American Indian-specific health programming; and

(3) Creation of co-funding recommendations and opportunities for the unmet health services programming needs of American Indians.

J. HEALTH ACCOUNTS

NEW SECTION. **Sec. 469.** HEALTH SERVICES ACCOUNT. The health services account is created in the state treasury. Moneys in the account may be spent only after appropriation. Moneys in the account may be expended only for maintaining and expanding health services access for low-income residents, maintaining and expanding the public health system, maintaining and improving the capacity of the health care system, containing health care costs, and the regulation, planning, and administering of the health care system.

NEW SECTION. **Sec. 470.** PUBLIC HEALTH SERVICES ACCOUNT. The public health services account is created in the state treasury. Moneys in the account may be spent only after appropriation. Moneys in the account may be expended only for maintaining and improving the health of Washington residents through the public health system. For purposes of this section, the public health system shall consist of the state board of health, the state department of health, and local health departments and districts. Funds appropriated from this account to local health departments and districts shall be distributed ratably based on county population as last determined by the office of financial management.

NEW SECTION. **Sec. 471.** HEALTH SYSTEM CAPACITY ACCOUNT. The health system capacity account is created in the state treasury. Moneys in the account may be spent only after appropriation. Moneys in the account may be expended for the following purposes: Health data systems; health systems and public health research; health system regulation; health system planning, development, and administration; and improving the supply and geographic distribution of primary health service providers.

NEW SECTION. **Sec. 472.** PERSONAL HEALTH SERVICES ACCOUNT. The personal health services account is created in the treasury. Moneys in the account may be spent only after appropriation. Moneys in the account may be expended for the support of subsidized personal health services for low-income Washington residents.

Sec. 473. RCW 43.84.092 and 1993 c 4 s 9 are each amended to read as follows:

EARNINGS OF INVESTMENTS. (1) All earnings of investments of surplus balances in the state treasury shall be deposited to the treasury income account, which account is hereby established in the state treasury.

(2) Monthly, the state treasurer shall distribute the earnings credited to the treasury income account. The state treasurer shall credit the general fund with all the earnings credited to the treasury income account except:

(a) The following accounts and funds shall receive their proportionate share of earnings based upon each account's and fund's average daily balance for the period: The capitol building construction account, the Cedar River channel construction and operation account, the Central Washington University capital projects account, the charitable, educational, penal and reformatory institutions account, the common school construction fund, the county criminal justice assistance account, the county sales and use tax equalization account, the data processing building construction account, the deferred compensation administrative account, the deferred compensation principal account, the department of retirement systems expense account, the Eastern Washington University capital projects account, the federal forest revolving account, the health services account, the public health services account, the health system capacity account, the personal health services account, the industrial insurance premium refund account, the judges' retirement account, the judicial retirement administrative account, the judicial retirement principal account, the local leasehold excise tax account, the local sales and use tax account, the medical aid account, the municipal criminal justice assistance account, the municipal sales and use tax equalization account, the natural resources deposit account, the perpetual surveillance and maintenance account, the public employees' retirement system plan I account, the public employees' retirement system plan II account, the Puyallup tribal settlement account, the resource management cost account, the site closure account, the special wildlife account, the state employees' insurance account, the state employees' insurance reserve account, the state investment board expense account, the state investment board commingled trust fund accounts, the supplemental pension account, the teachers' retirement system plan I account, the teachers' retirement system plan II account, the University of Washington bond retirement fund, the University of

Washington building account, the volunteer fire fighters' relief and pension principal account, the volunteer fire fighters' relief and pension administrative account, the Washington judicial retirement system account, the Washington law enforcement officers' and fire fighters' system plan I retirement account, the Washington law enforcement officers' and fire fighters' system plan II retirement account, the Washington state patrol retirement account, the Washington State University building account, the Washington State University bond retirement fund, and the Western Washington University capital projects account. Earnings derived from investing balances of the agricultural permanent fund, the normal school permanent fund, the permanent common school fund, the scientific permanent fund, and the state university permanent fund shall be allocated to their respective beneficiary accounts. All earnings to be distributed under this subsection (2)(a) shall first be reduced by the allocation to the state treasurer's service fund pursuant to RCW 43.08.190.

(b) The following accounts and funds shall receive eighty percent of their proportionate share of earnings based upon each account's or fund's average daily balance for the period: The central Puget Sound public transportation account, the city hardship assistance account, the county arterial preservation account, the economic development account, the essential rail assistance account, the essential rail banking account, the ferry bond retirement fund, the grade crossing protective fund, the high capacity transportation account, the highway bond retirement fund, the highway construction stabilization account, the highway safety account, the marine operating fund, the motor vehicle fund, the motorcycle safety education account, the pilotage account, the public transportation systems account, the Puget Sound capital construction account, the Puget Sound ferry operations account, the recreational vehicle account, the rural arterial trust account, the special category C account, the state patrol highway account, the transfer relief account, the transportation capital facilities account, the transportation equipment fund, the transportation fund, the transportation improvement account, and the urban arterial trust account.

(3) In conformance with Article II, section 37 of the state Constitution, no treasury accounts or funds shall be allocated earnings without the specific affirmative directive of this section.

K. EXCLUSIONS AND STUDIES

NEW SECTION. **Sec. 474.** CODE REVISIONS AND WAIVERS. (1) The commission shall determine the state and federal laws that would need to be repealed, amended, or waived to implement chapter . . ., Laws of 1993 (this act), and report its recommendations, with proposed revisions to the Revised Code of Washington, to the governor, and appropriate committees of the legislature by July 1, 1994.

(2) The governor, in consultation with the commission, shall take the following steps in an effort to receive waivers or exemptions from federal statutes necessary to fully implement chapter . . ., Laws of 1993 (this act) to include, but not be limited to:

(a) Negotiate with the United States congress and the federal department of health and human services, health care financing administration to obtain a statutory or regulatory waiver of provisions of the medical assistance statute, Title XIX of the federal social security act that currently constitute barriers to full implementation of provisions of chapter . . ., Laws of 1993 (this act) related to access to health services for low-income residents of Washington state. Such waivers shall include any waiver needed to require that: (i) Medical assistance recipients enroll in managed care systems, as defined in chapter ..., Laws of 1993 (this act); and (ii) enrollee point of service, cost-sharing levels adopted pursuant to section 449 of this act be applied to medical assistance recipients. In negotiating the waiver, consideration shall be given to the degree to which supplemental benefits should be offered to medicaid recipients, if at all. Waived provisions may include and are not limited to: Categorical eligibility restrictions related to age, disability, blindness, or family structure; income and resource limitations tied to financial eligibility requirements of the federal aid to families with dependent children and supplemental security income programs; administrative requirements regarding single state agencies, choice of providers, and fee for service reimbursement; and other limitations on health services provider payment methods.

(b) Negotiate with the United States congress and the federal department of health and human services, health care financing administration to obtain a statutory or regulatory waiver of provisions of the medicare statute, Title XVIII of the federal social security act that currently constitute barriers to full implementation of provisions

of chapter . . ., Laws of 1993 (this act) related to access to health services for elderly and disabled residents of Washington state. Such waivers shall include any waivers needed to implement managed care programs. Waived provisions include and are not limited to: Beneficiary cost-sharing requirements; restrictions on scope of services; and limitations on health services provider payment methods.

(c) Negotiate with the United States congress and the federal department of health and human services to obtain any statutory or regulatory waivers of provisions of the United States public health services act necessary to ensure integration of federally funded community and migrant health clinics and other health services funded through the public health services act into the health services system established pursuant to chapter . . ., Laws of 1993 (this act). The commission shall request in the waiver that funds from these sources continue to be allocated to federally funded community and migrant health clinics to the extent that such clinics' patients are not yet enrolled in certified health plans.

(d) Negotiate with the United States congress to obtain a statutory exemption from provisions of the Employee Retirement Income Security Act that limit the state's ability to ensure that all employees and their dependents in the state comply with the requirement to enroll in certified health plans, and have their employers participate in financing their enrollment in such plans.

(e) Request that the United States congress amend the Internal Revenue Code to treat employee premium contributions to plans, such as the basic health plan or the uniform benefits package offered through a certified health plan, as fully deductible from adjusted gross income.

(3) On or before December 1, 1995, the commission shall report the following to the appropriate committees of the legislature:

(a) The status of its efforts to obtain the waivers provided in subsection (2) of this section;

(b) If all federal statutory or regulatory waivers necessary to fully implement chapter ..., Laws of 1993 (this act) have not been obtained:

(i) The extent to which chapter ..., Laws of 1993 (this act) can be implemented without receipt of all of such waivers; and

(ii) Changes in chapter ..., Laws of 1993 (this act) necessary to implement a residency-based health services system using one or a

limited number of sponsors, or an alternative system that will ensure access to care and control health services costs.

NEW SECTION. **Sec. 475.** REPORTS OF HEALTH CARE COST CONTROL AND ACCESS COMMISSION. In carrying out its powers and duties under chapter . . ., Laws of 1993 (this act), the design of the uniform benefits package, and the development of guidelines and standards, the commission shall consider the reports of the health care cost control and access commission established under House Concurrent Resolution No. 4443 adopted by the legislature in 1990. Nothing in chapter . . ., Laws of 1993 (this act) requires the commission to follow any specific recommendation contained in those reports except as it may also be included in chapter . . ., Laws of 1993 (this act) or other law.

NEW SECTION. **Sec. 476.** EVALUATIONS, PLANS, AND STUDIES. (1) By July 1, 1997, the legislative budget committee either directly or by contract shall conduct the following study:

A study to determine the desirability and feasibility of consolidating the following programs, services, and funding sources into the delivery and financing of uniform benefits package services through certified health plans:

(a) State and federal veterans' health services;

(b) Civilian health and medical program of the uniformed services (CHAMPUS) of the federal department of defense and other federal agencies; and

(c) Federal employee health benefits.

(2) The legislative budget committee shall evaluate the implementation of the provisions of chapter . . ., Laws of 1993 (this act). The study shall determine to what extent chapter . . ., Laws of 1993 (this act) has been implemented consistent with the principles and elements set forth in chapter . . ., Laws of 1993 (this act) and shall report its findings to the governor and appropriate committees of the legislature by July 1, 2003.

NEW SECTION. **Sec. 477.** FINANCIAL AND ACCOUNTING STRUCTURE OF STATE PURCHASED HEALTH CARE. The commission, the office of financial management, and the legislative evaluation and accountability program committee shall jointly review the financial and accounting structure of all current state-purchased health care programs and any new

programs established in chapter . . ., Laws of 1993 (this act). They shall report to the legislature on or before December 1, 1994, with recommendations on how to structure a state-purchased health services budget that: (1) Meets federal and state audit requirements; (2) exercises adequate fiscal and programmatic control; (3) provides management and organizational accountability and control; and (4) provides continuity with historical health services expenditure data.

NEW SECTION. **Sec. 478.** EVALUATION OF REFORM EFFORT. The office of financial management may undertake or facilitate evaluations of health care reform, including analysis of fiscal and economic impacts, the effectiveness of managed care and managed competition, and effects of reform on access and quality of service.

NEW SECTION. **Sec. 479.** COORDINATION OF CERTIFIED HEALTH PLANS AND OTHER INSURANCE. (1) On or before December 1, 1994, the legislative budget committee, whether directly or by contract, shall conduct a study related to coordination of certified health plans and other property and casualty insurance products. The goal of the study shall be to determine methods for containing costs of health services paid for through coverage underwritten by property and casualty insurers.

(2) The study shall address methods to integrate coverage sold by property and casualty insurance companies that covers medical and hospital expenses with coverage provided through certified health plans.

NEW SECTION. **Sec. 480.** HOSPITAL REGULATION STUDY. The legislative budget committee, through a competitive bidding process restricted to those with suitable expertise to conduct such a study, shall contract for an examination of local, state, and federal regulations that apply to hospitals and shall report to the health care policy committees of the legislature by July 1, 1994, on the following:

(1) An inventory of health and safety regulations that apply to hospitals;

(2) A description of the costs to local, state, and federal agencies for operating the regulatory programs;

(3) An estimate of the costs to hospitals to comply with the regulations;

(4) A description of whether regulatory functions are duplicated among different regulatory programs;

(5) An analysis of the effectiveness of regulatory programs in meeting their safety and health objectives;

(6) An analysis of hospital charity care requirements under RCW 70.170.060 and their relevance under the health care reforms created under chapter . . ., Laws of 1993 (this act);

(7) Recommendations on elimination or consolidation of unnecessary or duplicative regulatory activities that would not result in a reduction in the health and safety objectives.

NEW SECTION. **Sec. 481.** NURSING HOME STUDY. The legislative budget committee, through a competitive bidding process restricted to those with suitable expertise to conduct such a study, shall contract for an examination of local, state, and federal regulations that apply to nursing homes and shall report to the health care policy committees of the legislature by July 1, 1994, on the following:

(1) An inventory of health and safety regulations that apply to nursing homes;

(2) A description of the costs to local, state, and federal agencies for operating the regulatory programs;

(3) An estimate of the costs to nursing homes to comply with the regulations;

(4) A description of whether regulatory functions are duplicated among different regulatory programs;

(5) An analysis of the effectiveness of regulatory programs in meeting their safety and health objectives;

(6) Recommendations on elimination or consolidation of unnecessary or duplicative regulatory activities that would not result in a reduction in the health and safety objectives. The review shall specifically address documentation or protocols that are redundant and efficiencies that could be realized through the development of standardized physicians' protocols for repetitive but nonlife-threatening conditions.

NEW SECTION. **Sec. 482.** CERTIFIED HEALTH PLAN LICENSING STUDY. The insurance commissioner shall undertake a study of the feasibility and benefits of developing a single licensing category for certified health plans that would replace current statues licensing disability

insurers, health care service contractors, and health maintenance organizations. The commissioner shall report his or her findings and recommendations to the legislature by January 1, 1994, and final findings and recommendations to the legislature by October 1, 1994. In conducting such study, the commissioner shall:

(1) Consider standards for the regulation and inclusion of preferred provider organizations, independent practice associations, and independent physician organizations under such new certified health plan statute;

(2) Review existing capital and reserve statutes governing insurers, contractors, and health maintenance organizations to determine the appropriate level of capital and reserve for licensing of certified health plans to protect consumers while encouraging competition in the certified health plan market from new entrants into the market;

(3) Review existing rate regulation of disability insurance policies, health care service contracts, and health maintenance agreements and propose a uniform approach for regulation of rates that balances the need of certified health plans to freely compete and the need to protect consumers from inadequate, excessive, or unfairly discriminatory rates;

(4) Consider regulatory methods to ensure the adequate provision of and contracting with health care facilities and providers by certified health plans to meet the health care needs of enrollees of certified health plans;

(5) Consider the need to modify existing insurance statutes and regulations to govern the integration, development, and marketing of health care coverage that would supplement the uniform benefits package; and

(6) Consult with health care service contractors, health maintenance organizations, disability insurance companies, and other health care providers and facilities who would be affected by such changes.

NEW SECTION. **Sec. 483.** CRIME VICTIMS' COMPENSATION MEDICAL BENEFITS. (1) On or before January 1, 1995, the department of labor and industries in coordination with the commission, shall complete a study related to the medical services component of the crime victims' compensation program of the department of labor and industries. The

goal of the study shall be to determine whether and how the medical services component of the crime victims' compensation program can be modified to provide appropriate medical services to crime victims in a more cost-effective manner. In conducting the study, consideration shall be given to at least the following factors: Required benefit design, necessary statutory changes, and the use of managed care to provide services to crime victims. The study shall evaluate at least the following options:

(a) Whether the medical services component of the crime victims' 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 crime victims;

(b) Whether the medical services component of the crime victims' compensation program should be administered by the health care authority as the state health care purchasing agent;

(c) Whether the medical services component of the crime victims' compensation program should be included in the services offered by certified health plans.

(2) The department of labor and industries shall present the recommendations to the governor and the appropriate committees of the legislature by January 1, 1995.

NEW SECTION. **Sec. 484.** MEDICAL CARE SAVINGS ACCOUNTS. The Washington health services commission shall study and report to the legislature on the feasibility of offering employer-funded medical care savings account arrangements and reduced cost qualified higher deductible insurance policies as a choice to K-12 system, state, and local government employees in meeting their health care obligations.

L. WORKERS' COMPENSATION

NEW SECTION. **Sec. 485.** WORKERS' COMPENSATION MEDICAL BENEFITS. On or before January 1, 1995, the health services commission, in coordination with the department of labor and industries and the workers' compensation advisory committee, shall study and make an interim report, and on or before January 1, 1996, a final report, to the governor and appropriate committees of the legislature on the provision of medical benefits for injured workers under a consolidated

health care system. The study shall include a review of options and recommendations for modifying the industrial insurance system to provide medical services for injured workers in a more cost-effective manner under a consolidated system, and may include consideration of the purchase of industrial insurance medical benefits through the health care authority or the inclusion of industrial insurance medical benefits in the services offered by certified health plans or other appropriate options. The commission should also give consideration to at least the following issues: The use of managed care and the effect of managed care options on the injured workers' choice of health services provider; the potential cost savings or other impacts of various consolidation options; the benefit structure required under industrial insurance; the potential for consolidation to meet or exceed existing medical cost management of the medical aid fund; the impact of separating the medical management of claims from the disability management of claims; the relationship between return-to-work efforts, medical services, and disability prevention; the relationship between medical services and rehabilitation services; and the effects of the quasi-judicial system that determines industrial insurance rights and obligations. In addition, the final report shall include a proposed plan and timeline for including the medical benefits of the industrial insurance system in the services offered by certified health plans. The proposed plan shall assure that:

(1) The plan shall not take effect until at least ninety-seven percent of state residents have access to the uniform benefits package as required in chapter ..., Laws of 1993 (this act);

(2) The uniform benefits package of the certified health plan will provide benefits for injured workers that are at least equivalent to the medical benefits provided to injured workers under Title 51 RCW as determined by the department of labor and industries as of the effective date of the plan, including payments for services that are ancillary to industrial insurance medical benefits, such as but not limited to medical examinations for permanent disabilities;

(3) Other nonmedical benefits required to be provided under Title 51 RCW, such as but not limited to total or partial disability benefits or vocational rehabilitation benefits, are not affected;

(4) Employers who do not choose to become certified health plans under chapter..., Laws of 1993 (this act), will continue to be required to provide industrial insurance medical benefits under Title 51 RCW;

(5) Employees participating in the plan shall not be required to pay deductibles, copayments, or other point of service charges for services related to industrial insurance injuries or diseases, such costs to be paid by the department of labor and industries or self-insured employer, as applicable;

(6) The plan includes a mechanism to return to workers and employers, in equal shares, any savings that are realized in the costs of medical services for injured workers, as identified by the department of labor and industries;

(7) The majority of the employer's employees or, if the employees are represented for collective bargaining purposes, the exclusive bargaining representative voluntarily agree to the employer's participation in the plan.

NEW SECTION. **Sec. 486.** MANAGED CARE PILOT PROJECTS. (1) The department of labor and industries, in consultation with the workers' compensation advisory committee, may conduct pilot projects to purchase medical services for injured workers through managed care arrangements. The projects shall assess the effects of managed care on the cost and quality of, and employer and employee satisfaction with, medical services provided to injured workers.

(2) The pilot projects may be limited to specific employers. The implementation of a pilot project shall be conditioned upon a participating employer and a majority of its employees, or, if the employees are represented for collective bargaining purposes, the exclusive bargaining representative, voluntarily agreeing to the terms of the pilot. Unless the project is terminated by the department, both the employer and employees are bound by the project agreements for the duration of the project.

(3) Solely for the purpose and duration of a pilot project, the specific requirements of Title 51 RCW that are identified by the department as otherwise prohibiting implementation of the pilot project shall not apply to the participating employers and employees to the extent necessary for conducting the project. Managed care arrangements for the pilot projects may include the designation of doctors responsible for the care delivered to injured workers participating in the projects.

(4) The projects shall conclude no later than January 1, 1996. The department shall present the results of the pilot projects and any

recommendations related to the projects to the governor and appropriate committees of the legislature on or before October 1, 1996.

M. MISCELLANEOUS

NEW SECTION. **Sec. 487.** SHORT TITLE. This act may be known and cited as the Washington health services act of 1993.

Sec. 488. RCW 42.17.2401 and 1991 c 200 s 404 are each amended to read as follows:

EXECUTIVE STATE OFFICERS. For the purposes of RCW 42.17.240, the term "executive state officer" includes:

(1) The chief administrative law judge, the director of agriculture, the administrator of the office of marine safety, the administrator of the Washington basic health plan, the director of the department of services for the blind, the director of the state system of community and technical colleges, the director of community development, the secretary of corrections, the director of ecology, the commissioner of employment security, the chairman of the energy facility site evaluation council, the director of the energy office, the secretary of the state finance committee, the director of financial management, the director of fisheries, the executive secretary of the forest practices appeals board, the director of the gambling commission, the director of general administration, the secretary of health, the administrator of the Washington state health care authority, the executive secretary of the health care facilities authority, the executive secretary of the higher education facilities authority, the director of the higher education personnel board, the executive secretary of the horse racing commission, the executive secretary of the human rights commission, the executive secretary of the indeterminate sentence review board, the director of the department of information services, the director of the interagency committee for outdoor recreation, the executive director of the state investment board, the director of labor and industries, the director of licensing, the director of the lottery commission, the director of the office of minority and women’s business enterprises, the director of parks and recreation, the director of personnel, the executive director of the public disclosure commission, the director of retirement systems, the director of revenue, the secretary of social and health services, the

chief of the Washington state patrol, the executive secretary of the board of tax appeals, the director of trade and economic development, the secretary of transportation, the secretary of the utilities and transportation commission, the director of veterans affairs, the 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. 489. 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:

(i) The design and construction of public water system facilities, including proper sizing of pipes and storage for the number and type of customers;

(ii) Drinking water quality standards, monitoring requirements, and laboratory certification requirements;

(iii) Public water system management and reporting requirements;

(iv) Public water system planning and emergency response requirements;

(v) Public water system operation and maintenance requirements;

(vi) Water quality, reliability, and management of existing but inadequate public water systems; and

(vii) Quality standards for the source or supply, or both source and supply, of water for bottled water plants.

(b) Adopt rules and standards for prevention, control, and abatement of health hazards and nuisances related to the disposal of wastes, solid and liquid, including but not limited to sewage, garbage, refuse, and other environmental contaminants; adopt standards and procedures governing the design, construction, and operation of sewage, garbage, refuse and other solid waste collection, treatment, and disposal facilities;

(c) Adopt rules controlling public health related to environmental conditions including but not limited to heating, lighting, ventilation, sanitary facilities, cleanliness and space in all types of public facilities including but not limited to food service establishments, schools, institutions, recreational facilities and transient accommodations and in places of work;

(d) Adopt rules for the imposition and use of isolation and quarantine;

(e) Adopt rules for the prevention and control of infectious and noninfectious diseases, including food and vector borne illness, and rules governing the receipt and conveyance of remains of deceased persons, and such other sanitary matters as admit of and may best be controlled by universal rule; and

(f) Adopt rules for accessing existing data bases for the purposes of performing health related research.

(3) The state board may delegate any of its rule-adopting authority to the secretary and rescind such delegated authority.

(4) All local boards of health, health authorities and officials, officers of state institutions, police officers, sheriffs, constables, and all other officers and employees of the state, or any county, city, or township thereof, shall enforce all rules adopted by the state board of health. In the event of failure or refusal on the part of any member of such boards or any other official or person mentioned in this section to so act, he shall be subject to a fine of not less than fifty dollars, upon first conviction, and not less than one hundred dollars upon second conviction.

(5) The state board may advise the secretary on health policy issues pertaining to the department of health and the state.

NEW SECTION. **Sec. 490.** SEVERABILITY. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 491.** SAVINGS CLAUSE. The enactment of this act does not have the effect of terminating, or in any way modifying, any obligation or any liability, civil or criminal, which was already in existence on the effective date of this act.

NEW SECTION. **Sec. 492.** CAPTIONS. Captions used in this act do not constitute any part of the law.

NEW SECTION. **Sec. 493.** CODIFICATION. (1) Sections 401 through 407, 409, 425, 427 through 430, and 447 through 466 of this act shall constitute a new chapter in Title 43 RCW.

(2) Sections 426 and 431 through 446 of this act shall constitute a new chapter in Title 48 RCW.

(3) Sections 458 through 462 of this act shall constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec. 494.** RESERVATION OF LEGISLATIVE AUTHORITY. The legislature reserves the right to amend or repeal all or any part of

this act at any time and there shall be no vested private right of any kind against such amendment or repeal. All the rights, privileges, or immunities conferred by this act or any acts done pursuant thereto shall exist subject to the power of the legislature to amend or repeal this act at any time.

NEW SECTION. **Sec. 495.** EFFECTIVE DATE CLAUSE. This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect July 1, 1993, except for:

(1) Sections 234 through 257 of this act, which shall take effect July 1, 1995; and

(2) Sections 301 through 303 of this act, which shall take effect January 1, 1996.

NEW SECTION. **Sec. 496.** NULL AND VOID. If specific funding for section 418 of this act, referencing section 418 of this act by bill and section number, is not provided by June 30, 1993, in the omnibus appropriations act, section 418 of this act shall be null and void."

E2SSB 5304 - CONF REPT

By Conference Committee

ADOPTED 4/23/93

On page 1, line 1 of the title, after "care;" strike the remainder of the title and insert "amending RCW 70.47.010, 70.47.020, 70.47.030, 70.47.040, 70.47.060, 70.47.080, 41.05.011, 41.05.021, 41.05.050, 41.05.055, 41.05.065, 41.05.120, 41.05.140, 47.64.270, 74.09.055, 19.68.010, 70.05.010, 70.05.030, 70.05.040, 70.05.050, 70.05.070, 70.05.080, 70.05.120, 70.05.130, 70.05.150, 70.08.010, 70.12.030, 70.12.050, 70.46.020, 70.46.060, 70.46.080, 70.46.085, 70.46.090, 70.46.120, 82.44.110, 82.44.155, 43.20.030, 70.170.100, 70.170.110, 28B.125.010, 28B.115.080, 70.185.030, 43.70.460, 43.70.470, 48.30.300, 48.44.260, 48.46.380, 48.44.095, 48.14.080, 82.04.260, 82.04.4289, 82.24.020, 82.24.080, 82.26.020, 82.08.150, 66.24.290, 82.02.030, 43.70.320, 70.41.200, 70.41.230, 5.60.070, 4.22.070, 43.84.092, 42.17.2401, and 43.20.050; reenacting and amending RCW 28A.400.200, 28A.400.350, 48.21.200, and 48.46.080; adding a new section to chapter 70.47 RCW; adding new sections to chapter 41.05 RCW; adding a new section to Title 43 RCW; adding new sections to chapter 70.05 RCW; adding new sections to chapter 70.170 RCW; adding a new section to chapter 70.41 RCW; adding new sections to chapter 18.68 RCW; adding a new section to chapter 18.51 RCW; adding new sections to chapter 70.185 RCW; adding a new section to chapter 48.18 RCW; adding a new section to chapter 48.20 RCW; adding a new section to chapter 48.21 RCW; adding new sections to chapter 48.44 RCW; adding new sections to chapter 48.46 RCW; adding a new section to chapter 48.01 RCW; adding a new section to chapter 48.14 RCW; adding a new section to chapter 82.04 RCW; adding new sections to chapter 18.130 RCW; adding new sections to chapter 43.70 RCW; adding a new section to chapter 48.22 RCW; adding a new section to chapter 48.05 RCW; adding new sections to chapter 7.70 RCW; adding a new chapter to Title 43 RCW; adding new chapters to Title 48 RCW; creating new sections; recodifying RCW 70.08.010; repealing RCW 70.05.005, 70.05.020, 70.05.132, 70.05.145, 70.12.005, 70.46.030, 70.46.040, 70.46.050, 48.46.160, 48.46.905, 48.44.410, and 82.04.4288; prescribing penalties; providing effective dates; and declaring an emergency."

--- END ---