

E2SSB 5930 - CONF REPT
By Conference Committee

1 Strike everything after the enacting clause and insert the
2 following:

3 "USE STATE PURCHASING TO IMPROVE HEALTH CARE QUALITY

4 NEW SECTION. **Sec. 1.** (1) The health care authority and the
5 department of social and health services shall, by September 1, 2007,
6 develop a five-year plan to change reimbursement within their health
7 care programs to:

8 (a) Reward quality health outcomes rather than simply paying for
9 the receipt of particular services or procedures;

10 (b) Pay for care that reflects patient preference and is of proven
11 value;

12 (c) Require the use of evidence-based standards of care where
13 available;

14 (d) Tie provider rate increases to measurable improvements in
15 access to quality care;

16 (e) Direct enrollees to quality care systems;

17 (f) Better support primary care and provide a medical home to all
18 enrollees through reimbursement policies that create incentives for
19 providers to enter and remain in primary care practice and that address
20 disparities in payment between specialty procedures and primary care
21 services; and

22 (g) Pay for e-mail consultations, telemedicine, and telehealth
23 where doing so reduces the overall cost of care.

24 (2) In developing any component of the plan that links payment to
25 health care provider performance, the authority and the department
26 shall work in collaboration with the department of health, health
27 carriers, local public health jurisdictions, physicians and other
28 health care providers, the Puget Sound health alliance, and other
29 purchasers.

1 (3) The plan shall (a) identify any existing barriers and
2 opportunities to support implementation, including needed changes to
3 state or federal law; (b) identify the goals the plan is intended to
4 achieve and how progress toward those goals will be measured; and (c)
5 be submitted to the governor and the legislature upon completion. The
6 agencies shall report to the legislature by September 1, 2007. Any
7 component of the plan that links payment to health care provider
8 performance must be submitted to the legislature for consideration
9 prior to implementation by the department or the authority.

10 NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05 RCW
11 to read as follows:

12 (1) The legislature finds that there is growing evidence that, for
13 preference-sensitive care involving elective surgery, patient-
14 practitioner communication is improved through the use of high-quality
15 decision aids that detail the benefits, harms, and uncertainty of
16 available treatment options. Improved communication leads to more
17 fully informed patient decisions. The legislature intends to increase
18 the extent to which patients make genuinely informed, preference-based
19 treatment decisions, by promoting public/private collaborative efforts
20 to broaden the development, certification, use, and evaluation of
21 effective decision aids and by recognition of shared decision making
22 and patient decision aids in the state's laws on informed consent.

23 (2) The health care authority shall implement a shared
24 decision-making demonstration project. The demonstration project shall
25 be conducted at one or more multispecialty group practice sites
26 providing state purchased health care in the state of Washington, and
27 may include other practice sites providing state purchased health care.
28 The demonstration project shall include the following elements:

29 (a) Incorporation into clinical practice of one or more decision
30 aids for one or more identified preference-sensitive care areas
31 combined with ongoing training and support of involved practitioners
32 and practice teams, preferably at sites with necessary supportive
33 health information technology;

34 (b) An evaluation of the impact of the use of shared decision
35 making with decision aids, including the use of preference-sensitive
36 health care services selected for the demonstration project and
37 expenditures for those services, the impact on patients, including

1 patient understanding of the treatment options presented and
2 concordance between patient values and the care received, and patient
3 and practitioner satisfaction with the shared decision-making process;
4 and

5 (c) As a condition of participating in the demonstration project,
6 a participating practice site must bear the cost of selecting,
7 purchasing, and incorporating the chosen decision aids into clinical
8 practice.

9 (3) The health care authority may solicit and accept funding and
10 in-kind contributions to support the demonstration and evaluation, and
11 may scale the evaluation to fall within resulting resource parameters.

12 **Sec. 3.** RCW 7.70.060 and 1975-'76 2nd ex.s. c 56 s 11 are each
13 amended to read as follows:

14 (1) If a patient while legally competent, or his or her
15 representative if he or she is not competent, signs a consent form
16 which sets forth the following, the signed consent form shall
17 constitute prima facie evidence that the patient gave his or her
18 informed consent to the treatment administered and the patient has the
19 burden of rebutting this by a preponderance of the evidence:

20 ~~((1))~~ (a) A description, in language the patient could reasonably
21 be expected to understand, of:

22 ~~((a))~~ (i) The nature and character of the proposed treatment;

23 ~~((b))~~ (ii) The anticipated results of the proposed treatment;

24 ~~((c))~~ (iii) The recognized possible alternative forms of
25 treatment; and

26 ~~((d))~~ (iv) The recognized serious possible risks, complications,
27 and anticipated benefits involved in the treatment and in the
28 recognized possible alternative forms of treatment, including
29 nontreatment;

30 ~~((2))~~ (b) Or as an alternative, a statement that the patient
31 elects not to be informed of the elements set forth in (a) of this
32 subsection ~~((1) of this section)~~.

33 (2) If a patient while legally competent, or his or her
34 representative if he or she is not competent, signs an acknowledgement
35 of shared decision making as described in this section, such
36 acknowledgement shall constitute prima facie evidence that the patient

1 gave his or her informed consent to the treatment administered and the
2 patient has the burden of rebutting this by clear and convincing
3 evidence. An acknowledgement of shared decision making shall include:

4 (a) A statement that the patient, or his or her representative, and
5 the health care provider have engaged in shared decision making as an
6 alternative means of meeting the informed consent requirements set
7 forth by laws, accreditation standards, and other mandates;

8 (b) A brief description of the services that the patient and
9 provider jointly have agreed will be furnished;

10 (c) A brief description of the patient decision aid or aids that
11 have been used by the patient and provider to address the needs for (i)
12 high-quality, up-to-date information about the condition, including
13 risk and benefits of available options and, if appropriate, a
14 discussion of the limits of scientific knowledge about outcomes; (ii)
15 values clarification to help patients sort out their values and
16 preferences; and (iii) guidance or coaching in deliberation, designed
17 to improve the patient's involvement in the decision process;

18 (d) A statement that the patient or his or her representative
19 understands: The risk or seriousness of the disease or condition to be
20 prevented or treated; the available treatment alternatives, including
21 nontreatment; and the risks, benefits, and uncertainties of the
22 treatment alternatives, including nontreatment; and

23 (e) A statement certifying that the patient or his or her
24 representative has had the opportunity to ask the provider questions,
25 and to have any questions answered to the patient's satisfaction, and
26 indicating the patient's intent to receive the identified services.

27 (3) As used in this section, "shared decision making" means a
28 process in which the physician or other health care practitioner
29 discusses with the patient or his or her representative the information
30 specified in subsection (2) of this section with the use of a patient
31 decision aid and the patient shares with the provider such relevant
32 personal information as might make one treatment or side effect more or
33 less tolerable than others.

34 (4) As used in this section, "patient decision aid" means a
35 written, audio-visual, or online tool that provides a balanced
36 presentation of the condition and treatment options, benefits, and
37 harms, including, if appropriate, a discussion of the limits of

1 scientific knowledge about outcomes, and that is certified by one or
2 more national certifying organizations.

3 (5) Failure to use a form or to engage in shared decision making,
4 with or without the use of a patient decision aid, shall not be
5 admissible as evidence of failure to obtain informed consent. There
6 shall be no liability, civil or otherwise, resulting from a health care
7 provider choosing either the signed consent form set forth in
8 subsection (1)(a) of this section or the signed acknowledgement of
9 shared decision making as set forth in subsection (2) of this section.

10 **PREVENTION AND MANAGEMENT OF CHRONIC ILLNESS**

11 NEW SECTION. Sec. 4. A new section is added to chapter 74.09 RCW
12 to read as follows:

13 (1) The department of social and health services, in collaboration
14 with the department of health, shall:

15 (a) Design and implement medical homes for its aged, blind, and
16 disabled clients in conjunction with chronic care management programs
17 to improve health outcomes, access, and cost-effectiveness. Programs
18 must be evidence based, facilitating the use of information technology
19 to improve quality of care, must acknowledge the role of primary care
20 providers and include financial and other supports to enable these
21 providers to effectively carry out their role in chronic care
22 management, and must improve coordination of primary, acute, and long-
23 term care for those clients with multiple chronic conditions. The
24 department shall consider expansion of existing medical home and
25 chronic care management programs and build on the Washington state
26 collaborative initiative. The department shall use best practices in
27 identifying those clients best served under a chronic care management
28 model using predictive modeling through claims or other health risk
29 information; and

30 (b) Evaluate the effectiveness of current chronic care management
31 efforts in the health and recovery services administration and the
32 aging and disability services administration, comparison to best
33 practices, and recommendations for future efforts and organizational
34 structure to improve chronic care management.

35 (2) For purposes of this section:

1 (a) "Medical home" means a site of care that provides comprehensive
2 preventive and coordinated care centered on the patient needs and
3 assures high quality, accessible, and efficient care.

4 (b) "Chronic care management" means the department's program that
5 provides care management and coordination activities for medical
6 assistance clients determined to be at risk for high medical costs.
7 "Chronic care management" provides education and training and/or
8 coordination that assist program participants in improving self-
9 management skills to improve health outcomes and reduce medical costs
10 by educating clients to better utilize services.

11 NEW SECTION. **Sec. 5.** A new section is added to chapter 43.70 RCW
12 to read as follows:

13 (1) The department shall conduct a program of training and
14 technical assistance regarding care of people with chronic conditions
15 for providers of primary care. The program shall emphasize evidence-
16 based high quality preventive and chronic disease care. The department
17 may designate one or more chronic conditions to be the subject of the
18 program.

19 (2) The training and technical assistance program shall include the
20 following elements:

21 (a) Clinical information systems and sharing and organization of
22 patient data;

23 (b) Decision support to promote evidence-based care;

24 (c) Clinical delivery system design;

25 (d) Support for patients managing their own conditions; and

26 (e) Identification and use of community resources that are
27 available in the community for patients and their families.

28 (3) In selecting primary care providers to participate in the
29 program, the department shall consider the number and type of patients
30 with chronic conditions the provider serves, and the provider's
31 participation in the medicaid program, the basic health plan, and
32 health plans offered through the public employees' benefits board.

33 NEW SECTION. **Sec. 6.** (1) The health care authority, in
34 collaboration with the department of health, shall design and implement
35 a chronic care management program for state employees enrolled in the
36 state's self-insured uniform medical plan. Programs must be evidence

1 based, facilitating the use of information technology to improve
2 quality of care and must improve coordination of primary, acute, and
3 long-term care for those enrollees with multiple chronic conditions.
4 The authority shall consider expansion of existing medical home and
5 chronic care management programs. The authority shall use best
6 practices in identifying those employees best served under a chronic
7 care management model using predictive modeling through claims or other
8 health risk information.

9 (2) For purposes of this section:

10 (a) "Medical home" means a site of care that provides comprehensive
11 preventive and coordinated care centered on the patient needs and
12 assures high-quality, accessible, and efficient care.

13 (b) "Chronic care management" means the authority's program that
14 provides care management and coordination activities for health plan
15 enrollees determined to be at risk for high medical costs. "Chronic
16 care management" provides education and training and/or coordination
17 that assist program participants in improving self-management skills to
18 improve health outcomes and reduce medical costs by educating clients
19 to better utilize services.

20 **Sec. 7.** RCW 70.83.040 and 2005 c 518 s 938 are each amended to
21 read as follows:

22 When notified of positive screening tests, the state department of
23 health shall offer the use of its services and facilities, designed to
24 prevent mental retardation or physical defects in such children, to the
25 attending physician, or the parents of the newborn child if no
26 attending physician can be identified.

27 The services and facilities of the department, and other state and
28 local agencies cooperating with the department in carrying out programs
29 of detection and prevention of mental retardation and physical defects
30 shall be made available to the family and physician to the extent
31 required in order to carry out the intent of this chapter and within
32 the availability of funds. ~~((The department has the authority to
33 collect a reasonable fee, from the parents or other responsible party
34 of each infant screened to fund specialty clinics that provide
35 treatment services for hemoglobin diseases, phenylketonuria, congenital
36 adrenal hyperplasia, congenital hypothyroidism, and, during the 2005-07~~

1 ~~fiscal biennium, other disorders defined by the board of health under~~
2 ~~RCW 70.83.020. The fee may be collected through the facility where the~~
3 ~~screening specimen is obtained.))~~

4 NEW SECTION. **Sec. 8.** A new section is added to chapter 70.83 RCW
5 to read as follows:

6 The department has the authority to collect a fee of three dollars
7 and fifty cents from the parents or other responsible party of each
8 infant screened for congenital disorders as defined by the state board
9 of health under RCW 70.83.020 to fund specialty clinics that provide
10 treatment services for those with the defined disorders. The fee may
11 be collected through the facility where a screening specimen is
12 obtained.

13 **COST AND QUALITY INFORMATION FOR CONSUMERS AND PROVIDERS**

14 NEW SECTION. **Sec. 9.** A new section is added to chapter 41.05 RCW
15 to read as follows:

16 The Washington state quality forum is established within the
17 authority. In collaboration with the Puget Sound health alliance and
18 other local organizations, the forum shall:

19 (1) Collect and disseminate research regarding health care quality,
20 evidence-based medicine, and patient safety to promote best practices,
21 in collaboration with the technology assessment program and the
22 prescription drug program;

23 (2) Coordinate the collection of health care quality data among
24 state health care purchasing agencies;

25 (3) Adopt a set of measures to evaluate and compare health care
26 cost and quality and provider performance;

27 (4) Identify and disseminate information regarding variations in
28 clinical practice patterns across the state; and

29 (5) Produce an annual quality report detailing clinical practice
30 patterns for purchasers, providers, insurers, and policy makers. The
31 agencies shall report to the legislature by September 1, 2007.

32 NEW SECTION. **Sec. 10.** A new section is added to chapter 41.05 RCW
33 to read as follows:

34 (1) The administrator shall design and pilot a consumer-centric

1 health information infrastructure and the first health record banks
2 that will facilitate the secure exchange of health information when and
3 where needed and shall:

4 (a) Complete the plan of initial implementation, including but not
5 limited to determining the technical infrastructure for health record
6 banks and the account locator service, setting criteria and standards
7 for health record banks, and determining oversight of health record
8 banks;

9 (b) Implement the first health record banks in pilot sites as
10 funding allows;

11 (c) Involve health care consumers in meaningful ways in the design,
12 implementation, oversight, and dissemination of information on the
13 health record bank system; and

14 (d) Promote adoption of electronic medical records and health
15 information exchange through continuation of the Washington health
16 information collaborative, and by working with private payors and other
17 organizations in restructuring reimbursement to provide incentives for
18 providers to adopt electronic medical records in their practices.

19 (2) The administrator may establish an advisory board, a
20 stakeholder committee, and subcommittees to assist in carrying out the
21 duties under this section. The administrator may reappoint health
22 information infrastructure advisory board members to assure continuity
23 and shall appoint any additional representatives that may be required
24 for their expertise and experience.

25 (a) The administrator shall appoint the chair of the advisory
26 board, chairs, and cochairs of the stakeholder committee, if formed;

27 (b) Meetings of the board, stakeholder committee, and any advisory
28 group are subject to chapter 42.30 RCW, the open public meetings act,
29 including RCW 42.30.110(1)(1), which authorizes an executive session
30 during a regular or special meeting to consider proprietary or
31 confidential nonpublished information; and

32 (c) The members of the board, stakeholder committee, and any
33 advisory group:

34 (i) Shall agree to the terms and conditions imposed by the
35 administrator regarding conflicts of interest as a condition of
36 appointment;

37 (ii) Are immune from civil liability for any official acts

1 performed in good faith as members of the board, stakeholder committee,
2 or any advisory group.

3 (3) Members of the board may be compensated for participation in
4 accordance with a personal services contract to be executed after
5 appointment and before commencement of activities related to the work
6 of the board. Members of the stakeholder committee shall not receive
7 compensation but shall be reimbursed under RCW 43.03.050 and 43.03.060.

8 (4) The administrator may work with public and private entities to
9 develop and encourage the use of personal health records which are
10 portable, interoperable, secure, and respectful of patients' privacy.

11 (5) The administrator may enter into contracts to issue,
12 distribute, and administer grants that are necessary or proper to carry
13 out this section.

14 **Sec. 11.** RCW 43.70.110 and 2006 c 72 s 3 are each amended to read
15 as follows:

16 (1) The secretary shall charge fees to the licensee for obtaining
17 a license. After June 30, 1995, municipal corporations providing
18 emergency medical care and transportation services pursuant to chapter
19 18.73 RCW shall be exempt from such fees, provided that such other
20 emergency services shall only be charged for their pro rata share of
21 the cost of licensure and inspection, if appropriate. The secretary
22 may waive the fees when, in the discretion of the secretary, the fees
23 would not be in the best interest of public health and safety, or when
24 the fees would be to the financial disadvantage of the state.

25 (2) Except as provided in (~~RCW 18.79.202, until June 30, 2013, and~~
26 ~~except for the cost of regulating retired volunteer medical workers in~~
27 ~~accordance with RCW 18.130.360)) subsection (3) of this section, fees
28 charged shall be based on, but shall not exceed, the cost to the
29 department for the licensure of the activity or class of activities and
30 may include costs of necessary inspection.~~

31 (3) License fees shall include amounts in addition to the cost of
32 licensure activities in the following circumstances:

33 (a) For registered nurses and licensed practical nurses licensed
34 under chapter 18.79 RCW, support of a central nursing resource center
35 as provided in RCW 18.79.202, until June 30, 2013;

36 (b) For all health care providers licensed under RCW 18.130.040,

1 the cost of regulatory activities for retired volunteer medical worker
2 licensees as provided in RCW 18.130.360; and

3 (c) For physicians licensed under chapter 18.71 RCW, physician
4 assistants licensed under chapter 18.71A RCW, osteopathic physicians
5 licensed under chapter 18.57 RCW, osteopathic physicians' assistants
6 licensed under chapter 18.57A RCW, naturopaths licensed under chapter
7 18.36A RCW, podiatrists licensed under chapter 18.22 RCW, chiropractors
8 licensed under chapter 18.25 RCW, psychologists licensed under chapter
9 18.83 RCW, registered nurses licensed under chapter 18.79 RCW,
10 optometrists licensed under chapter 18.53 RCW, mental health counselors
11 licensed under chapter 18.225 RCW, massage therapists licensed under
12 chapter 18.108 RCW, clinical social workers licensed under chapter
13 18.225 RCW, and acupuncturists licensed under chapter 18.06 RCW, the
14 license fees shall include up to an additional twenty-five dollars to
15 be transferred by the department to the University of Washington for
16 the purposes of section 12 of this act.

17 (4) Department of health advisory committees may review fees
18 established by the secretary for licenses and comment upon the
19 appropriateness of the level of such fees.

20 NEW SECTION. Sec. 12. A new section is added to chapter 43.70 RCW
21 to read as follows:

22 Within the amounts transferred from the department of health under
23 RCW 43.70.110(3), the University of Washington shall, through the
24 health sciences library, provide online access to selected vital
25 clinical resources, medical journals, decision support tools, and
26 evidence-based reviews of procedures, drugs, and devices to the health
27 professionals listed in RCW 43.70.110(3)(c). Online access shall be
28 available no later than January 1, 2009.

29 **Sec. 13.** RCW 70.56.030 and 2006 c 8 s 107 are each amended to read
30 as follows:

31 (1) The department shall:

32 (a) Receive and investigate, where necessary, notifications and
33 reports of adverse events, including root cause analyses and corrective
34 action plans submitted as part of reports, and communicate to
35 individual facilities the department's conclusions, if any, regarding
36 an adverse event reported by a facility; (~~and~~)

1 this purpose, the department, in collaboration with the health care
2 authority, shall provide all persons receiving services under this
3 chapter with access to a twenty-four hour, seven day a week nurse
4 hotline. The health care authority and the department of social and
5 health services shall determine the most appropriate way to provide the
6 nurse hotline under section 15 of this act and this section, which may
7 include use of the 211 system established in chapter 43.211 RCW.

8 **REDUCE HEALTH CARE ADMINISTRATIVE COSTS**

9 NEW SECTION. **Sec. 17.** By December 1, 2007, the insurance
10 commissioner shall provide a report to the governor and the legislature
11 that identifies the key contributors to health care administrative
12 costs and evaluates opportunities to reduce them, including suggested
13 changes to state law. The report shall be completed in collaboration
14 with health care providers, hospitals, carriers, state health
15 purchasing agencies, the Washington healthcare forum, and other
16 interested parties.

17 **COVERAGE FOR DEPENDENTS TO AGE TWENTY-FIVE**

18 NEW SECTION. **Sec. 18.** A new section is added to chapter 41.05 RCW
19 to read as follows:

20 (1) Any plan offered to employees under this chapter must offer
21 each employee the option of covering any unmarried dependent of the
22 employee under the age of twenty-five.

23 (2) Any employee choosing under subsection (1) of this section to
24 cover a dependent who is: (a) Age twenty through twenty-three and not
25 a registered student at an accredited secondary school, college,
26 university, vocational school, or school of nursing; or (b) age twenty-
27 four, shall be required to pay the full cost of such coverage.

28 (3) Any employee choosing under subsection (1) of this section to
29 cover a dependent with disabilities, developmental disabilities, mental
30 illness, or mental retardation, who is incapable of self-support, may
31 continue covering that dependent under the same premium and payment
32 structure as for dependents under the age of twenty, irrespective of
33 age.

1 state resources for the state's basic health program, for the medical
2 assistance program, as codified at Title XIX of the federal social
3 security act, and the state's children's health insurance program, as
4 codified at Title XXI of the federal social security act. The
5 department shall propose options including but not limited to:

6 (a) Offering alternative benefit designs to promote high quality
7 care, improve health outcomes, and encourage cost-effective treatment
8 options and redirect savings to finance additional coverage;

9 (b) Creation of a health opportunity account demonstration program
10 for individuals eligible for transitional medical benefits. When a
11 participant in the health opportunity account demonstration program
12 satisfies his or her deductible, the benefits provided shall be those
13 included in the medicaid benefit package in effect during the period of
14 the demonstration program; and

15 (c) Promoting private health insurance plans and premium subsidies
16 to purchase employer-sponsored insurance wherever possible, including
17 federal approval to expand the department's employer-sponsored
18 insurance premium assistance program to enrollees covered through the
19 state's children's health insurance program.

20 (2) Prior to submitting requests for federal waivers or state plan
21 amendments, the department shall consult with and seek input from
22 stakeholders and other interested parties.

23 (3) The department of social and health services, in collaboration
24 with the Washington state health care authority, shall ensure that
25 enrollees are not simultaneously enrolled in the state's basic health
26 program and the medical assistance program or the state's children's
27 health insurance program to ensure coverage for the maximum number of
28 people within available funds.

29 NEW SECTION. **Sec. 24.** A new section is added to chapter 48.43 RCW
30 to read as follows:

31 When the department of social and health services determines that
32 it is cost-effective to enroll a person eligible for medical assistance
33 under chapter 74.09 RCW in an employer-sponsored health plan, a carrier
34 shall permit the enrollment of the person in the health plan for which
35 he or she is otherwise eligible without regard to any open enrollment
36 period restrictions.

1 **REINSURANCE**

2 NEW SECTION. **Sec. 25.** (1) The office of financial management, in
3 collaboration with the office of the insurance commissioner, shall
4 evaluate options and design a state-supported reinsurance program to
5 address the impact of high cost enrollees in the individual and small
6 group health insurance markets, and submit an interim report to the
7 governor and the legislature by December 1, 2007, and a final report,
8 including implementing legislation and supporting information,
9 including financing options, by September 1, 2008. In designing the
10 program, the office of financial management shall:

11 (a) Estimate the quantitative impact on premium savings, premium
12 stability over time and across groups of enrollees, individual and
13 employer take-up, number of uninsured, and government costs associated
14 with a government-funded stop-loss insurance program, including
15 distinguishing between one-time premium savings and savings in
16 subsequent years. In evaluating the various reinsurance models,
17 evaluate and consider (i) the reduction in total health care costs to
18 the state and private sector, and (ii) the reduction in individual
19 premiums paid by employers, employees, and individuals;

20 (b) Identify all relevant design issues and alternative options for
21 each issue. At a minimum, the evaluation shall examine (i) a
22 reinsurance corridor of ten thousand dollars to ninety thousand
23 dollars, and a reimbursement of ninety percent; (ii) the impacts of
24 providing reinsurance for all small group products or a subset of
25 products; and (iii) the applicability of a chronic care program such as
26 the approach used by the department of labor and industries with the
27 centers of occupational health and education. Where quantitative
28 impacts cannot be estimated, the office of financial management shall
29 assess qualitative impacts of design issues and their options,
30 including potential disincentives for reducing premiums, achieving
31 premium stability, sustaining/increasing take-up, decreasing the number
32 of uninsured, and managing government's stop-loss insurance costs;

33 (c) Identify market and regulatory changes needed to maximize the
34 chance of the program achieving its policy goals, including how the
35 program will relate to other coverage programs and markets. Design
36 efforts shall coordinate with other design efforts targeting small

1 group programs that may be directed by the legislature, as well as
2 other approaches examining alternatives to managing risk;

3 (d) Address conditions under which overall expenditures could
4 increase as a result of a government-funded stop-loss program and
5 options to mitigate those conditions, such as passive versus aggressive
6 use of disease and care management programs by insurers;

7 (e) Determine whether the Washington state health insurance pool
8 should be retained, and if so, develop options for additional sources
9 of funding;

10 (f) Evaluate, and quantify where possible, the behavioral responses
11 of insurers to the program including impacts on insurer premiums and
12 practices for settling legal disputes around large claims; and

13 (g) Provide alternatives for transitioning from the status quo and,
14 where applicable, alternatives for phasing in some design elements,
15 such as threshold or corridor levels, to balance government costs and
16 premium savings.

17 (2) Within funds specifically appropriated for this purpose, the
18 office of financial management may contract with actuaries and other
19 experts as necessary to meet the requirements of this section.

20 **THE WASHINGTON STATE HEALTH INSURANCE POOL AND THE BASIC HEALTH PLAN**

21 **Sec. 26.** RCW 48.41.110 and 2001 c 196 s 4 are each amended to read
22 as follows:

23 (1) The pool shall offer one or more care management plans of
24 coverage. Such plans may, but are not required to, include point of
25 service features that permit participants to receive in-network
26 benefits or out-of-network benefits subject to differential cost
27 shares. (~~Covered persons enrolled in the pool on January 1, 2001, may~~
28 ~~continue coverage under the pool plan in which they are enrolled on~~
29 ~~that date. However,~~) The pool may incorporate managed care features
30 into ((such)) existing plans.

31 (2) The administrator shall prepare a brochure outlining the
32 benefits and exclusions of ((the)) pool ((policy)) policies in plain
33 language. After approval by the board, such brochure shall be made
34 reasonably available to participants or potential participants.

35 (3) The health insurance ((policy)) policies issued by the pool
36 shall pay only reasonable amounts for medically necessary eligible

1 health care services rendered or furnished for the diagnosis or
2 treatment of covered illnesses, injuries, and conditions (~~which are~~
3 ~~not otherwise limited or excluded~~). Eligible expenses are the
4 reasonable amounts for the health care services and items for which
5 benefits are extended under (~~the~~) a pool policy. (~~Such benefits~~
6 ~~shall at minimum include, but not be limited to, the following services~~
7 ~~or related items:~~)

8 (4) The pool shall offer at least two policies, one of which will
9 be a comprehensive policy that must comply with RCW 48.41.120 and must
10 at a minimum include the following services or related items:

11 (a) Hospital services, including charges for the most common
12 semiprivate room, for the most common private room if semiprivate rooms
13 do not exist in the health care facility, or for the private room if
14 medically necessary, (~~but limited to~~) including no less than a total
15 of one hundred eighty inpatient days in a calendar year, and (~~limited~~
16 ~~to~~) no less than thirty days inpatient care for mental and nervous
17 conditions, or alcohol, drug, or chemical dependency or abuse per
18 calendar year;

19 (b) Professional services including surgery for the treatment of
20 injuries, illnesses, or conditions, other than dental, which are
21 rendered by a health care provider, or at the direction of a health
22 care provider, by a staff of registered or licensed practical nurses,
23 or other health care providers;

24 (c) (~~The first~~) No less than twenty outpatient professional
25 visits for the diagnosis or treatment of one or more mental or nervous
26 conditions or alcohol, drug, or chemical dependency or abuse rendered
27 during a calendar year by one or more physicians, psychologists, or
28 community mental health professionals, or, at the direction of a
29 physician, by other qualified licensed health care practitioners, in
30 the case of mental or nervous conditions, and rendered by a state
31 certified chemical dependency program approved under chapter 70.96A
32 RCW, in the case of alcohol, drug, or chemical dependency or abuse;

33 (d) Drugs and contraceptive devices requiring a prescription;

34 (e) Services of a skilled nursing facility, excluding custodial and
35 convalescent care, for not (~~more~~) less than one hundred days in a
36 calendar year as prescribed by a physician;

37 (f) Services of a home health agency;

1 (g) Chemotherapy, radioisotope, radiation, and nuclear medicine
2 therapy;

3 (h) Oxygen;

4 (i) Anesthesia services;

5 (j) Prostheses, other than dental;

6 (k) Durable medical equipment which has no personal use in the
7 absence of the condition for which prescribed;

8 (l) Diagnostic x-rays and laboratory tests;

9 (m) Oral surgery (~~((limited to))~~) including at least the following:
10 Fractures of facial bones; excisions of mandibular joints, lesions of
11 the mouth, lip, or tongue, tumors, or cysts excluding treatment for
12 temporomandibular joints; incision of accessory sinuses, mouth salivary
13 glands or ducts; dislocations of the jaw; plastic reconstruction or
14 repair of traumatic injuries occurring while covered under the pool;
15 and excision of impacted wisdom teeth;

16 (n) Maternity care services;

17 (o) Services of a physical therapist and services of a speech
18 therapist;

19 (p) Hospice services;

20 (q) Professional ambulance service to the nearest health care
21 facility qualified to treat the illness or injury; and

22 (r) Other medical equipment, services, or supplies required by
23 physician's orders and medically necessary and consistent with the
24 diagnosis, treatment, and condition.

25 ~~((+4))~~ (5) The board shall design and employ cost containment
26 measures and requirements such as, but not limited to, care
27 coordination, provider network limitations, preadmission certification,
28 and concurrent inpatient review which may make the pool more cost-
29 effective.

30 ~~((+5))~~ (6) The pool benefit policy may contain benefit
31 limitations, exceptions, and cost shares such as copayments,
32 coinsurance, and deductibles that are consistent with managed care
33 products, except that differential cost shares may be adopted by the
34 board for nonnetwork providers under point of service plans. ~~((The
35 pool benefit policy cost shares and limitations must be consistent with
36 those that are generally included in health plans approved by the
37 insurance commissioner; however,))~~ No limitation, exception, or

1 reduction may be used that would exclude coverage for any disease,
2 illness, or injury.

3 ~~((+6+))~~ (7) The pool may not reject an individual for health plan
4 coverage based upon preexisting conditions of the individual or deny,
5 exclude, or otherwise limit coverage for an individual's preexisting
6 health conditions; except that it shall impose a six-month benefit
7 waiting period for preexisting conditions for which medical advice was
8 given, for which a health care provider recommended or provided
9 treatment, or for which a prudent layperson would have sought advice or
10 treatment, within six months before the effective date of coverage.
11 The preexisting condition waiting period shall not apply to prenatal
12 care services. The pool may not avoid the requirements of this section
13 through the creation of a new rate classification or the modification
14 of an existing rate classification. Credit against the waiting period
15 shall be as provided in subsection ~~((+7+))~~ (8) of this section.

16 ~~((+7+))~~ (8)(a) Except as provided in (b) of this subsection, the
17 pool shall credit any preexisting condition waiting period in its plans
18 for a person who was enrolled at any time during the sixty-three day
19 period immediately preceding the date of application for the new pool
20 plan. For the person previously enrolled in a group health benefit
21 plan, the pool must credit the aggregate of all periods of preceding
22 coverage not separated by more than sixty-three days toward the waiting
23 period of the new health plan. For the person previously enrolled in
24 an individual health benefit plan other than a catastrophic health
25 plan, the pool must credit the period of coverage the person was
26 continuously covered under the immediately preceding health plan toward
27 the waiting period of the new health plan. For the purposes of this
28 subsection, a preceding health plan includes an employer-provided self-
29 funded health plan.

30 (b) The pool shall waive any preexisting condition waiting period
31 for a person who is an eligible individual as defined in section
32 2741(b) of the federal health insurance portability and accountability
33 act of 1996 (42 U.S.C. 300gg-41(b)).

34 ~~((+8+))~~ (9) If an application is made for the pool policy as a
35 result of rejection by a carrier, then the date of application to the
36 carrier, rather than to the pool, should govern for purposes of
37 determining preexisting condition credit.

1 (10) The pool shall contract with organizations that provide care
2 management that has been demonstrated to be effective and shall
3 encourage enrollees who are eligible for care management services to
4 participate. The pool may encourage the use of shared decision making
5 and certified decision aids for preference-sensitive care areas.

6 **Sec. 27.** RCW 48.41.160 and 1987 c 431 s 16 are each amended to
7 read as follows:

8 (1) ~~((A pool policy offered under this chapter shall contain~~
9 ~~provisions under which the pool is obligated to renew the policy until~~
10 ~~the day on which the individual in whose name the policy is issued~~
11 ~~first becomes eligible for medicare coverage. At that time, coverage~~
12 ~~of dependents shall terminate if such dependents are eligible for~~
13 ~~coverage under a different health plan. Dependents who become eligible~~
14 ~~for medicare prior to the individual in whose name the policy is~~
15 ~~issued, shall receive benefits in accordance with RCW 48.41.150)) On or~~
16 before December 31, 2007, the pool shall cancel all existing pool
17 policies and replace them with policies that are identical to the
18 existing policies except for the inclusion of a provision providing for
19 a guarantee of the continuity of coverage consistent with this section.
20 As a means to minimize the number of policy changes for enrollees,
21 replacement policies provided under this subsection also may include
22 the plan modifications authorized in RCW 48.41.100, 48.41.110, and
23 48.41.120.

24 (2) A pool policy shall contain a guarantee of the individual's
25 right to continued coverage, subject to the provisions of subsections
26 (4) and (5) of this section.

27 (3) The guarantee of continuity of coverage required by this
28 section shall not prevent the pool from canceling or nonrenewing a
29 policy for:

30 (a) Nonpayment of premium;

31 (b) Violation of published policies of the pool;

32 (c) Failure of a covered person who becomes eligible for medicare
33 benefits by reason of age to apply for a pool medical supplement plan,
34 or a medicare supplement plan or other similar plan offered by a
35 carrier pursuant to federal laws and regulations;

36 (d) Failure of a covered person to pay any deductible or copayment
37 amount owed to the pool and not the provider of health care services;

1 (e) Covered persons committing fraudulent acts as to the pool;
2 (f) Covered persons materially breaching the pool policy; or
3 (g) Changes adopted to federal or state laws when such changes no
4 longer permit the continued offering of such coverage.

5 (4)(a) The guarantee of continuity of coverage provided by this
6 section requires that if the pool replaces a plan, it must make the
7 replacement plan available to all individuals in the plan being
8 replaced. The replacement plan must include all of the services
9 covered under the replaced plan, and must not significantly limit
10 access to the kind of services covered under the replacement plan
11 through unreasonable cost-sharing requirements or otherwise. The pool
12 may also allow individuals who are covered by a plan that is being
13 replaced an unrestricted right to transfer to a fully comparable plan.

14 (b) The guarantee of continuity of coverage provided by this
15 section requires that if the pool discontinues offering a plan: (i)
16 The pool must provide notice to each individual of the discontinuation
17 at least ninety days prior to the date of the discontinuation; (ii) the
18 pool must offer to each individual provided coverage under the
19 discontinued plan the option to enroll in any other plan currently
20 offered by the pool for which the individual is otherwise eligible; and
21 (iii) in exercising the option to discontinue a plan and in offering
22 the option of coverage under (b)(ii) of this subsection, the pool must
23 act uniformly without regard to any health status-related factor of
24 enrolled individuals or individuals who may become eligible for this
25 coverage.

26 (c) The pool cannot replace or discontinue a plan under this
27 subsection (4) until it has completed an evaluation of the impact of
28 replacing the plan upon:

29 (i) The cost and quality of care to pool enrollees;
30 (ii) Pool financing and enrollment;
31 (iii) The board's ability to offer comprehensive and other plans to
32 its enrollees;
33 (iv) Other items identified by the board.

34 In its evaluation, the board must request input from the
35 constituents represented by the board members.

36 (d) The guarantee of continuity of coverage provided by this
37 section does not apply if the pool has zero enrollment in a plan.

1 (5) The pool may not change the rates for pool policies except on
2 a class basis, with a clear disclosure in the policy of the pool's
3 right to do so.

4 ~~((+3+))~~ (6) A pool policy offered under this chapter shall provide
5 that, upon the death of the individual in whose name the policy is
6 issued, every other individual then covered under the policy may elect,
7 within a period specified in the policy, to continue coverage under the
8 same or a different policy.

9 **Sec. 28.** RCW 48.41.200 and 2000 c 79 s 17 are each amended to read
10 as follows:

11 (1) The pool shall determine the standard risk rate by calculating
12 the average individual standard rate charged for coverage comparable to
13 pool coverage by the five largest members, measured in terms of
14 individual market enrollment, offering such coverages in the state. In
15 the event five members do not offer comparable coverage, the standard
16 risk rate shall be established using reasonable actuarial techniques
17 and shall reflect anticipated experience and expenses for such coverage
18 in the individual market.

19 (2) Subject to subsection (3) of this section, maximum rates for
20 pool coverage shall be as follows:

21 (a) Maximum rates for a pool indemnity health plan shall be one
22 hundred fifty percent of the rate calculated under subsection (1) of
23 this section;

24 (b) Maximum rates for a pool care management plan shall be one
25 hundred twenty-five percent of the rate calculated under subsection (1)
26 of this section; and

27 (c) Maximum rates for a person eligible for pool coverage pursuant
28 to RCW 48.41.100(1)(a) who was enrolled at any time during the sixty-
29 three day period immediately prior to the date of application for pool
30 coverage in a group health benefit plan or an individual health benefit
31 plan other than a catastrophic health plan as defined in RCW 48.43.005,
32 where such coverage was continuous for at least eighteen months, shall
33 be:

34 (i) For a pool indemnity health plan, one hundred twenty-five
35 percent of the rate calculated under subsection (1) of this section;
36 and

1 (ii) For a pool care management plan, one hundred ten percent of
2 the rate calculated under subsection (1) of this section.

3 (3)(a) Subject to (b) and (c) of this subsection:

4 (i) The rate for any person (~~((aged fifty to sixty four))~~) whose
5 current gross family income is less than two hundred fifty-one percent
6 of the federal poverty level shall be reduced by thirty percent from
7 what it would otherwise be;

8 (ii) The rate for any person (~~((aged fifty to sixty four))~~) whose
9 current gross family income is more than two hundred fifty but less
10 than three hundred one percent of the federal poverty level shall be
11 reduced by fifteen percent from what it would otherwise be;

12 (iii) The rate for any person who has been enrolled in the pool for
13 more than thirty-six months shall be reduced by five percent from what
14 it would otherwise be.

15 (b) In no event shall the rate for any person be less than one
16 hundred ten percent of the rate calculated under subsection (1) of this
17 section.

18 (c) Rate reductions under (a)(i) and (ii) of this subsection shall
19 be available only to the extent that funds are specifically
20 appropriated for this purpose in the omnibus appropriations act.

21 **Sec. 29.** RCW 48.41.037 and 2000 c 79 s 36 are each amended to read
22 as follows:

23 The Washington state health insurance pool account is created in
24 the custody of the state treasurer. All receipts from moneys
25 specifically appropriated to the account must be deposited in the
26 account. Expenditures from this account shall be used to cover
27 deficits incurred by the Washington state health insurance pool under
28 this chapter in excess of the threshold established in this section.
29 To the extent funds are available in the account, funds shall be
30 expended from the account to offset that portion of the deficit that
31 would otherwise have to be recovered by imposing an assessment on
32 members in excess of a threshold of seventy cents per insured person
33 per month. The commissioner shall authorize expenditures from the
34 account, to the extent that funds are available in the account, upon
35 certification by the pool board that assessments will exceed the
36 threshold level established in this section. The account is subject to

1 the allotment procedures under chapter 43.88 RCW, but an appropriation
2 is not required for expenditures.

3 Whether the assessment has reached the threshold of seventy cents
4 per insured person per month shall be determined by dividing the total
5 aggregate amount of assessment by the proportion of total assessed
6 members. Thus, stop loss members shall be counted as one-tenth of a
7 whole member in the denominator given that is the amount they are
8 assessed proportionately relative to a fully insured medical member.

9 **Sec. 30.** RCW 48.41.100 and 2001 c 196 s 3 are each amended to read
10 as follows:

11 (1) The following persons who are residents of this state are
12 eligible for pool coverage:

13 (a) Any person who provides evidence of a carrier's decision not to
14 accept him or her for enrollment in an individual health benefit plan
15 as defined in RCW 48.43.005 based upon, and within ninety days of the
16 receipt of, the results of the standard health questionnaire designated
17 by the board and administered by health carriers under RCW 48.43.018;

18 (b) Any person who continues to be eligible for pool coverage based
19 upon the results of the standard health questionnaire designated by the
20 board and administered by the pool administrator pursuant to subsection
21 (3) of this section;

22 (c) Any person who resides in a county of the state where no
23 carrier or insurer eligible under chapter 48.15 RCW offers to the
24 public an individual health benefit plan other than a catastrophic
25 health plan as defined in RCW 48.43.005 at the time of application to
26 the pool, and who makes direct application to the pool; and

27 (d) Any medicare eligible person upon providing evidence of
28 rejection for medical reasons, a requirement of restrictive riders, an
29 up-rated premium, or a preexisting conditions limitation on a medicare
30 supplemental insurance policy under chapter 48.66 RCW, the effect of
31 which is to substantially reduce coverage from that received by a
32 person considered a standard risk by at least one member within six
33 months of the date of application.

34 (2) The following persons are not eligible for coverage by the
35 pool:

36 (a) Any person having terminated coverage in the pool unless (i)
37 twelve months have lapsed since termination, or (ii) that person can

1 show continuous other coverage which has been involuntarily terminated
2 for any reason other than nonpayment of premiums. However, these
3 exclusions do not apply to eligible individuals as defined in section
4 2741(b) of the federal health insurance portability and accountability
5 act of 1996 (42 U.S.C. Sec. 300gg-41(b));

6 (b) Any person on whose behalf the pool has paid out (~~one~~) two
7 million dollars in benefits;

8 (c) Inmates of public institutions and persons whose benefits are
9 duplicated under public programs. However, these exclusions do not
10 apply to eligible individuals as defined in section 2741(b) of the
11 federal health insurance portability and accountability act of 1996 (42
12 U.S.C. Sec. 300gg-41(b));

13 (d) Any person who resides in a county of the state where any
14 carrier or insurer regulated under chapter 48.15 RCW offers to the
15 public an individual health benefit plan other than a catastrophic
16 health plan as defined in RCW 48.43.005 at the time of application to
17 the pool and who does not qualify for pool coverage based upon the
18 results of the standard health questionnaire, or pursuant to subsection
19 (1)(d) of this section.

20 (3) When a carrier or insurer regulated under chapter 48.15 RCW
21 begins to offer an individual health benefit plan in a county where no
22 carrier had been offering an individual health benefit plan:

23 (a) If the health benefit plan offered is other than a catastrophic
24 health plan as defined in RCW 48.43.005, any person enrolled in a pool
25 plan pursuant to subsection (1)(c) of this section in that county shall
26 no longer be eligible for coverage under that plan pursuant to
27 subsection (1)(c) of this section, but may continue to be eligible for
28 pool coverage based upon the results of the standard health
29 questionnaire designated by the board and administered by the pool
30 administrator. The pool administrator shall offer to administer the
31 questionnaire to each person no longer eligible for coverage under
32 subsection (1)(c) of this section within thirty days of determining
33 that he or she is no longer eligible;

34 (b) Losing eligibility for pool coverage under this subsection (3)
35 does not affect a person's eligibility for pool coverage under
36 subsection (1)(a), (b), or (d) of this section; and

37 (c) The pool administrator shall provide written notice to any
38 person who is no longer eligible for coverage under a pool plan under

1 this subsection (3) within thirty days of the administrator's
2 determination that the person is no longer eligible. The notice shall:
3 (i) Indicate that coverage under the plan will cease ninety days from
4 the date that the notice is dated; (ii) describe any other coverage
5 options, either in or outside of the pool, available to the person;
6 (iii) describe the procedures for the administration of the standard
7 health questionnaire to determine the person's continued eligibility
8 for coverage under subsection (1)(b) of this section; and (iv) describe
9 the enrollment process for the available options outside of the pool.

10 (4) The board shall ensure that an independent analysis of the
11 eligibility standards for the pool coverage is conducted, including
12 examining the eight percent eligibility threshold, eligibility for
13 medicaid enrollees and other publicly sponsored enrollees, and the
14 impacts on the pool and the state budget. The board shall report the
15 findings to the legislature by December 1, 2007.

16 **Sec. 31.** RCW 48.41.120 and 2000 c 79 s 14 are each amended to read
17 as follows:

18 (1) Subject to the limitation provided in subsection (3) of this
19 section, ((a)) the comprehensive pool policy offered ((in accordance
20 with)) under RCW 48.41.110((+3)) (4) shall impose a deductible as
21 provided in this subsection. Deductibles of five hundred dollars and
22 one thousand dollars on a per person per calendar year basis shall
23 initially be offered. The board may authorize deductibles in other
24 amounts. The deductible shall be applied to the first five hundred
25 dollars, one thousand dollars, or other authorized amount of eligible
26 expenses incurred by the covered person.

27 (2) Subject to the limitations provided in subsection (3) of this
28 section, a mandatory coinsurance requirement shall be imposed at
29 ((the)) a rate ((of)) not to exceed twenty percent of eligible expenses
30 in excess of the mandatory deductible and which supports the efficient
31 delivery of high quality health care services for the medical
32 conditions of pool enrollees.

33 (3) The maximum aggregate out of pocket payments for eligible
34 expenses by the insured in the form of deductibles and coinsurance
35 under ((a)) the comprehensive pool policy offered ((in accordance
36 with)) under RCW 48.41.110((+3)) (4) shall not exceed in a calendar
37 year:

1 (a) One thousand five hundred dollars per individual, or three
2 thousand dollars per family, per calendar year for the five hundred
3 dollar deductible policy;

4 (b) Two thousand five hundred dollars per individual, or five
5 thousand dollars per family per calendar year for the one thousand
6 dollar deductible policy; or

7 (c) An amount authorized by the board for any other deductible
8 policy.

9 (4) Except for those enrolled in a high deductible health plan
10 qualified under federal law for use with a health savings account,
11 eligible expenses incurred by a covered person in the last three months
12 of a calendar year, and applied toward a deductible, shall also be
13 applied toward the deductible amount in the next calendar year.

14 (5) The board may modify cost-sharing as an incentive for enrollees
15 to participate in care management services and other cost-effective
16 programs and policies.

17 **Sec. 32.** RCW 48.43.005 and 2006 c 25 s 16 are each amended to read
18 as follows:

19 Unless otherwise specifically provided, the definitions in this
20 section apply throughout this chapter.

21 (1) "Adjusted community rate" means the rating method used to
22 establish the premium for health plans adjusted to reflect actuarially
23 demonstrated differences in utilization or cost attributable to
24 geographic region, age, family size, and use of wellness activities.

25 (2) "Basic health plan" means the plan described under chapter
26 70.47 RCW, as revised from time to time.

27 (3) "Basic health plan model plan" means a health plan as required
28 in RCW 70.47.060(2)(e).

29 (4) "Basic health plan services" means that schedule of covered
30 health services, including the description of how those benefits are to
31 be administered, that are required to be delivered to an enrollee under
32 the basic health plan, as revised from time to time.

33 (5) "Catastrophic health plan" means:

34 (a) In the case of a contract, agreement, or policy covering a
35 single enrollee, a health benefit plan requiring a calendar year
36 deductible of, at a minimum, one thousand (~~five~~) seven hundred fifty
37 dollars and an annual out-of-pocket expense required to be paid under

1 the plan (other than for premiums) for covered benefits of at least
2 three thousand five hundred dollars, both amounts to be adjusted
3 annually by the insurance commissioner; and

4 (b) In the case of a contract, agreement, or policy covering more
5 than one enrollee, a health benefit plan requiring a calendar year
6 deductible of, at a minimum, three thousand five hundred dollars and an
7 annual out-of-pocket expense required to be paid under the plan (other
8 than for premiums) for covered benefits of at least ((five)) six
9 thousand ((five hundred)) dollars, both amounts to be adjusted annually
10 by the insurance commissioner; or

11 (c) Any health benefit plan that provides benefits for hospital
12 inpatient and outpatient services, professional and prescription drugs
13 provided in conjunction with such hospital inpatient and outpatient
14 services, and excludes or substantially limits outpatient physician
15 services and those services usually provided in an office setting.

16 In July, 2008, and in each July thereafter, the insurance
17 commissioner shall adjust the minimum deductible and out-of-pocket
18 expense required for a plan to qualify as a catastrophic plan to
19 reflect the percentage change in the consumer price index for medical
20 care for a preceding twelve months, as determined by the United States
21 department of labor. The adjusted amount shall apply on the following
22 January 1st.

23 (6) "Certification" means a determination by a review organization
24 that an admission, extension of stay, or other health care service or
25 procedure has been reviewed and, based on the information provided,
26 meets the clinical requirements for medical necessity, appropriateness,
27 level of care, or effectiveness under the auspices of the applicable
28 health benefit plan.

29 (7) "Concurrent review" means utilization review conducted during
30 a patient's hospital stay or course of treatment.

31 (8) "Covered person" or "enrollee" means a person covered by a
32 health plan including an enrollee, subscriber, policyholder,
33 beneficiary of a group plan, or individual covered by any other health
34 plan.

35 (9) "Dependent" means, at a minimum, the enrollee's legal spouse
36 and unmarried dependent children who qualify for coverage under the
37 enrollee's health benefit plan.

1 (10) "Eligible employee" means an employee who works on a full-time
2 basis with a normal work week of thirty or more hours. The term
3 includes a self-employed individual, including a sole proprietor, a
4 partner of a partnership, and may include an independent contractor, if
5 the self-employed individual, sole proprietor, partner, or independent
6 contractor is included as an employee under a health benefit plan of a
7 small employer, but does not work less than thirty hours per week and
8 derives at least seventy-five percent of his or her income from a trade
9 or business through which he or she has attempted to earn taxable
10 income and for which he or she has filed the appropriate internal
11 revenue service form. Persons covered under a health benefit plan
12 pursuant to the consolidated omnibus budget reconciliation act of 1986
13 shall not be considered eligible employees for purposes of minimum
14 participation requirements of chapter 265, Laws of 1995.

15 (11) "Emergency medical condition" means the emergent and acute
16 onset of a symptom or symptoms, including severe pain, that would lead
17 a prudent layperson acting reasonably to believe that a health
18 condition exists that requires immediate medical attention, if failure
19 to provide medical attention would result in serious impairment to
20 bodily functions or serious dysfunction of a bodily organ or part, or
21 would place the person's health in serious jeopardy.

22 (12) "Emergency services" means otherwise covered health care
23 services medically necessary to evaluate and treat an emergency medical
24 condition, provided in a hospital emergency department.

25 (13) "Enrollee point-of-service cost-sharing" means amounts paid to
26 health carriers directly providing services, health care providers, or
27 health care facilities by enrollees and may include copayments,
28 coinsurance, or deductibles.

29 (14) "Grievance" means a written complaint submitted by or on
30 behalf of a covered person regarding: (a) Denial of payment for
31 medical services or nonprovision of medical services included in the
32 covered person's health benefit plan, or (b) service delivery issues
33 other than denial of payment for medical services or nonprovision of
34 medical services, including dissatisfaction with medical care, waiting
35 time for medical services, provider or staff attitude or demeanor, or
36 dissatisfaction with service provided by the health carrier.

37 (15) "Health care facility" or "facility" means hospices licensed
38 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,

1 rural health care facilities as defined in RCW 70.175.020, psychiatric
2 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
3 under chapter 18.51 RCW, community mental health centers licensed under
4 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed
5 under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical
6 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment
7 facilities licensed under chapter 70.96A RCW, and home health agencies
8 licensed under chapter 70.127 RCW, and includes such facilities if
9 owned and operated by a political subdivision or instrumentality of the
10 state and such other facilities as required by federal law and
11 implementing regulations.

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

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

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

18 (17) "Health care service" means that service offered or provided
19 by health care facilities and health care providers relating to the
20 prevention, cure, or treatment of illness, injury, or disease.

21 (18) "Health carrier" or "carrier" means a disability insurer
22 regulated under chapter 48.20 or 48.21 RCW, a health care service
23 contractor as defined in RCW 48.44.010, or a health maintenance
24 organization as defined in RCW 48.46.020.

25 (19) "Health plan" or "health benefit plan" means any policy,
26 contract, or agreement offered by a health carrier to provide, arrange,
27 reimburse, or pay for health care services except the following:

28 (a) Long-term care insurance governed by chapter 48.84 RCW;

29 (b) Medicare supplemental health insurance governed by chapter
30 48.66 RCW;

31 (c) Coverage supplemental to the coverage provided under chapter
32 55, Title 10, United States Code;

33 (d) Limited health care services offered by limited health care
34 service contractors in accordance with RCW 48.44.035;

35 (e) Disability income;

36 (f) Coverage incidental to a property/casualty liability insurance
37 policy such as automobile personal injury protection coverage and
38 homeowner guest medical;

1 (g) Workers' compensation coverage;
2 (h) Accident only coverage;
3 (i) Specified disease and hospital confinement indemnity when
4 marketed solely as a supplement to a health plan;
5 (j) Employer-sponsored self-funded health plans;
6 (k) Dental only and vision only coverage; and
7 (l) Plans deemed by the insurance commissioner to have a short-term
8 limited purpose or duration, or to be a student-only plan that is
9 guaranteed renewable while the covered person is enrolled as a regular
10 full-time undergraduate or graduate student at an accredited higher
11 education institution, after a written request for such classification
12 by the carrier and subsequent written approval by the insurance
13 commissioner.

14 (20) "Material modification" means a change in the actuarial value
15 of the health plan as modified of more than five percent but less than
16 fifteen percent.

17 (21) "Preexisting condition" means any medical condition, illness,
18 or injury that existed any time prior to the effective date of
19 coverage.

20 (22) "Premium" means all sums charged, received, or deposited by a
21 health carrier as consideration for a health plan or the continuance of
22 a health plan. Any assessment or any "membership," "policy,"
23 "contract," "service," or similar fee or charge made by a health
24 carrier in consideration for a health plan is deemed part of the
25 premium. "Premium" shall not include amounts paid as enrollee point-
26 of-service cost-sharing.

27 (23) "Review organization" means a disability insurer regulated
28 under chapter 48.20 or 48.21 RCW, health care service contractor as
29 defined in RCW 48.44.010, or health maintenance organization as defined
30 in RCW 48.46.020, and entities affiliated with, under contract with, or
31 acting on behalf of a health carrier to perform a utilization review.

32 (24) "Small employer" or "small group" means any person, firm,
33 corporation, partnership, association, political subdivision, sole
34 proprietor, or self-employed individual that is actively engaged in
35 business that, on at least fifty percent of its working days during the
36 preceding calendar quarter, employed at least two but no more than
37 fifty eligible employees, with a normal work week of thirty or more
38 hours, the majority of whom were employed within this state, and is not

1 formed primarily for purposes of buying health insurance and in which
2 a bona fide employer-employee relationship exists. In determining the
3 number of eligible employees, companies that are affiliated companies,
4 or that are eligible to file a combined tax return for purposes of
5 taxation by this state, shall be considered an employer. Subsequent to
6 the issuance of a health plan to a small employer and for the purpose
7 of determining eligibility, the size of a small employer shall be
8 determined annually. Except as otherwise specifically provided, a
9 small employer shall continue to be considered a small employer until
10 the plan anniversary following the date the small employer no longer
11 meets the requirements of this definition. A self-employed individual
12 or sole proprietor must derive at least seventy-five percent of his or
13 her income from a trade or business through which the individual or
14 sole proprietor has attempted to earn taxable income and for which he
15 or she has filed the appropriate internal revenue service form 1040,
16 schedule C or F, for the previous taxable year except for a self-
17 employed individual or sole proprietor in an agricultural trade or
18 business, who must derive at least fifty-one percent of his or her
19 income from the trade or business through which the individual or sole
20 proprietor has attempted to earn taxable income and for which he or she
21 has filed the appropriate internal revenue service form 1040, for the
22 previous taxable year. A self-employed individual or sole proprietor
23 who is covered as a group of one on the day prior to June 10, 2004,
24 shall also be considered a "small employer" to the extent that
25 individual or group of one is entitled to have his or her coverage
26 renewed as provided in RCW 48.43.035(6).

27 (25) "Utilization review" means the prospective, concurrent, or
28 retrospective assessment of the necessity and appropriateness of the
29 allocation of health care resources and services of a provider or
30 facility, given or proposed to be given to an enrollee or group of
31 enrollees.

32 (26) "Wellness activity" means an explicit program of an activity
33 consistent with department of health guidelines, such as, smoking
34 cessation, injury and accident prevention, reduction of alcohol misuse,
35 appropriate weight reduction, exercise, automobile and motorcycle
36 safety, blood cholesterol reduction, and nutrition education for the
37 purpose of improving enrollee health status and reducing health service
38 costs.

1 **Sec. 33.** RCW 48.41.190 and 1989 c 121 s 10 are each amended to
2 read as follows:

3 (~~Neither the participation by members, the establishment of rates,~~
4 ~~forms, or procedures for coverages issued by the pool, nor any other~~
5 ~~joint or collective action required by this chapter or the state of~~
6 ~~Washington shall be the basis of any legal action, civil or criminal~~
7 ~~liability or penalty against the pool, any member of the board of~~
8 ~~directors, or members of the pool either jointly or separately.)) The
9 pool, members of the pool, board directors of the pool, officers of the
10 pool, employees of the pool, the commissioner, the commissioner's
11 representatives, and the commissioner's employees shall not be civilly
12 or criminally liable and shall not have any penalty or cause of action
13 of any nature arise against them for any action taken or not taken,
14 including any discretionary decision or failure to make a discretionary
15 decision, when the action or inaction is done in good faith and in the
16 performance of the powers and duties under this chapter. Nothing in
17 this section prohibits legal actions against the pool to enforce the
18 pool's statutory or contractual duties or obligations.~~

19 **Sec. 34.** RCW 41.05.075 and 2006 c 103 s 3 are each amended to read
20 as follows:

21 (1) The administrator shall provide benefit plans designed by the
22 board through a contract or contracts with insuring entities, through
23 self-funding, self-insurance, or other methods of providing insurance
24 coverage authorized by RCW 41.05.140.

25 (2) The administrator shall establish a contract bidding process
26 that:

27 (a) Encourages competition among insuring entities;

28 (b) Maintains an equitable relationship between premiums charged
29 for similar benefits and between risk pools including premiums charged
30 for retired state and school district employees under the separate risk
31 pools established by RCW 41.05.022 and 41.05.080 such that insuring
32 entities may not avoid risk when establishing the premium rates for
33 retirees eligible for medicare;

34 (c) Is timely to the state budgetary process; and

35 (d) Sets conditions for awarding contracts to any insuring entity.

36 (3) The administrator shall establish a requirement for review of

1 utilization and financial data from participating insuring entities on
2 a quarterly basis.

3 (4) The administrator shall centralize the enrollment files for all
4 employee and retired or disabled school employee health plans offered
5 under chapter 41.05 RCW and develop enrollment demographics on a plan-
6 specific basis.

7 (5) All claims data shall be the property of the state. The
8 administrator may require of any insuring entity that submits a bid to
9 contract for coverage all information deemed necessary including:

10 (a) Subscriber or member demographic and claims data necessary for
11 risk assessment and adjustment calculations in order to fulfill the
12 administrator's duties as set forth in this chapter; and

13 (b) Subscriber or member demographic and claims data necessary to
14 implement performance measures or financial incentives related to
15 performance under subsection (7) of this section.

16 (6) All contracts with insuring entities for the provision of
17 health care benefits shall provide that the beneficiaries of such
18 benefit plans may use on an equal participation basis the services of
19 practitioners licensed pursuant to chapters 18.22, 18.25, 18.32, 18.53,
20 18.57, 18.71, 18.74, 18.83, and 18.79 RCW, as it applies to registered
21 nurses and advanced registered nurse practitioners. However, nothing
22 in this subsection may preclude the administrator from establishing
23 appropriate utilization controls approved pursuant to RCW 41.05.065(2)
24 (a), (b), and (d).

25 (7) The administrator shall, in collaboration with other state
26 agencies that administer state purchased health care programs, private
27 health care purchasers, health care facilities, providers, and
28 carriers:

29 (a) Use evidence-based medicine principles to develop common
30 performance measures and implement financial incentives in contracts
31 with insuring entities, health care facilities, and providers that:

32 (i) Reward improvements in health outcomes for individuals with
33 chronic diseases, increased utilization of appropriate preventive
34 health services, and reductions in medical errors; and

35 (ii) Increase, through appropriate incentives to insuring entities,
36 health care facilities, and providers, the adoption and use of
37 information technology that contributes to improved health outcomes,
38 better coordination of care, and decreased medical errors;

1 (b) Through state health purchasing, reimbursement, or pilot
2 strategies, promote and increase the adoption of health information
3 technology systems, including electronic medical records, by hospitals
4 as defined in RCW 70.41.020(4), integrated delivery systems, and
5 providers that:

- 6 (i) Facilitate diagnosis or treatment;
- 7 (ii) Reduce unnecessary duplication of medical tests;
- 8 (iii) Promote efficient electronic physician order entry;
- 9 (iv) Increase access to health information for consumers and their
10 providers; and
- 11 (v) Improve health outcomes;

12 (c) Coordinate a strategy for the adoption of health information
13 technology systems using the final health information technology report
14 and recommendations developed under chapter 261, Laws of 2005.

15 (8) The administrator may permit the Washington state health
16 insurance pool to contract to utilize any network maintained by the
17 authority or any network under contract with the authority.

18 **Sec. 35.** RCW 70.47.020 and 2005 c 188 s 2 are each amended to read
19 as follows:

20 As used in this chapter:

21 (1) "Washington basic health plan" or "plan" means the system of
22 enrollment and payment for basic health care services, administered by
23 the plan administrator through participating managed health care
24 systems, created by this chapter.

25 (2) "Administrator" means the Washington basic health plan
26 administrator, who also holds the position of administrator of the
27 Washington state health care authority.

28 (3) "Health coverage tax credit program" means the program created
29 by the Trade Act of 2002 (P.L. 107-210) that provides a federal tax
30 credit that subsidizes private health insurance coverage for displaced
31 workers certified to receive certain trade adjustment assistance
32 benefits and for individuals receiving benefits from the pension
33 benefit guaranty corporation.

34 (4) "Health coverage tax credit eligible enrollee" means individual
35 workers and their qualified family members who lose their jobs due to
36 the effects of international trade and are eligible for certain trade
37 adjustment assistance benefits; or are eligible for benefits under the

1 alternative trade adjustment assistance program; or are people who
2 receive benefits from the pension benefit guaranty corporation and are
3 at least fifty-five years old.

4 (5) "Managed health care system" means: (a) Any health care
5 organization, including health care providers, insurers, health care
6 service contractors, health maintenance organizations, or any
7 combination thereof, that provides directly or by contract basic health
8 care services, as defined by the administrator and rendered by duly
9 licensed providers, to a defined patient population enrolled in the
10 plan and in the managed health care system; or (b) a self-funded or
11 self-insured method of providing insurance coverage to subsidized
12 enrollees provided under RCW 41.05.140 and subject to the limitations
13 under RCW 70.47.100(7).

14 (6) "Subsidized enrollee" means:

15 (a) An individual, or an individual plus the individual's spouse or
16 dependent children:

17 ~~((a))~~ (i) Who is not eligible for medicare;

18 ~~((b))~~ (ii) Who is not confined or residing in a government-
19 operated institution, unless he or she meets eligibility criteria
20 adopted by the administrator;

21 ~~((c))~~ (iii) Who is not a full-time student who has received a
22 temporary visa to study in the United States;

23 ~~((d))~~ (iv) Who resides in an area of the state served by a
24 managed health care system participating in the plan;

25 ~~((e))~~ (v) Whose gross family income at the time of enrollment
26 does not exceed two hundred percent of the federal poverty level as
27 adjusted for family size and determined annually by the federal
28 department of health and human services; and

29 ~~((f))~~ (vi) Who chooses to obtain basic health care coverage from
30 a particular managed health care system in return for periodic payments
31 to the plan~~((7))~~;

32 (b) An individual who meets the requirements in (a)(i) through (iv)
33 and (vi) of this subsection and who is a foster parent licensed under
34 chapter 74.15 RCW and whose gross family income at the time of
35 enrollment does not exceed three hundred percent of the federal poverty
36 level as adjusted for family size and determined annually by the
37 federal department of health and human services; and

1 (c) To the extent that state funds are specifically appropriated
2 for this purpose, with a corresponding federal match, (~~("subsidized~~
3 ~~enrollee" also means)) an individual, or an individual's spouse or~~
4 dependent children, who meets the requirements in (a)(i) through
5 (~~((d))~~) (iv) and (~~((f))~~) (vi) of this subsection and whose gross family
6 income at the time of enrollment is more than two hundred percent, but
7 less than two hundred fifty-one percent, of the federal poverty level
8 as adjusted for family size and determined annually by the federal
9 department of health and human services.

10 (7) "Nonsubsidized enrollee" means an individual, or an individual
11 plus the individual's spouse or dependent children: (a) Who is not
12 eligible for medicare; (b) who is not confined or residing in a
13 government-operated institution, unless he or she meets eligibility
14 criteria adopted by the administrator; (c) who is accepted for
15 enrollment by the administrator as provided in RCW 48.43.018, either
16 because the potential enrollee cannot be required to complete the
17 standard health questionnaire under RCW 48.43.018, or, based upon the
18 results of the standard health questionnaire, the potential enrollee
19 would not qualify for coverage under the Washington state health
20 insurance pool; (d) who resides in an area of the state served by a
21 managed health care system participating in the plan; (~~((d))~~) (e) who
22 chooses to obtain basic health care coverage from a particular managed
23 health care system; and (~~((e))~~) (f) who pays or on whose behalf is paid
24 the full costs for participation in the plan, without any subsidy from
25 the plan.

26 (8) "Subsidy" means the difference between the amount of periodic
27 payment the administrator makes to a managed health care system on
28 behalf of a subsidized enrollee plus the administrative cost to the
29 plan of providing the plan to that subsidized enrollee, and the amount
30 determined to be the subsidized enrollee's responsibility under RCW
31 70.47.060(2).

32 (9) "Premium" means a periodic payment, (~~(based upon gross family~~
33 ~~income)) which an individual, their employer or another financial~~
34 sponsor makes to the plan as consideration for enrollment in the plan
35 as a subsidized enrollee, a nonsubsidized enrollee, or a health
36 coverage tax credit eligible enrollee.

37 (10) "Rate" means the amount, negotiated by the administrator with

1 and paid to a participating managed health care system, that is based
2 upon the enrollment of subsidized, nonsubsidized, and health coverage
3 tax credit eligible enrollees in the plan and in that system.

4 **Sec. 36.** RCW 70.47.060 and 2006 c 343 s 9 are each amended to read
5 as follows:

6 The administrator has the following powers and duties:

7 (1) To design and from time to time revise a schedule of covered
8 basic health care services, including physician services, inpatient and
9 outpatient hospital services, prescription drugs and medications, and
10 other services that may be necessary for basic health care. In
11 addition, the administrator may, to the extent that funds are
12 available, offer as basic health plan services chemical dependency
13 services, mental health services and organ transplant services;
14 however, no one service or any combination of these three services
15 shall increase the actuarial value of the basic health plan benefits by
16 more than five percent excluding inflation, as determined by the office
17 of financial management. All subsidized and nonsubsidized enrollees in
18 any participating managed health care system under the Washington basic
19 health plan shall be entitled to receive covered basic health care
20 services in return for premium payments to the plan. The schedule of
21 services shall emphasize proven preventive and primary health care and
22 shall include all services necessary for prenatal, postnatal, and well-
23 child care. However, with respect to coverage for subsidized enrollees
24 who are eligible to receive prenatal and postnatal services through the
25 medical assistance program under chapter 74.09 RCW, the administrator
26 shall not contract for such services except to the extent that such
27 services are necessary over not more than a one-month period in order
28 to maintain continuity of care after diagnosis of pregnancy by the
29 managed care provider. The schedule of services shall also include a
30 separate schedule of basic health care services for children, eighteen
31 years of age and younger, for those subsidized or nonsubsidized
32 enrollees who choose to secure basic coverage through the plan only for
33 their dependent children. In designing and revising the schedule of
34 services, the administrator shall consider the guidelines for assessing
35 health services under the mandated benefits act of 1984, RCW 48.47.030,
36 and such other factors as the administrator deems appropriate.

1 (2)(a) To design and implement a structure of periodic premiums due
2 the administrator from subsidized enrollees that is based upon gross
3 family income, giving appropriate consideration to family size and the
4 ages of all family members. The enrollment of children shall not
5 require the enrollment of their parent or parents who are eligible for
6 the plan. The structure of periodic premiums shall be applied to
7 subsidized enrollees entering the plan as individuals pursuant to
8 subsection (11) of this section and to the share of the cost of the
9 plan due from subsidized enrollees entering the plan as employees
10 pursuant to subsection (12) of this section.

11 (b) To determine the periodic premiums due the administrator from
12 subsidized enrollees under RCW 70.47.020(6)(b). Premiums due for
13 foster parents with gross family income up to two hundred percent of
14 the federal poverty level shall be set at the minimum premium amount
15 charged to enrollees with income below sixty-five percent of the
16 federal poverty level. Premiums due for foster parents with gross
17 family income between two hundred percent and three hundred percent of
18 the federal poverty level shall not exceed one hundred dollars per
19 month.

20 (c) To determine the periodic premiums due the administrator from
21 nonsubsidized enrollees. Premiums due from nonsubsidized enrollees
22 shall be in an amount equal to the cost charged by the managed health
23 care system provider to the state for the plan plus the administrative
24 cost of providing the plan to those enrollees and the premium tax under
25 RCW 48.14.0201.

26 ((+e)) (d) To determine the periodic premiums due the
27 administrator from health coverage tax credit eligible enrollees.
28 Premiums due from health coverage tax credit eligible enrollees must be
29 in an amount equal to the cost charged by the managed health care
30 system provider to the state for the plan, plus the administrative cost
31 of providing the plan to those enrollees and the premium tax under RCW
32 48.14.0201. The administrator will consider the impact of eligibility
33 determination by the appropriate federal agency designated by the Trade
34 Act of 2002 (P.L. 107-210) as well as the premium collection and
35 remittance activities by the United States internal revenue service
36 when determining the administrative cost charged for health coverage
37 tax credit eligible enrollees.

1 ~~((d))~~ (e) An employer or other financial sponsor may, with the
2 prior approval of the administrator, pay the premium, rate, or any
3 other amount on behalf of a subsidized or nonsubsidized enrollee, by
4 arrangement with the enrollee and through a mechanism acceptable to the
5 administrator. The administrator shall establish a mechanism for
6 receiving premium payments from the United States internal revenue
7 service for health coverage tax credit eligible enrollees.

8 ~~((e))~~ (f) To develop, as an offering by every health carrier
9 providing coverage identical to the basic health plan, as configured on
10 January 1, 2001, a basic health plan model plan with uniformity in
11 enrollee cost-sharing requirements.

12 (3) To evaluate, with the cooperation of participating managed
13 health care system providers, the impact on the basic health plan of
14 enrolling health coverage tax credit eligible enrollees. The
15 administrator shall issue to the appropriate committees of the
16 legislature preliminary evaluations on June 1, 2005, and January 1,
17 2006, and a final evaluation by June 1, 2006. The evaluation shall
18 address the number of persons enrolled, the duration of their
19 enrollment, their utilization of covered services relative to other
20 basic health plan enrollees, and the extent to which their enrollment
21 contributed to any change in the cost of the basic health plan.

22 (4) To end the participation of health coverage tax credit eligible
23 enrollees in the basic health plan if the federal government reduces or
24 terminates premium payments on their behalf through the United States
25 internal revenue service.

26 (5) To design and implement a structure of enrollee cost-sharing
27 due a managed health care system from subsidized, nonsubsidized, and
28 health coverage tax credit eligible enrollees. The structure shall
29 discourage inappropriate enrollee utilization of health care services,
30 and may utilize copayments, deductibles, and other cost-sharing
31 mechanisms, but shall not be so costly to enrollees as to constitute a
32 barrier to appropriate utilization of necessary health care services.

33 (6) To limit enrollment of persons who qualify for subsidies so as
34 to prevent an overexpenditure of appropriations for such purposes.
35 Whenever the administrator finds that there is danger of such an
36 overexpenditure, the administrator shall close enrollment until the
37 administrator finds the danger no longer exists. Such a closure does
38 not apply to health coverage tax credit eligible enrollees who receive

1 a premium subsidy from the United States internal revenue service as
2 long as the enrollees qualify for the health coverage tax credit
3 program.

4 (7) To limit the payment of subsidies to subsidized enrollees, as
5 defined in RCW 70.47.020. The level of subsidy provided to persons who
6 qualify may be based on the lowest cost plans, as defined by the
7 administrator.

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

12 (9) To solicit and accept applications from managed health care
13 systems, as defined in this chapter, for inclusion as eligible basic
14 health care providers under the plan for subsidized enrollees,
15 nonsubsidized enrollees, or health coverage tax credit eligible
16 enrollees. The administrator shall endeavor to assure that covered
17 basic health care services are available to any enrollee of the plan
18 from among a selection of two or more participating managed health care
19 systems. In adopting any rules or procedures applicable to managed
20 health care systems and in its dealings with such systems, the
21 administrator shall consider and make suitable allowance for the need
22 for health care services and the differences in local availability of
23 health care resources, along with other resources, within and among the
24 several areas of the state. Contracts with participating managed
25 health care systems shall ensure that basic health plan enrollees who
26 become eligible for medical assistance may, at their option, continue
27 to receive services from their existing providers within the managed
28 health care system if such providers have entered into provider
29 agreements with the department of social and health services.

30 (10) To receive periodic premiums from or on behalf of subsidized,
31 nonsubsidized, and health coverage tax credit eligible enrollees,
32 deposit them in the basic health plan operating account, keep records
33 of enrollee status, and authorize periodic payments to managed health
34 care systems on the basis of the number of enrollees participating in
35 the respective managed health care systems.

36 (11) To accept applications from individuals residing in areas
37 served by the plan, on behalf of themselves and their spouses and
38 dependent children, for enrollment in the Washington basic health plan

1 as subsidized, nonsubsidized, or health coverage tax credit eligible
2 enrollees, to give priority to members of the Washington national guard
3 and reserves who served in Operation Enduring Freedom, Operation Iraqi
4 Freedom, or Operation Noble Eagle, and their spouses and dependents,
5 for enrollment in the Washington basic health plan, to establish
6 appropriate minimum-enrollment periods for enrollees as may be
7 necessary, and to determine, upon application and on a reasonable
8 schedule defined by the authority, or at the request of any enrollee,
9 eligibility due to current gross family income for sliding scale
10 premiums. Funds received by a family as part of participation in the
11 adoption support program authorized under RCW 26.33.320 and 74.13.100
12 through 74.13.145 shall not be counted toward a family's current gross
13 family income for the purposes of this chapter. When an enrollee fails
14 to report income or income changes accurately, the administrator shall
15 have the authority either to bill the enrollee for the amounts overpaid
16 by the state or to impose civil penalties of up to two hundred percent
17 of the amount of subsidy overpaid due to the enrollee incorrectly
18 reporting income. The administrator shall adopt rules to define the
19 appropriate application of these sanctions and the processes to
20 implement the sanctions provided in this subsection, within available
21 resources. No subsidy may be paid with respect to any enrollee whose
22 current gross family income exceeds twice the federal poverty level or,
23 subject to RCW 70.47.110, who is a recipient of medical assistance or
24 medical care services under chapter 74.09 RCW. If a number of
25 enrollees drop their enrollment for no apparent good cause, the
26 administrator may establish appropriate rules or requirements that are
27 applicable to such individuals before they will be allowed to reenroll
28 in the plan.

29 (12) To accept applications from business owners on behalf of
30 themselves and their employees, spouses, and dependent children, as
31 subsidized or nonsubsidized enrollees, who reside in an area served by
32 the plan. The administrator may require all or the substantial
33 majority of the eligible employees of such businesses to enroll in the
34 plan and establish those procedures necessary to facilitate the orderly
35 enrollment of groups in the plan and into a managed health care system.
36 The administrator may require that a business owner pay at least an
37 amount equal to what the employee pays after the state pays its portion
38 of the subsidized premium cost of the plan on behalf of each employee

1 enrolled in the plan. Enrollment is limited to those not eligible for
2 medicare who wish to enroll in the plan and choose to obtain the basic
3 health care coverage and services from a managed care system
4 participating in the plan. The administrator shall adjust the amount
5 determined to be due on behalf of or from all such enrollees whenever
6 the amount negotiated by the administrator with the participating
7 managed health care system or systems is modified or the administrative
8 cost of providing the plan to such enrollees changes.

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

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

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

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

4 (17) To provide, consistent with available funding, assistance for
5 rural residents, underserved populations, and persons of color.

6 (18) In consultation with appropriate state and local government
7 agencies, to establish criteria defining eligibility for persons
8 confined or residing in government-operated institutions.

9 (19) To administer the premium discounts provided under RCW
10 48.41.200(3)(a) (i) and (ii) pursuant to a contract with the Washington
11 state health insurance pool.

12 (20) To give priority in enrollment to persons who disenrolled from
13 the program in order to enroll in medicaid, and subsequently became
14 ineligible for medicaid coverage.

15 **Sec. 37.** RCW 48.43.018 and 2004 c 244 s 3 are each amended to read
16 as follows:

17 (1) Except as provided in (a) through (e) of this subsection, a
18 health carrier may require any person applying for an individual health
19 benefit plan and the health care authority shall require any person
20 applying for nonsubsidized enrollment in the basic health plan to
21 complete the standard health questionnaire designated under chapter
22 48.41 RCW.

23 (a) If a person is seeking an individual health benefit plan or
24 enrollment in the basic health plan as a nonsubsidized enrollee due to
25 his or her change of residence from one geographic area in Washington
26 state to another geographic area in Washington state where his or her
27 current health plan is not offered, completion of the standard health
28 questionnaire shall not be a condition of coverage if application for
29 coverage is made within ninety days of relocation.

30 (b) If a person is seeking an individual health benefit plan or
31 enrollment in the basic health plan as a nonsubsidized enrollee:

32 (i) Because a health care provider with whom he or she has an
33 established care relationship and from whom he or she has received
34 treatment within the past twelve months is no longer part of the
35 carrier's provider network under his or her existing Washington
36 individual health benefit plan; and

1 (ii) His or her health care provider is part of another carrier's
2 or a basic health plan managed care system's provider network; and

3 (iii) Application for a health benefit plan under that carrier's
4 provider network individual coverage or for basic health plan
5 nonsubsidized enrollment is made within ninety days of his or her
6 provider leaving the previous carrier's provider network; then
7 completion of the standard health questionnaire shall not be a
8 condition of coverage.

9 (c) If a person is seeking an individual health benefit plan or
10 enrollment in the basic health plan as a nonsubsidized enrollee due to
11 his or her having exhausted continuation coverage provided under 29
12 U.S.C. Sec. 1161 et seq., completion of the standard health
13 questionnaire shall not be a condition of coverage if application for
14 coverage is made within ninety days of exhaustion of continuation
15 coverage. A health carrier or the health care authority as
16 administrator of basic health plan nonsubsidized coverage shall accept
17 an application without a standard health questionnaire from a person
18 currently covered by such continuation coverage if application is made
19 within ninety days prior to the date the continuation coverage would be
20 exhausted and the effective date of the individual coverage applied for
21 is the date the continuation coverage would be exhausted, or within
22 ninety days thereafter.

23 (d) If a person is seeking an individual health benefit plan or
24 enrollment in the basic health plan as a nonsubsidized enrollee due to
25 his or her receiving notice that his or her coverage under a conversion
26 contract is discontinued, completion of the standard health
27 questionnaire shall not be a condition of coverage if application for
28 coverage is made within ninety days of discontinuation of eligibility
29 under the conversion contract. A health carrier or the health care
30 authority as administrator of basic health plan nonsubsidized coverage
31 shall accept an application without a standard health questionnaire
32 from a person currently covered by such conversion contract if
33 application is made within ninety days prior to the date eligibility
34 under the conversion contract would be discontinued and the effective
35 date of the individual coverage applied for is the date eligibility
36 under the conversion contract would be discontinued, or within ninety
37 days thereafter.

1 (e) If a person is seeking an individual health benefit plan (~~and,~~
2 ~~but for the number of persons employed by his or her employer, would~~
3 ~~have qualified for~~) or enrollment in the basic health plan as a
4 nonsubsidized enrollee following disenrollment from a health plan that
5 is exempt from continuation coverage provided under 29 U.S.C. Sec. 1161
6 et seq., completion of the standard health questionnaire shall not be
7 a condition of coverage if: (i) (~~Application for coverage is made~~
8 ~~within ninety days of a qualifying event as defined in 29 U.S.C. Sec.~~
9 ~~1163; and (ii)~~) The person had at least twenty-four months of
10 continuous group coverage including church plans immediately prior to
11 (~~the qualifying event. A health carrier shall accept an application~~
12 ~~without a standard health questionnaire from a person with at least~~
13 ~~twenty four months of continuous group coverage if~~) disenrollment;
14 (ii) application is made no more than ninety days prior to the date of
15 (~~a qualifying event~~) disenrollment; and (iii) the effective date of
16 the individual coverage applied for is the date of (~~the qualifying~~
17 ~~event~~) disenrollment, or within ninety days thereafter.

18 (f) If a person is seeking an individual health benefit plan,
19 completion of the standard health questionnaire shall not be a
20 condition of coverage if: (i) The person had at least twenty-four
21 months of continuous basic health plan coverage under chapter 70.47 RCW
22 immediately prior to disenrollment; and (ii) application for coverage
23 is made within ninety days of disenrollment from the basic health plan.
24 A health carrier shall accept an application without a standard health
25 questionnaire from a person with at least twenty-four months of
26 continuous basic health plan coverage if application is made no more
27 than ninety days prior to the date of disenrollment and the effective
28 date of the individual coverage applied for is the date of
29 disenrollment, or within ninety days thereafter.

30 (2) If, based upon the results of the standard health
31 questionnaire, the person qualifies for coverage under the Washington
32 state health insurance pool, the following shall apply:

33 (a) The carrier may decide not to accept the person's application
34 for enrollment in its individual health benefit plan and the health
35 care authority, as administrator of basic health plan nonsubsidized
36 coverage, shall not accept the person's application for enrollment as
37 a nonsubsidized enrollee; and

1 (b) Within fifteen business days of receipt of a completed
2 application, the carrier or the health care authority as administrator
3 of basic health plan nonsubsidized coverage shall provide written
4 notice of the decision not to accept the person's application for
5 enrollment to both the person and the administrator of the Washington
6 state health insurance pool. The notice to the person shall state that
7 the person is eligible for health insurance provided by the Washington
8 state health insurance pool, and shall include information about the
9 Washington state health insurance pool and an application for such
10 coverage. If the carrier or the health care authority as administrator
11 of basic health plan nonsubsidized coverage does not provide or
12 postmark such notice within fifteen business days, the application is
13 deemed approved.

14 (3) If the person applying for an individual health benefit plan:
15 (a) Does not qualify for coverage under the Washington state health
16 insurance pool based upon the results of the standard health
17 questionnaire; (b) does qualify for coverage under the Washington state
18 health insurance pool based upon the results of the standard health
19 questionnaire and the carrier elects to accept the person for
20 enrollment; or (c) is not required to complete the standard health
21 questionnaire designated under this chapter under subsection (1)(a) or
22 (b) of this section, the carrier or the health care authority as
23 administrator of basic health plan nonsubsidized coverage, whichever
24 entity administered the standard health questionnaire, shall accept the
25 person for enrollment if he or she resides within the carrier's or the
26 basic health plan's service area and provide or assure the provision of
27 all covered services regardless of age, sex, family structure,
28 ethnicity, race, health condition, geographic location, employment
29 status, socioeconomic status, other condition or situation, or the
30 provisions of RCW 49.60.174(2). The commissioner may grant a temporary
31 exemption from this subsection if, upon application by a health
32 carrier, the commissioner finds that the clinical, financial, or
33 administrative capacity to serve existing enrollees will be impaired if
34 a health carrier is required to continue enrollment of additional
35 eligible individuals.

36 **Sec. 38.** RCW 43.70.670 and 2003 c 274 s 2 are each amended to read
37 as follows:

1 (1) "Human immunodeficiency virus insurance program," as used in
2 this section, means a program that provides health insurance coverage
3 for individuals with human immunodeficiency virus, as defined in RCW
4 70.24.017(7), who are not eligible for medical assistance programs from
5 the department of social and health services as defined in RCW
6 74.09.010(8) and meet eligibility requirements established by the
7 department of health.

8 (2) The department of health may pay for health insurance coverage
9 on behalf of persons with human immunodeficiency virus, who meet
10 department eligibility requirements, and who are eligible for
11 "continuation coverage" as provided by the federal consolidated omnibus
12 budget reconciliation act of 1985, group health insurance policies, or
13 individual policies. ~~((The number of insurance policies supported by
14 this program in the Washington state health insurance pool as defined
15 in RCW 48.41.030(18) shall not grow beyond the July 1, 2003, level.))~~

16 PREVENTION AND HEALTH PROMOTION

17 NEW SECTION. **Sec. 39.** (1) The Washington state health care
18 authority, the department of social and health services, the department
19 of labor and industries, and the department of health shall, by
20 September 1, 2007, develop a five-year plan to integrate disease and
21 accident prevention and health promotion into state purchased health
22 programs that they administer by:

23 (a) Structuring benefits and reimbursements to promote healthy
24 choices and disease and accident prevention;

25 (b) Encouraging enrollees in state health programs to complete a
26 health assessment, and providing appropriate follow up;

27 (c) Reimbursing for cost-effective prevention activities; and

28 (d) Developing prevention and health promotion contracting
29 standards for state programs that contract with health carriers.

30 (2) The plan shall: (a) Identify any existing barriers and
31 opportunities to support implementation, including needed changes to
32 state or federal law; (b) identify the goals the plan is intended to
33 achieve and how progress towards those goals will be measured and
34 reported; and (c) be submitted to the governor and the legislature upon
35 completion.

1 **Sec. 40.** RCW 41.05.540 and 2005 c 360 s 8 are each amended to read
2 as follows:

3 (1) The health care authority, in coordination with (~~the~~
4 ~~department of personnel,~~) the department of health, health plans
5 participating in public employees' benefits board programs, and the
6 University of Washington's center for health promotion, (~~may create a~~
7 ~~worksite health promotion program to develop and implement initiatives~~
8 ~~designed to increase physical activity and promote improved self care~~
9 ~~and engagement in health care decision making among state employees.~~

10 ~~(2) The health care authority shall report to the governor and the~~
11 ~~legislature by December 1, 2006, on progress in implementing, and~~
12 ~~evaluating the results of, the worksite health promotion program))~~
13 shall establish and maintain a state employee health program focused on
14 reducing the health risks and improving the health status of state
15 employees, dependents, and retirees enrolled in the public employees'
16 benefits board. The program shall use public and private sector best
17 practices to achieve goals of measurable health outcomes, measurable
18 productivity improvements, positive impact on the cost of medical care,
19 and positive return on investment. The program shall establish
20 standards for health promotion and disease prevention activities, and
21 develop a mechanism to update standards as evidence-based research
22 brings new information and best practices forward.

23 (2) The state employee health program shall:

24 (a) Provide technical assistance and other services as needed to
25 wellness staff in all state agencies and institutions of higher
26 education;

27 (b) Develop effective communication tools and ongoing training for
28 wellness staff;

29 (c) Contract with outside vendors for evaluation of program goals;

30 (d) Strongly encourage the widespread completion of online health
31 assessment tools for all state employees, dependents, and retirees.
32 The health assessment tool must be voluntary and confidential. Health
33 assessment data and claims data shall be used to:

34 (i) Engage state agencies and institutions of higher education in
35 providing evidence-based programs targeted at reducing identified
36 health risks;

37 (ii) Guide contracting with third-party vendors to implement
38 behavior change tools for targeted high-risk populations; and

1 (iii) Guide the benefit structure for state employees, dependents,
2 and retirees to include covered services and medications known to
3 manage and reduce health risks.

4 (3) The health care authority shall report to the legislature in
5 December 2008 and December 2010 on outcome goals for the employee
6 health program.

7 **NEW SECTION. Sec. 41.** A new section is added to chapter 41.05 RCW
8 to read as follows:

9 (1) The health care authority through the state employee health
10 program shall implement a state employee health demonstration project.
11 The agencies selected must: (a) Show a high rate of health risk
12 assessment completion; (b) document an infrastructure capable of
13 implementing employee health programs using current and emerging best
14 practices; (c) show evidence of senior management support; and (d)
15 together employ a total of no more than eight thousand employees who
16 are enrolled in health plans of the public employees' benefits board.
17 Demonstration project agencies shall operate employee health programs
18 for their employees in collaboration with the state employee health
19 program.

20 (2) Agency demonstration project employee health programs:

21 (a) Shall include but are not limited to the following key
22 elements: Outreach to all staff with efforts made to reach the largest
23 percentage of employees possible; awareness-building information that
24 promotes health; motivational opportunities that encourage employees to
25 improve their health; behavior change opportunities that demonstrate
26 and support behavior change; and tools to improve employee health care
27 decisions;

28 (b) Must have wellness staff with direct accountability to agency
29 senior management;

30 (c) Shall initiate and maintain employee health programs using
31 current and emerging best practices in the field of health promotion;

32 (d) May offer employees such incentives as cash for completing
33 health risk assessments, free preventive screenings, training in
34 behavior change tools, improved nutritional standards on agency
35 campuses, bike racks, walking maps, on-site weight reduction programs,
36 and regular communication to promote personal health awareness.

1 (3) The state employee health program shall evaluate each of the
2 four programs separately and compare outcomes for each of them with the
3 entire state employee population to assess effectiveness of the
4 programs. Specifically, the program shall measure at least the
5 following outcomes in the demonstration population: The reduction in
6 the percent of the population that is overweight or obese, the
7 reduction in risk factors related to diabetes, the reduction in risk
8 factors related to absenteeism, the reduction in tobacco consumption,
9 the reduction in high blood pressure and high cholesterol, and the
10 increase in appropriate use of preventive health services. The state
11 employee health program shall report to the legislature in December
12 2008 and December 2010 on the demonstration project.

13 (4) This section expires June 30, 2011.

14 **PRESCRIPTION MONITORING PROGRAM**

15 NEW SECTION. **Sec. 42.** The definitions in this section apply
16 throughout this chapter unless the context clearly requires otherwise.

17 (1) "Controlled substance" has the meaning provided in RCW
18 69.50.101.

19 (2) "Department" means the department of health.

20 (3) "Patient" means the person or animal who is the ultimate user
21 of a drug for whom a prescription is issued or for whom a drug is
22 dispensed.

23 (4) "Dispenser" means a practitioner or pharmacy that delivers a
24 Schedule II, III, IV, or V controlled substance to the ultimate user,
25 but does not include:

26 (a) A practitioner or other authorized person who administers, as
27 defined in RCW 69.41.010, a controlled substance; or

28 (b) A licensed wholesale distributor or manufacturer, as defined in
29 chapter 18.64 RCW, of a controlled substance.

30 NEW SECTION. **Sec. 43.** (1) When sufficient funding is provided for
31 such purpose through federal or private grants, or is appropriated by
32 the legislature, the department shall establish and maintain a
33 prescription monitoring program to monitor the prescribing and
34 dispensing of all Schedules II, III, IV, and V controlled substances
35 and any additional drugs identified by the board of pharmacy as

1 demonstrating a potential for abuse by all professionals licensed to
2 prescribe or dispense such substances in this state. The program shall
3 be designed to improve health care quality and effectiveness by
4 reducing abuse of controlled substances, reducing duplicative
5 prescribing and over-prescribing of controlled substances, and
6 improving controlled substance prescribing practices with the intent of
7 eventually establishing an electronic database available in real time
8 to dispensers and prescribers of control substances. As much as
9 possible, the department should establish a common database with other
10 states.

11 (2) Except as provided in subsection (4) of this section, each
12 dispenser shall submit to the department by electronic means
13 information regarding each prescription dispensed for a drug included
14 under subsection (1) of this section. Drug prescriptions for more than
15 immediate one day use should be reported. The information submitted
16 for each prescription shall include, but not be limited to:

- 17 (a) Patient identifier;
- 18 (b) Drug dispensed;
- 19 (c) Date of dispensing;
- 20 (d) Quantity dispensed;
- 21 (e) Prescriber; and
- 22 (f) Dispenser.

23 (3) Each dispenser shall submit the information in accordance with
24 transmission methods established by the department.

25 (4) The data submission requirements of this section do not apply
26 to:

27 (a) Medications provided to patients receiving inpatient services
28 provided at hospitals licensed under chapter 70.41 RCW; or patients of
29 such hospitals receiving services at the clinics, day surgery areas, or
30 other settings within the hospital's license where the medications are
31 administered in single doses; or

32 (b) Pharmacies operated by the department of corrections for the
33 purpose of providing medications to offenders in department of
34 corrections institutions who are receiving pharmaceutical services from
35 a department of corrections pharmacy, except that the department of
36 corrections must submit data related to each offender's current
37 prescriptions for controlled substances upon the offender's release
38 from a department of corrections institution.

1 (5) The department shall seek federal grants to support the
2 activities described in this act. The department may not require a
3 practitioner or a pharmacist to pay a fee or tax specifically dedicated
4 to the operation of the system.

5 NEW SECTION. **Sec. 44.** To the extent that funding is provided for
6 such purpose through federal or private grants, or is appropriated by
7 the legislature, the health care authority shall study the feasibility
8 of enhancing the prescription monitoring program established in section
9 43 of this act in order to improve the quality of state purchased
10 health services by reducing legend drug abuse, reducing duplicative and
11 overprescribing of legend drugs, and improving legend drug prescribing
12 practices. The study shall address the steps necessary to expand the
13 program to allow those who prescribe or dispense prescription drugs to
14 perform a web-based inquiry and obtain real time information regarding
15 the legend drug utilization history of persons for whom they are
16 providing medical or pharmaceutical care when such persons are
17 receiving health services through state purchased health care programs.

18 NEW SECTION. **Sec. 45.** (1) Prescription information submitted to
19 the department shall be confidential, in compliance with chapter 70.02
20 RCW and federal health care information privacy requirements and not
21 subject to disclosure, except as provided in subsections (3) and (4) of
22 this section.

23 (2) The department shall maintain procedures to ensure that the
24 privacy and confidentiality of patients and patient information
25 collected, recorded, transmitted, and maintained is not disclosed to
26 persons except as in subsections (3) and (4) of this section.

27 (3) The department may provide data in the prescription monitoring
28 program to the following persons:

29 (a) Persons authorized to prescribe or dispense controlled
30 substances, for the purpose of providing medical or pharmaceutical care
31 for their patients;

32 (b) An individual who requests the individual's own prescription
33 monitoring information;

34 (c) Health professional licensing, certification, or regulatory
35 agency or entity;

1 (d) Appropriate local, state, and federal law enforcement or
2 prosecutorial officials who are engaged in a bona fide specific
3 investigation involving a designated person;

4 (e) Authorized practitioners of the department of social and health
5 services regarding medicaid program recipients;

6 (f) The director or director's designee within the department of
7 labor and industries regarding workers' compensation claimants;

8 (g) The director or the director's designee within the department
9 of corrections regarding offenders committed to the department of
10 corrections;

11 (h) Other entities under grand jury subpoena or court order; and

12 (i) Personnel of the department for purposes of administration and
13 enforcement of this chapter or chapter 69.50 RCW.

14 (4) The department may provide data to public or private entities
15 for statistical, research, or educational purposes after removing
16 information that could be used to identify individual patients,
17 dispensers, prescribers, and persons who received prescriptions from
18 dispensers.

19 (5) A dispenser or practitioner acting in good faith is immune from
20 any civil, criminal, or administrative liability that might otherwise
21 be incurred or imposed for requesting, receiving, or using information
22 from the program.

23 NEW SECTION. **Sec. 46.** The department may contract with another
24 agency of this state or with a private vendor, as necessary, to ensure
25 the effective operation of the prescription monitoring program. Any
26 contractor is bound to comply with the provisions regarding
27 confidentiality of prescription information in section 45 of this act
28 and is subject to the penalties specified in section 48 of this act for
29 unlawful acts.

30 NEW SECTION. **Sec. 47.** The department shall adopt rules to
31 implement this chapter.

32 NEW SECTION. **Sec. 48.** (1) A dispenser who knowingly fails to
33 submit prescription monitoring information to the department as
34 required by this chapter or knowingly submits incorrect prescription
35 information is subject to disciplinary action under chapter 18.130 RCW.

1 (2) A person authorized to have prescription monitoring information
2 under this chapter who knowingly discloses such information in
3 violation of this chapter is subject to civil penalty.

4 (3) A person authorized to have prescription monitoring information
5 under this chapter who uses such information in a manner or for a
6 purpose in violation of this chapter is subject to civil penalty.

7 (4) In accordance with chapter 70.02 RCW and federal health care
8 information privacy requirements, any physician or pharmacist
9 authorized to access a patient's prescription monitoring may discuss or
10 release that information to other health care providers involved with
11 the patient in order to provide safe and appropriate care coordination.

12 **Sec. 49.** RCW 42.56.360 and 2006 c 209 s 9 and 2006 c 8 s 112 are
13 each reenacted and amended to read as follows:

14 (1) The following health care information is exempt from disclosure
15 under this chapter:

16 (a) Information obtained by the board of pharmacy as provided in
17 RCW 69.45.090;

18 (b) Information obtained by the board of pharmacy or the department
19 of health and its representatives as provided in RCW 69.41.044,
20 69.41.280, and 18.64.420;

21 (c) Information and documents created specifically for, and
22 collected and maintained by a quality improvement committee under RCW
23 43.70.510 or 70.41.200, or by a peer review committee under RCW
24 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640
25 or 18.20.390, and notifications or reports of adverse events or
26 incidents made under RCW 70.56.020 or 70.56.040, regardless of which
27 agency is in possession of the information and documents;

28 (d)(i) Proprietary financial and commercial information that the
29 submitting entity, with review by the department of health,
30 specifically identifies at the time it is submitted and that is
31 provided to or obtained by the department of health in connection with
32 an application for, or the supervision of, an antitrust exemption
33 sought by the submitting entity under RCW 43.72.310;

34 (ii) If a request for such information is received, the submitting
35 entity must be notified of the request. Within ten business days of
36 receipt of the notice, the submitting entity shall provide a written
37 statement of the continuing need for confidentiality, which shall be

1 provided to the requester. Upon receipt of such notice, the department
2 of health shall continue to treat information designated under this
3 subsection (1)(d) as exempt from disclosure;

4 (iii) If the requester initiates an action to compel disclosure
5 under this chapter, the submitting entity must be joined as a party to
6 demonstrate the continuing need for confidentiality;

7 (e) Records of the entity obtained in an action under RCW 18.71.300
8 through 18.71.340;

9 (f) Except for published statistical compilations and reports
10 relating to the infant mortality review studies that do not identify
11 individual cases and sources of information, any records or documents
12 obtained, prepared, or maintained by the local health department for
13 the purposes of an infant mortality review conducted by the department
14 of health under RCW 70.05.170; (~~and~~)

15 (g) Complaints filed under chapter 18.130 RCW after July 27, 1997,
16 to the extent provided in RCW 18.130.095(1); and

17 (h) Information obtained by the department of health under chapter
18 70.-- RCW (sections 42 through 48 of this act).

19 (2) Chapter 70.02 RCW applies to public inspection and copying of
20 health care information of patients.

21 STRATEGIC HEALTH PLANNING

22 NEW SECTION. **Sec. 50.** The definitions in this section apply
23 throughout this chapter unless the context clearly requires otherwise.

24 (1) "Health care provider" means an individual who holds a license
25 issued by a disciplining authority identified in RCW 18.130.040 and who
26 practices his or her profession in a health care facility or provides
27 a health service.

28 (2) "Health facility" or "facility" means hospices licensed under
29 chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural
30 health care facilities as defined in RCW 70.175.020, psychiatric
31 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
32 under chapter 18.51 RCW, community mental health centers licensed under
33 chapter 71.05 or 71.24 RCW, kidney disease treatment centers,
34 ambulatory diagnostic, treatment, or surgical facilities, drug and
35 alcohol treatment facilities licensed under chapter 70.96A RCW, and
36 home health agencies licensed under chapter 70.127 RCW, and includes

1 such facilities if owned and operated by a political subdivision,
2 including a public hospital district, or instrumentality of the state
3 and such other facilities as required by federal law and implementing
4 regulations.

5 (3) "Health service" or "service" means that service, including
6 primary care service, offered or provided by health care facilities and
7 health care providers relating to the prevention, cure, or treatment of
8 illness, injury, or disease.

9 (4) "Health service area" means a geographic region appropriate for
10 effective health planning that includes a broad range of health
11 services.

12 (5) "Office" means the office of financial management.

13 (6) "Strategy" means the statewide health resources strategy.

14 NEW SECTION. **Sec. 51.** (1) The office shall serve as a
15 coordinating body for public and private efforts to improve quality in
16 health care, promote cost-effectiveness in health care, and plan health
17 facility and health service availability. In addition, the office
18 shall facilitate access to health care data collected by public and
19 private organizations as needed to conduct its planning
20 responsibilities.

21 (2) The office shall:

22 (a) Conduct strategic health planning activities related to the
23 preparation of the strategy, as specified in this chapter;

24 (b) Develop a computerized system for accessing, analyzing, and
25 disseminating data relevant to strategic health planning
26 responsibilities. The office may contract with an organization to
27 create the computerized system capable of meeting the needs of the
28 office;

29 (c) Maintain access to deidentified data collected and stored by
30 any public and private organizations as necessary to support its
31 planning responsibilities, including state-purchased health care
32 program data, hospital discharge data, and private efforts to collect
33 utilization and claims-related data. The office is authorized to enter
34 into any data sharing agreements and contractual arrangements necessary
35 to obtain data or to distribute data. Among the sources of
36 deidentified data that the office may access are any databases
37 established pursuant to the recommendations of the health information

1 infrastructure advisory board established by chapter 261, Laws of 2005.
2 The office may store limited data sets as necessary to support its
3 activities. Unless specifically authorized, the office shall not
4 collect data directly from the records of health care providers and
5 health care facilities, but shall make use of databases that have
6 already collected such information; and

7 (d) Conduct research and analysis or arrange for research and
8 analysis projects to be conducted by public or private organizations to
9 further the purposes of the strategy.

10 (3) The office shall establish a technical advisory committee to
11 assist in the development of the strategy. Members of the committee
12 shall include health economists, health planners, representatives of
13 government and nongovernment health care purchasers, representatives of
14 state agencies that use or regulate entities with an interest in health
15 planning, representatives of acute care facilities, representatives of
16 long-term care facilities, representatives of community-based long-term
17 care providers, representatives of health care providers, a
18 representative of one or more federally recognized Indian tribes, and
19 representatives of health care consumers. The committee shall include
20 members with experience in the provision of health services to rural
21 communities.

22 NEW SECTION. **Sec. 52.** (1) The office, in consultation with the
23 technical advisory committee established under section 51 of this act,
24 shall develop a statewide health resources strategy. The strategy
25 shall establish statewide health planning policies and goals related to
26 the availability of health care facilities and services, quality of
27 care, and cost of care. The strategy shall identify needs according to
28 geographic regions suitable for comprehensive health planning as
29 designated by the office.

30 (2) The development of the strategy shall consider the following
31 general goals and principles:

32 (a) That excess capacity of health services and facilities place
33 considerable economic burden on the public who pay for the construction
34 and operation of these facilities as patients, health insurance
35 purchasers, carriers, and taxpayers; and

36 (b) That the development and ongoing maintenance of current and
37 accurate health care information and statistics related to cost and

1 quality of health care, as well as projections of need for health
2 facilities and services, are essential to effective strategic health
3 planning.

4 (3) The strategy, with public input by health service areas, shall
5 include:

6 (a) A health system assessment and objectives component that:

7 (i) Describes state and regional population demographics, health
8 status indicators, and trends in health status and health care needs;
9 and

10 (ii) Identifies key policy objectives for the state health system
11 related to access to care, health outcomes, quality, and cost-
12 effectiveness;

13 (b) A health care facilities and services plan that shall assess
14 the demand for health care facilities and services to inform state
15 health planning efforts and direct certificate of need determinations,
16 for those facilities and services subject to certificate of need as
17 provided in chapter 70.38 RCW. The plan shall include:

18 (i) An inventory of each geographic region's existing health care
19 facilities and services;

20 (ii) Projections of need for each category of health care facility
21 and service, including those subject to certificate of need;

22 (iii) Policies to guide the addition of new or expanded health care
23 facilities and services to promote the use of quality, evidence-based,
24 cost-effective health care delivery options, including any
25 recommendations for criteria, standards, and methods relevant to the
26 certificate of need review process; and

27 (iv) An assessment of the availability of health care providers,
28 public health resources, transportation infrastructure, and other
29 considerations necessary to support the needed health care facilities
30 and services in each region;

31 (c) A health care data resource plan that identifies data elements
32 necessary to properly conduct planning activities and to review
33 certificate of need applications, including data related to inpatient
34 and outpatient utilization and outcomes information, and financial and
35 utilization information related to charity care, quality, and cost.
36 The plan shall inventory existing data resources, both public and
37 private, that store and disclose information relevant to the health
38 planning process, including information necessary to conduct

1 certificate of need activities pursuant to chapter 70.38 RCW. The plan
2 shall identify any deficiencies in the inventory of existing data
3 resources and the data necessary to conduct comprehensive health
4 planning activities. The plan may recommend that the office be
5 authorized to access existing data sources and conduct appropriate
6 analyses of such data or that other agencies expand their data
7 collection activities as statutory authority permits. The plan may
8 identify any computing infrastructure deficiencies that impede the
9 proper storage, transmission, and analysis of health planning data.
10 The plan shall provide recommendations for increasing the availability
11 of data related to health planning to provide greater community
12 involvement in the health planning process and consistency in data used
13 for certificate of need applications and determinations;

14 (d) An assessment of emerging trends in health care delivery and
15 technology as they relate to access to health care facilities and
16 services, quality of care, and costs of care. The assessment shall
17 recommend any changes to the scope of health care facilities and
18 services covered by the certificate of need program that may be
19 warranted by these emerging trends. In addition, the assessment may
20 recommend any changes to criteria used by the department to review
21 certificate of need applications, as necessary;

22 (e) A rural health resource plan to assess the availability of
23 health resources in rural areas of the state, assess the unmet needs of
24 these communities, and evaluate how federal and state reimbursement
25 policies can be modified, if necessary, to more efficiently and
26 effectively meet the health care needs of rural communities. The plan
27 shall consider the unique health care needs of rural communities, the
28 adequacy of the rural health workforce, and transportation needs for
29 accessing appropriate care.

30 (4) The office shall submit the initial strategy to the governor
31 and the appropriate committees of the senate and house of
32 representatives by January 1, 2010. Every two years the office shall
33 submit an updated strategy. The health care facilities and services
34 plan as it pertains to a distinct geographic planning region may be
35 updated by individual categories on a rotating, biannual schedule.

36 (5) The office shall hold at least one public hearing and allow
37 opportunity to submit written comments prior to the issuance of the
38 initial strategy or an updated strategy. A public hearing shall be

1 held prior to issuing a draft of an updated health care facilities and
2 services plan, and another public hearing shall be held before final
3 adoption of an updated health care facilities and services plan. Any
4 hearing related to updating a health care facilities and services plan
5 for a specific planning region shall be held in that region with
6 sufficient notice to the public and an opportunity to comment.

7 NEW SECTION. **Sec. 53.** The office shall submit the strategy to the
8 department of health to direct its activities related to the
9 certificate of need review program under chapter 70.38 RCW. As the
10 health care facilities and services plan is updated for any specific
11 geographic planning region, the office shall submit that plan to the
12 department of health to direct its activities related to the
13 certificate of need review program under chapter 70.38 RCW. The office
14 shall not issue determinations of the merits of specific project
15 proposals submitted by applicants for certificates of need.

16 NEW SECTION. **Sec. 54.** (1) The office may respond to requests for
17 data and other information from its computerized system for special
18 studies and analysis consistent with requirements for confidentiality
19 of patient, provider, and facility-specific records. The office may
20 require requestors to pay any or all of the reasonable costs associated
21 with such requests that might be approved.

22 (2) Data elements related to the identification of individual
23 patient's, provider's, and facility's care outcomes are confidential,
24 are exempt from RCW 42.56.030 through 42.56.570 and 42.17.350 through
25 42.17.450, and are not subject to discovery by subpoena or admissible
26 as evidence.

27 **Sec. 55.** RCW 70.38.015 and 1989 1st ex.s. c 9 s 601 are each
28 amended to read as follows:

29 It is declared to be the public policy of this state:

30 (1) That strategic health planning ((~~to~~)) efforts must be supported
31 by appropriately tailored regulatory activities that can effectuate the
32 goals and principles of the statewide health resources strategy
33 developed pursuant to chapter 43.-- RCW (sections 50 through 54 of this
34 act). The implementation of the strategy can promote, maintain, and
35 assure the health of all citizens in the state, ((~~to~~)) provide

1 accessible health services, health manpower, health facilities, and
2 other resources while controlling (~~(excessive)~~) increases in costs, and
3 (~~(to)~~) recognize prevention as a high priority in health programs(~~(, is~~
4 ~~essential to the health, safety, and welfare of the people of the~~
5 ~~state. Health planning should be responsive to changing health and~~
6 ~~social needs and conditions)~~). Involvement in health planning from
7 both consumers and providers throughout the state should be encouraged;

8 (2) (~~(That the development of health services and resources,~~
9 ~~including the construction, modernization, and conversion of health~~
10 ~~facilities, should be accomplished in a planned, orderly fashion,~~
11 ~~consistent with identified priorities and without unnecessary~~
12 ~~duplication or fragmentation)~~) That the certificate of need program is
13 a component of a health planning regulatory process that is consistent
14 with the statewide health resources strategy and public policy goals
15 that are clearly articulated and regularly updated;

16 (3) That the development and maintenance of adequate health care
17 information, statistics and projections of need for health facilities
18 and services is essential to effective health planning and resources
19 development;

20 (4) That the development of nonregulatory approaches to health care
21 cost containment should be considered, including the strengthening of
22 price competition; and

23 (5) That health planning should be concerned with public health and
24 health care financing, access, and quality, recognizing their close
25 interrelationship and emphasizing cost control of health services,
26 including cost-effectiveness and cost-benefit analysis.

27 NEW SECTION. Sec. 56. (1) For the purposes of this section and
28 RCW 70.38.015 and 70.38.135, "statewide health resource strategy" or
29 "strategy" means the statewide health resource strategy developed by
30 the office of financial management pursuant to chapter 43.-- RCW
31 (sections 50 through 54 of this act).

32 (2) Effective January 1, 2010, for those facilities and services
33 covered by the certificate of need programs, certificate of need
34 determinations must be consistent with the statewide health resources
35 strategy developed pursuant to section 52 of this act, including any
36 health planning policies and goals identified in the statewide health
37 resources strategy in effect at the time of application. The

1 department may waive specific terms of the strategy if the applicant
2 demonstrates that consistency with those terms will create an undue
3 burden on the population that a particular project would serve, or in
4 emergency circumstances which pose a threat to public health.

5 **Sec. 57.** RCW 70.38.135 and 1989 1st ex.s. c 9 s 607 are each
6 amended to read as follows:

7 The secretary shall have authority to:

8 (1) Provide when needed temporary or intermittent services of
9 experts or consultants or organizations thereof, by contract, when such
10 services are to be performed on a part time or fee-for-service basis;

11 (2) Make or cause to be made such on-site surveys of health care or
12 medical facilities as may be necessary for the administration of the
13 certificate of need program;

14 (3) Upon review of recommendations, if any, from the board of
15 health or the office of financial management as contained in the
16 Washington health resources strategy;

17 (a) Promulgate rules under which health care facilities providers
18 doing business within the state shall submit to the department such
19 data related to health and health care as the department finds
20 necessary to the performance of its functions under this chapter;

21 (b) Promulgate rules pertaining to the maintenance and operation of
22 medical facilities which receive federal assistance under the
23 provisions of Title XVI;

24 (c) Promulgate rules in implementation of the provisions of this
25 chapter, including the establishment of procedures for public hearings
26 for predecisions and post-decisions on applications for certificate of
27 need;

28 (d) Promulgate rules providing circumstances and procedures of
29 expedited certificate of need review if there has not been a
30 significant change in existing health facilities of the same type or in
31 the need for such health facilities and services;

32 (4) Grant allocated state funds to qualified entities, as defined
33 by the department, to fund not more than seventy-five percent of the
34 costs of regional planning activities, excluding costs related to
35 review of applications for certificates of need, provided for in this
36 chapter or approved by the department; and

1 (5) Contract with and provide reasonable reimbursement for
2 qualified entities to assist in determinations of certificates of need.

3 **HEALTH INSURANCE PARTNERSHIP**

4 **Sec. 58.** RCW 70.47A.030 and 2006 c 255 s 3 are each amended to
5 read as follows:

6 (1) To the extent funding is appropriated in the operating budget
7 for this purpose, the ((small-employer)) health insurance partnership
8 ((program)) is established. The administrator shall be responsible for
9 the implementation and operation of the ((small-employer)) health
10 insurance partnership ((program)), directly or by contract. The
11 administrator shall offer premium subsidies to eligible ((employees))
12 partnership participants under RCW 70.47A.040.

13 (2) Consistent with policies adopted by the board under section 59
14 of this act, the administrator shall, directly or by contract:

15 (a) Establish and administer procedures for enrolling small
16 employers in the partnership, including publicizing the existence of
17 the partnership and disseminating information on enrollment, and
18 establishing rules related to minimum participation of employees in
19 small groups purchasing health insurance through the partnership.
20 Opportunities to publicize the program for outreach and education of
21 small employers on the value of insurance shall explore the use of
22 online employer guides. As a condition of participating in the
23 partnership, a small employer must agree to establish a cafeteria plan
24 under section 125 of the federal internal revenue code that will enable
25 employees to use pretax dollars to pay their share of their health
26 benefit plan premium. The partnership shall provide technical
27 assistance to small employers for this purpose;

28 (b) Establish and administer procedures for health benefit plan
29 enrollment by employees of small employers during open enrollment
30 periods and outside of open enrollment periods upon the occurrence of
31 any qualifying event specified in the federal health insurance
32 portability and accountability act of 1996 or applicable state law.
33 Neither the employer nor the partnership shall limit an employee's
34 choice of coverage from among all the health benefit plans offered;

35 (c) Establish and manage a system for the partnership to be

1 designated as the sponsor or administrator of a participating small
2 employer health benefit plan and to undertake the obligations required
3 of a plan administrator under federal law;

4 (d) Establish and manage a system of collecting and transmitting to
5 the applicable carriers all premium payments or contributions made by
6 or on behalf of partnership participants, including employer
7 contributions, automatic payroll deductions for partnership
8 participants, premium subsidy payments, and contributions from
9 philanthropies;

10 (e) Establish and manage a system for determining eligibility for
11 and making premium subsidy payments under this act;

12 (f) Establish a mechanism to apply a surcharge to all health
13 benefit plans, which shall be used only to pay for administrative and
14 operational expenses of the partnership. The surcharge must be applied
15 uniformly to all health benefit plans offered through the partnership
16 and must be included in the premium for each health benefit plan.
17 Surcharges may not be used to pay any premium assistance payments under
18 this chapter;

19 (g) Design a schedule of premium subsidies that is based upon gross
20 family income, giving appropriate consideration to family size and the
21 ages of all family members based on a benchmark health benefit plan
22 designated by the board. The amount of an eligible partnership
23 participant's premium subsidy shall be determined by applying a sliding
24 scale subsidy schedule with the percentage of premium similar to that
25 developed for subsidized basic health plan enrollees under RCW
26 70.47.060. The subsidy shall be applied to the employee's premium
27 obligation for his or her health benefit plan, so that employees
28 benefit financially from any employer contribution to the cost of their
29 coverage through the partnership.

30 (3) The administrator may enter into interdepartmental agreements
31 with the office of the insurance commissioner, the department of social
32 and health services, and any other state agencies necessary to
33 implement this chapter.

34 NEW SECTION. Sec. 59. A new section is added to chapter 70.47A
35 RCW to read as follows:

36 (1) The health insurance partnership board is hereby established.
37 The governor shall appoint a nine-member board composed as follows:

1 (a) Two representatives of small employers;

2 (b) Two representatives of employees of small employers, one of
3 whom shall represent low-wage employees;

4 (c) Four employee health plan benefits specialists; and

5 (d) The administrator.

6 (2) The governor shall appoint the initial members of the board to
7 staggered terms not to exceed four years. Initial appointments shall
8 be made on or before June 1, 2007. Members appointed thereafter shall
9 serve two-year terms. Members of the board shall be compensated in
10 accordance with RCW 43.03.250 and shall be reimbursed for their travel
11 expenses while on official business in accordance with RCW 43.03.050
12 and 43.03.060. The board shall prescribe rules for the conduct of its
13 business. The administrator shall be chair of the board. Meetings of
14 the board shall be at the call of the chair.

15 (3) The board may establish technical advisory committees or seek
16 the advice of technical experts when necessary to execute the powers
17 and duties included in this section.

18 (4) The board and employees of the board shall not be civilly or
19 criminally liable and shall not have any penalty or cause of action of
20 any nature arise against them for any action taken or not taken,
21 including any discretionary decision or failure to make a discretionary
22 decision, when the action or inaction is done in good faith and in the
23 performance of the powers and duties under this chapter. Nothing in
24 this section prohibits legal actions against the board to enforce the
25 board's statutory or contractual duties or obligations.

26 **PUBLIC HEALTH**

27 NEW SECTION. **Sec. 60.** A new section is added to chapter 43.70 RCW
28 to read as follows:

29 (1) Protecting the public's health across the state is a
30 fundamental responsibility of the state. With any new state funding of
31 the public health system as appropriated for the purposes of sections
32 60 through 65 of this act, the state expects that measurable benefits
33 will be realized to the health of the residents of Washington. A
34 transparent process that shows the impact of increased public health
35 spending on performance measures related to the health outcomes in
36 subsection (2) of this section is of great value to the state and its

1 residents. In addition, a well-funded public health system is expected
2 to become a more integral part of the state's emergency preparedness
3 system.

4 (2) Subject to the availability of amounts appropriated for the
5 purposes of sections 60 through 65 of this act, distributions to local
6 health jurisdictions shall deliver the following outcomes:

7 (a) Create a disease response system capable of responding at all
8 times;

9 (b) Stop the increase in, and reduce, sexually transmitted disease
10 rates;

11 (c) Reduce vaccine preventable diseases;

12 (d) Build capacity to quickly contain disease outbreaks;

13 (e) Decrease childhood and adult obesity and types I and II
14 diabetes rates, and resulting kidney failure and dialysis;

15 (f) Increase childhood immunization rates;

16 (g) Improve birth outcomes and decrease child abuse;

17 (h) Reduce animal-to-human disease rates; and

18 (i) Monitor and protect drinking water across jurisdictional
19 boundaries.

20 (3) Benchmarks for these outcomes shall be drawn from the national
21 healthy people 2010 goals, other reliable data sets, and any subsequent
22 national goals.

23 NEW SECTION. **Sec. 61.** A new section is added to chapter 43.70 RCW
24 to read as follows:

25 The definitions in this section apply throughout sections 60
26 through 65 of this act unless the context clearly requires otherwise.

27 (1) "Core public health functions of statewide significance" or
28 "public health functions" means health services that:

29 (a) Address: Communicable disease prevention and response;
30 preparation for, and response to, public health emergencies caused by
31 pandemic disease, earthquake, flood, or terrorism; prevention and
32 management of chronic diseases and disabilities; promotion of healthy
33 families and the development of children; assessment of local health
34 conditions, risks, and trends, and evaluation of the effectiveness of
35 intervention efforts; and environmental health concerns;

36 (b) Promote uniformity in the public health activities conducted by

1 all local health jurisdictions in the public health system, increase
2 the overall strength of the public health system, or apply to broad
3 public health efforts; and

4 (c) If left neglected or inadequately addressed, are reasonably
5 likely to have a significant adverse impact on counties beyond the
6 borders of the local health jurisdiction.

7 (2) "Local health jurisdiction" or "jurisdiction" means a county
8 board of health organized under chapter 70.05 RCW, a health district
9 organized under chapter 70.46 RCW, or a combined city and county health
10 department organized under chapter 70.08 RCW.

11 NEW SECTION. **Sec. 62.** A new section is added to chapter 43.70 RCW
12 to read as follows:

13 (1) The department shall accomplish the tasks included in
14 subsection (2) of this section by utilizing the expertise of varied
15 interests, as provided in this subsection.

16 (a) In addition to the perspectives of local health jurisdictions,
17 the state board of health, the Washington health foundation, and
18 department staff that are currently engaged in development of the
19 public health services improvement plan under RCW 43.70.520, the
20 secretary shall actively engage:

21 (i) Individuals or entities with expertise in the development of
22 performance measures, accountability and systems management, such as
23 the University of Washington school of public health and community
24 medicine, and experts in the development of evidence-based medical
25 guidelines or public health practice guidelines; and

26 (ii) Individuals or entities who will be impacted by performance
27 measures developed under this section and have relevant expertise, such
28 as community clinics, public health nurses, large employers, tribal
29 health providers, family planning providers, and physicians.

30 (b) In developing the performance measures, consideration shall be
31 given to levels of performance necessary to promote uniformity in core
32 public health functions of statewide significance among all local
33 health jurisdictions, best scientific evidence, national standards of
34 performance, and innovations in public health practice. The
35 performance measures shall be developed to meet the goals and outcomes
36 in section 60 of this act. The office of the state auditor shall

1 provide advice and consultation to the committee to assist in the
2 development of effective performance measures and health status
3 indicators.

4 (c) On or before November 1, 2007, the experts assembled under this
5 section shall provide recommendations to the secretary related to the
6 activities and services that qualify as core public health functions of
7 statewide significance and performance measures. The secretary shall
8 provide written justification for any departure from the
9 recommendations.

10 (2) By January 1, 2008, the department shall:

11 (a) Adopt a prioritized list of activities and services performed
12 by local health jurisdictions that qualify as core public health
13 functions of statewide significance as defined in section 61 of this
14 act; and

15 (b) Adopt appropriate performance measures with the intent of
16 improving health status indicators applicable to the core public health
17 functions of statewide significance that local health jurisdictions
18 must provide.

19 (3) The secretary may revise the list of activities and the
20 performance measures in future years as appropriate. Prior to
21 modifying either the list or the performance measures, the secretary
22 must provide a written explanation of the rationale for such changes.

23 (4) The department and the local health jurisdictions shall abide
24 by the prioritized list of activities and services and the performance
25 measures developed pursuant to this section.

26 (5) The department, in consultation with representatives of county
27 governments, shall provide local jurisdictions with financial
28 incentives to encourage and increase local investments in core public
29 health functions. The local jurisdictions shall not supplant existing
30 local funding with such state-incented resources.

31 NEW SECTION. **Sec. 63.** A new section is added to chapter 43.70 RCW
32 to read as follows:

33 Beginning November 15, 2009, the department shall report to the
34 legislature and the governor annually on the distribution of funds to
35 local health jurisdictions under sections 60 through 65 of this act and
36 the use of those funds. The initial report must discuss the
37 performance measures adopted by the secretary and any impact the

1 funding in this act has had on local health jurisdiction performance
2 and health status indicators. Future reports shall evaluate trends in
3 performance over time and the effects of expenditures on performance
4 over time.

5 **Sec. 64.** RCW 43.70.520 and 1993 c 492 s 467 are each amended to
6 read as follows:

7 (1) The legislature finds that the public health functions of
8 community assessment, policy development, and assurance of service
9 delivery are essential elements in achieving the objectives of health
10 reform in Washington state. The legislature further finds that the
11 population-based services provided by state and local health
12 departments are cost-effective and are a critical strategy for the
13 long-term containment of health care costs. The legislature further
14 finds that the public health system in the state lacks the capacity to
15 fulfill these functions consistent with the needs of a reformed health
16 care system. The legislature further finds that public health nurses
17 and nursing services are an essential part of our public health system,
18 delivering evidence-based care and providing core services including
19 prevention of illness, injury, or disability; the promotion of health;
20 and maintenance of the health of populations.

21 (2) The department of health shall develop, in consultation with
22 local health departments and districts, the state board of health, the
23 health services commission, area Indian health service, and other state
24 agencies, health services providers, and citizens concerned about
25 public health, a public health services improvement plan. The plan
26 shall provide a detailed accounting of deficits in the core functions
27 of assessment, policy development, assurance of the current public
28 health system, how additional public health funding would be used, and
29 describe the benefits expected from expanded expenditures.

30 (3) The plan shall include:

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

33 (i) Enumeration of communities not meeting those standards;

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

36 (iii) An analysis of the costs and benefits expected from adopting

1 minimum public health standards for assessment, policy development, and
2 assurances;

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

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

8 (ii) ~~((Timing of increased funding for public health services
9 linked to specific objectives for improving public health))~~ Linking
10 funding for public health services to performance measures that relate
11 to achieving improved health outcomes; and

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

19 (4) The department shall coordinate this planning process with the
20 study activities required in section 258, chapter 492, Laws of 1993.

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

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

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

33 (8) Among the specific population-based public health activities to
34 be considered in the public health services improvement plan are:
35 Health data assessment and chronic and infectious disease surveillance;
36 rapid response to outbreaks of communicable disease; efforts to prevent
37 and control specific communicable diseases, such as tuberculosis and
38 acquired immune deficiency syndrome; health education to promote

1 healthy behaviors and to reduce the prevalence of chronic disease, such
2 as those linked to the use of tobacco; access to primary care in
3 coordination with existing community and migrant health clinics and
4 other not for profit health care organizations; programs to ensure
5 children are born as healthy as possible and they receive immunizations
6 and adequate nutrition; efforts to prevent intentional and
7 unintentional injury; programs to ensure the safety of drinking water
8 and food supplies; poison control; trauma services; and other
9 activities that have the potential to improve the health of the
10 population or special populations and reduce the need for or cost of
11 health services.

12 NEW SECTION. **Sec. 65.** A new section is added to chapter 43.70 RCW
13 to read as follows:

14 (1) Each local health jurisdiction shall submit to the secretary
15 such data as the secretary determines is necessary to allow the
16 secretary to assess whether the local health jurisdiction has used the
17 funds in a manner consistent with achieving the performance measures in
18 section 62 of this act.

19 (2) If the secretary determines that the data submitted
20 demonstrates that the local health jurisdiction is not spending the
21 funds in a manner consistent with achieving the performance measures,
22 the secretary shall:

23 (a) Provide a report to the governor identifying the local health
24 jurisdiction and the specific items that the secretary identified as
25 inconsistent with achieving the performance measures; and

26 (b) Require that the local health jurisdiction submit a plan of
27 correction to the secretary within sixty days of receiving notice from
28 the secretary, which explains the measures that the jurisdiction will
29 take to resume spending funds in a manner consistent with achieving the
30 performance measures. The secretary shall provide technical assistance
31 to the local health jurisdiction to support the jurisdiction in
32 successfully completing the activities included in the plan of
33 correction.

34 (3) Upon a determination by the secretary that a local health
35 jurisdiction that had previously been identified as not spending the
36 funds in a manner consistent with achieving the performance measures

1 has resumed consistency, the secretary shall notify the governor that
2 the jurisdiction has returned to consistent status.

3 (4) Any local health jurisdiction that has not resumed spending
4 funds in a manner consistent with achieving the performance measures
5 within one year of the secretary reporting the jurisdiction to the
6 governor shall be precluded from receiving any funds appropriated for
7 the purposes of sections 60 through 65 of this act. Funds may resume
8 once the local health jurisdiction has demonstrated to the satisfaction
9 of the secretary that it has returned to consistent status.

10 **Sec. 66.** RCW 70.48.130 and 1993 c 409 s 1 are each amended to read
11 as follows:

12 It is the intent of the legislature that all jail inmates receive
13 appropriate and cost-effective emergency and necessary medical care.
14 Governing units, the department of social and health services, and
15 medical care providers shall cooperate to achieve the best rates
16 consistent with adequate care.

17 Payment for emergency or necessary health care shall be by the
18 governing unit, except that the department of social and health
19 services shall directly reimburse the provider pursuant to chapter
20 74.09 RCW, in accordance with the rates and benefits established by the
21 department, if the confined person is eligible under the department's
22 medical care programs as authorized under chapter 74.09 RCW. After
23 payment by the department, the financial responsibility for any
24 remaining balance, including unpaid client liabilities that are a
25 condition of eligibility or participation under chapter 74.09 RCW,
26 shall be borne by the medical care provider and the governing unit as
27 may be mutually agreed upon between the medical care provider and the
28 governing unit. In the absence of mutual agreement between the medical
29 care provider and the governing unit, the financial responsibility for
30 any remaining balance shall be borne equally between the medical care
31 provider and the governing unit. Total payments from all sources to
32 providers for care rendered to confined persons eligible under chapter
33 74.09 RCW shall not exceed the amounts that would be paid by the
34 department for similar services provided under Title XIX medicaid,
35 unless additional resources are obtained from the confined person.

36 As part of the screening process upon booking or preparation of an
37 inmate into jail, general information concerning the inmate's ability

1 to pay for medical care shall be identified, including insurance or
2 other medical benefits or resources to which an inmate is entitled.
3 This information shall be made available to the department, the
4 governing unit, and any provider of health care services.

5 The governing unit or provider may obtain reimbursement from the
6 confined person for the cost of health care services not provided under
7 chapter 74.09 RCW, including reimbursement from any insurance program
8 or from other medical benefit programs available to the confined
9 person. Nothing in this chapter precludes civil or criminal remedies
10 to recover the costs of medical care provided jail inmates or paid for
11 on behalf of inmates by the governing unit. As part of a judgment and
12 sentence, the courts are authorized to order defendants to repay all or
13 part of the medical costs incurred by the governing unit or provider
14 during confinement.

15 To the extent that a confined person is unable to be financially
16 responsible for medical care and is ineligible for the department's
17 medical care programs under chapter 74.09 RCW, or for coverage from
18 private sources, and in the absence of an interlocal agreement or other
19 contracts to the contrary, the governing unit may obtain reimbursement
20 for the cost of such medical services from the unit of government
21 (~~whose law enforcement officers~~) that initiated the charges on which
22 the person is being held in the jail: PROVIDED, That reimbursement for
23 the cost of such services shall be by the state for state prisoners
24 being held in a jail who are accused of either escaping from a state
25 facility or of committing an offense in a state facility.

26 There shall be no right of reimbursement to the governing unit from
27 units of government (~~whose law enforcement officers~~) that initiated
28 the charges for which a person is being held in the jail for care
29 provided after the charges are disposed of by sentencing or otherwise,
30 unless by intergovernmental agreement pursuant to chapter 39.34 RCW.

31 Under no circumstance shall necessary medical services be denied or
32 delayed because of disputes over the cost of medical care or a
33 determination of financial responsibility for payment of the costs of
34 medical care provided to confined persons.

35 Nothing in this section shall limit any existing right of any
36 party, governing unit, or unit of government against the person
37 receiving the care for the cost of the care provided.

1 or safety, or support of the state government and its existing public
2 institutions, and take effect July 1, 2007.

3 NEW SECTION. **Sec. 75.** Section 30 of this act is necessary for the
4 immediate preservation of the public peace, health, or safety, or
5 support of the state government and its existing public institutions,
6 and takes effect immediately.

7 NEW SECTION. **Sec. 76.** Section 66 of this act expires June 30,
8 2009."

9 Correct the title.

--- END ---