E2SSB 5930 - H COMM AMD
By Committee on Health Care & Wellness

NOT ADOPTED 04/12/2007

Strike everything after the enacting clause and insert the following:

"**USE STATE PURCHASING TO IMPROVE HEALTH CARE QUALITY**

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

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

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

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

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

(e) Direct enrollees to quality care systems;

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

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

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

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

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

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

(2) The health care authority shall:

(a) Work in collaboration with the health professions, contracting health carriers, nonproprietary public interest or university-based research groups, and quality improvement organizations to increase awareness of appropriate, high-quality decision aids, and to train physicians and other practitioners in their use.

(b) In consultation with the national committee for quality assurance, identify a certification process for patient decision aids.

(c) Implement a shared decision-making demonstration project. The demonstration project shall be conducted at one or more multispecialty group practice sites providing state purchased health care in the state of Washington, and may include other practice sites providing state purchased health care. The demonstration project shall include the following elements:

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

(ii) An evaluation of the impact of the use of shared decision making with decision aids, including the use of preference-sensitive health care services selected for the demonstration project and expenditures for those services, the impact on patients, including patient understanding of the treatment options presented and concordance between patient values and the care received, and patient and practitioner satisfaction with the shared decision-making process.

(3) The health care authority may solicit and accept funding to support the demonstration and evaluation.

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

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

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

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

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

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

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

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

(2) If a patient while legally competent, or his or her representative if he or she is not competent, signs an acknowledgement

of shared decision making as described in this section, such acknowledgement shall constitute prima facie evidence that the patient gave his or her informed consent to the treatment administered and the patient has the burden of rebutting this by clear and convincing evidence. An acknowledgement of shared decision making shall include:

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

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

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

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

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

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

(4) As used in this section, "patient decision aid" means a written, audio-visual, or online tool that provides a balanced presentation of the condition and treatment options, benefits, and

harms, including, if appropriate, a discussion of the limits of scientific knowledge about outcomes, and that is certified by one or more national certifying organizations approved by the health care authority under section 2 of this act.

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

PREVENTION AND MANAGEMENT OF CHRONIC ILLNESS

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

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

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

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

(2) For purposes of this section:

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

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

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

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

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

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

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

(c) Clinical delivery system design;

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

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

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

NEW SECTION. **Sec. 6.** (1) The health care authority, in collaboration with the department of health, shall design and implement a medical home for chronically ill state employees enrolled in the

state's self-insured uniform medical plan. Programs must be evidence based, facilitating the use of information technology to improve quality of care and must improve coordination of primary, acute, and long-term care for those enrollees with multiple chronic conditions. The authority shall consider expansion of existing medical home and chronic care management programs. The authority shall use best practices in identifying those employees best served under a chronic care management model using predictive modeling through claims or other health risk information.

(2) For purposes of this section:

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

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

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

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

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

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

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

The department has the authority to collect the following fees from the parents or other responsible party of each infant screened for congenital disorders as defined by the state board of health under RCW 70.83.020:

(1) A fee as authorized under RCW 43.20B.020 sufficient to cover the cost of activities related to administering newborn screening requirements under RCW 70.83.020; and

(2) A fee of three dollars and fifty cents to fund specialty clinics that provide treatment services for those with the defined disorders.

The fee may be collected through the facility where the screening specimen is obtained.

COST AND QUALITY INFORMATION FOR CONSUMERS AND PROVIDERS

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

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

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

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

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

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

(5) Produce an annual quality report detailing clinical practice

patterns for purchasers, providers, insurers, and policy makers. The agencies shall report to the legislature by September 1, 2007.

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

(1) The administrator shall design and pilot a consumer-centric health information infrastructure and the first health record banks that will facilitate the secure exchange of health information when and where needed and shall:

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

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

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

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

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

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

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

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

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

(ii) Are immune from civil liability for any official acts performed in good faith as members of the board, stakeholder committee, or any advisory group.

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

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

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

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

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

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

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

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

(b) For all health care providers licensed under RCW 18.130.040, the cost of regulatory activities for retired volunteer medical worker licensees as provided in RCW 18.130.360; and

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

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

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

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

REDUCING UNNECESSARY EMERGENCY ROOM USE

Sec. 13. RCW 41.05.220 and 1998 c 245 s 38 are each amended to read as follows:

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

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

(3) In contracting with community health centers to provide primary health and dental services, migrant health services, and maternity health care services under subsection (1) of this section the authority shall give priority to those community health centers working with local hospitals, local community health collaboratives, and/or local public health jurisdictions to successfully reduce unnecessary emergency room use.

NEW SECTION. **Sec. 14.** The Washington state health care authority and the department of social and health services shall report to the legislature by December 1, 2007, on recent trends in unnecessary emergency room use by enrollees in state purchased health care programs that they administer and the uninsured, and then partner with community organizations and local health care providers to design a demonstration pilot to reduce such unnecessary visits.

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

In collaboration with the department of social and health services, the administrator shall provide all persons enrolled in health plans under this chapter and chapter 70.47 RCW with access to a twenty-four hour, seven day a week nurse hotline.

NEW SECTION. **Sec. 16.** A new section is added to chapter 74.09 RCW to read as follows:

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

REDUCE HEALTH CARE ADMINISTRATIVE COSTS

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

COVERAGE FOR DEPENDENTS TO AGE TWENTY-FIVE

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

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

(2) Any employee choosing under subsection (1) of this section to cover a dependent who is: (a) Age twenty through twenty-three and not a registered student at an accredited secondary school, college,

university, vocational school, or school of nursing; or (b) age twenty-four, shall be required to pay the full cost of such coverage.

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

NEW SECTION. **Sec. 19.** A new section is added to chapter 48.20 RCW to read as follows:

Any disability insurance contract that provides coverage for a subscriber's dependent must offer the option of covering any unmarried dependent under the age of twenty-five.

NEW SECTION. **Sec. 20.** A new section is added to chapter 48.21 RCW to read as follows:

Any group disability insurance contract or blanket disability insurance contract that provides coverage for a participating member's dependent must offer each participating member the option of covering any unmarried dependent under the age of twenty-five.

NEW SECTION. **Sec. 21.** A new section is added to chapter 48.44 RCW to read as follows:

(1) Any individual health care service plan contract that provides coverage for a subscriber's dependent must offer the option of covering any unmarried dependent under the age of twenty-five.

(2) Any group health care service plan contract that provides coverage for a participating member's dependent must offer each participating member the option of covering any unmarried dependent under the age of twenty-five.

NEW SECTION. **Sec. 22.** A new section is added to chapter 48.46 RCW to read as follows:

(1) Any individual health maintenance agreement that provides coverage for a subscriber's dependent must offer the option of covering any unmarried dependent under the age of twenty-five.

(2) Any group health maintenance agreement that provides coverage for a participating member's dependent must offer each participating member the option of covering any unmarried dependent under the age of twenty-five.

SUSTAINABILITY AND ACCESS TO PUBLIC PROGRAMS

NEW SECTION. **Sec. 23.** (1) The department of social and health services shall develop a series of options that require federal waivers and state plan amendments to expand coverage and leverage federal and state resources for the state's basic health program, for the medical assistance program, as codified at Title XIX of the federal social security act, and the state's children's health insurance program, as codified at Title XXI of the federal social security act. The department shall propose options including but not limited to:

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

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

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

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

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

program shall be given to those who disenrolled from the program in order to enroll in medicaid, and subsequently became ineligible for medicaid coverage.

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

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

REINSURANCE

NEW SECTION. **Sec. 25.** (1) The office of financial management, in collaboration with the office of the insurance commissioner, shall evaluate options and design a state-supported reinsurance program to address the impact of high cost enrollees in the individual and small group health insurance markets, and submit implementing legislation and supporting information, including financing options, to the governor and the legislature by December 1, 2007. In designing the program, the office of financial management shall:

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

(b) Identify all relevant design issues and alternative options for each issue. At a minimum, the evaluation shall examine (i) a reinsurance corridor of ten thousand dollars to ninety thousand dollars, and a reimbursement of ninety percent; (ii) the impacts of providing reinsurance for all small group products or a subset of products; and (iii) the applicability of a chronic care program such as

the approach used by the department of labor and industries with the centers of occupational health and education. Where quantitative impacts cannot be estimated, the office of financial management shall assess qualitative impacts of design issues and their options, including potential disincentives for reducing premiums, achieving premium stability, sustaining/increasing take-up, decreasing the number of uninsured, and managing government's stop-loss insurance costs;

(c) Identify market and regulatory changes needed to maximize the chance of the program achieving its policy goals, including how the program will relate to other coverage programs and markets. Design efforts shall coordinate with other design efforts targeting small group programs that may be directed by the legislature, as well as other approaches examining alternatives to managing risk;

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

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

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

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

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

THE WASHINGTON STATE HEALTH INSURANCE POOL AND THE BASIC HEALTH PLAN

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

(1) The pool shall offer one or more care management plans of coverage. Such plans may, but are not required to, include point of service features that permit participants to receive in-network

benefits or out-of-network benefits subject to differential cost shares. ((~~Covered persons enrolled in the pool on January 1, 2001, may continue coverage under the pool plan in which they are enrolled on that date. However,~~)) The pool may incorporate managed care features and encourage enrollees to participate in chronic care and disease management and evidence-based protocols into ((~~such~~)) existing plans.

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

(3) The health insurance ((~~policy~~)) policies issued by the pool shall pay only reasonable amounts for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of covered illnesses, injuries, and conditions ((~~which are not otherwise limited or excluded~~)). Eligible expenses are the reasonable amounts for the health care services and items for which benefits are extended under ((~~the~~)) a pool policy. ((~~Such benefits shall at minimum include, but not be limited to, the following services or related items:~~))

(4) The pool shall offer at least one policy which at a minimum includes, but is not limited to, the following services or related items:

(a) Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, but limited to a total of one hundred eighty inpatient days in a calendar year, and limited to thirty days inpatient care for mental and nervous conditions, or alcohol, drug, or chemical dependency or abuse per calendar year;

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

(c) The first twenty outpatient professional visits for the diagnosis or treatment of one or more mental or nervous conditions or alcohol, drug, or chemical dependency or abuse rendered during a calendar year by one or more physicians, psychologists, or community

mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners, in the case of mental or nervous conditions, and rendered by a state certified chemical dependency program approved under chapter 70.96A RCW, in the case of alcohol, drug, or chemical dependency or abuse;

(d) Drugs and contraceptive devices requiring a prescription;

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

(f) Services of a home health agency;

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

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

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

(l) Diagnostic x-rays and laboratory tests;

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

(n) Maternity care services;

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

(p) Hospice services;

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

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

((~~(4)~~)) (5) The pool shall offer at least one policy which closely adheres to benefits available in the private, individual market.

(6) The board shall design and employ cost containment measures and

requirements such as, but not limited to, care coordination, provider network limitations, preadmission certification, and concurrent inpatient review which may make the pool more cost-effective.

((~~(5)~~)) (7) The pool benefit policy may contain benefit limitations, exceptions, and cost shares such as copayments, coinsurance, and deductibles that are consistent with managed care products, except that differential cost shares may be adopted by the board for nonnetwork providers under point of service plans. ((~~The pool benefit policy cost shares and limitations must be consistent with those that are generally included in health plans approved by the insurance commissioner; however,~~)) No limitation, exception, or reduction may be used that would exclude coverage for any disease, illness, or injury.

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

((~~(7)~~)) (9)(a) Except as provided in (b) of this subsection, the pool shall credit any preexisting condition waiting period in its plans for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the new pool plan. For the person previously enrolled in a group health benefit plan, the pool must credit the aggregate of all periods of preceding coverage not separated by more than sixty-three days toward the waiting period of the new health plan. For the person previously enrolled in an individual health benefit plan other than a catastrophic health plan, the pool must credit the period of coverage the person was continuously covered under the immediately preceding health plan toward

the waiting period of the new health plan. For the purposes of this subsection, a preceding health plan includes an employer-provided self-funded health plan.

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

((~~(8)~~)) (10) If an application is made for the pool policy as a result of rejection by a carrier, then the date of application to the carrier, rather than to the pool, should govern for purposes of determining preexisting condition credit.

(11) The pool shall contract with organizations that provide care management that has been demonstrated to be effective and shall encourage enrollees who are eligible for care management services to participate.

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

(1) ((~~A pool policy offered under this chapter shall contain provisions under which the pool is obligated to renew the policy until the day on which the individual in whose name the policy is issued first becomes eligible for medicare coverage. At that time, coverage of dependents shall terminate if such dependents are eligible for coverage under a different health plan. Dependents who become eligible for medicare prior to the individual in whose name the policy is issued, shall receive benefits in accordance with RCW 48.41.150~~)) On or before December 31, 2007, the pool shall cancel all existing pool policies and replace them with policies that are identical to the existing policies except for the inclusion of a provision providing for a guarantee of the continuity of coverage consistent with this section.

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

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

(a) Nonpayment of premium;

(b) Violation of published policies of the pool;

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

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

(e) Covered persons committing fraudulent acts as to the pool;

(f) Covered persons materially breaching the pool policy; or

(g) Changes adopted to federal or state laws when such changes no longer permit the continued offering of such coverage.

(4)(a) The guarantee of continuity of coverage provided by this section requires that if the pool replaces a plan, it must make the replacement plan available to all individuals in the plan being replaced. The replacement plan must include all of the services covered under the replaced plan, through unreasonable cost-sharing requirements or otherwise. The pool may also allow individuals who are covered by a plan that is being replaced an unrestricted right to transfer to a fully comparable plan.

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

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

(i) The cost and quality of care to pool enrollees;

(ii) Pool financing and enrollment;

(iii) The board's ability to offer comprehensive and other plans to its enrollees;

(iv) Other items identified by the board.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Washington state health insurance pool account is created in the custody of the state treasurer. All receipts from moneys specifically appropriated to the account must be deposited in the account. Expenditures from this account shall be used to cover deficits incurred by the Washington state health insurance pool under this chapter in excess of the threshold established in this section. To the extent funds are available in the account, funds shall be expended from the account to offset that portion of the deficit that would otherwise have to be recovered by imposing an assessment on members in excess of a threshold of seventy cents per insured person per month. The commissioner shall authorize expenditures from the account, to the extent that funds are available in the account, upon

certification by the pool board that assessments will exceed the threshold level established in this section. The account is subject to the allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

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

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

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

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

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

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

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

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

(a) Any person having terminated coverage in the pool unless (i) twelve months have lapsed since termination, or (ii) that person can show continuous other coverage which has been involuntarily terminated for any reason other than nonpayment of premiums. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) "Catastrophic health plan" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

(i) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(j) Employer-sponsored self-funded health plans;

(k) Dental only and vision only coverage; and

(l) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Encourages competition among insuring entities;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Facilitate diagnosis or treatment;

(ii) Reduce unnecessary duplication of medical tests;

(iii) Promote efficient electronic physician order entry;

(iv) Increase access to health information for consumers and their providers; and

(v) Improve health outcomes;

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

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

Sec. 35. RCW 48.43.018 and 2004 c 244 s 3 are each amended to read as follows:

(1) Except as provided in (a) through (e) of this subsection, a health carrier may require any person applying for an individual health benefit plan to complete the standard health questionnaire designated under chapter 48.41 RCW.

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

(b) If a person is seeking an individual health benefit plan:

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

(ii) His or her health care provider is part of another carrier's provider network; and

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

(c) If a person is seeking an individual health benefit plan due to his or her having exhausted continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of exhaustion of continuation coverage. A health carrier shall accept an application without a standard health questionnaire from a person currently covered by such continuation coverage if application is made within ninety days prior to the date the continuation coverage would be exhausted and the effective date of the individual coverage applied for is the date the continuation coverage would be exhausted, or within ninety days thereafter.

(d) If a person is seeking an individual health benefit plan due to his or her receiving notice that his or her coverage under a conversion contract is discontinued, completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of discontinuation of eligibility under the conversion contract. A health carrier shall accept an application without a standard health questionnaire from a person currently covered by such conversion contract if application is made within ninety days prior to the date eligibility under the conversion contract would be discontinued and the effective date of the individual coverage applied for is the date eligibility under the conversion contract would be discontinued, or within ninety days thereafter.

(e) If a person is seeking an individual health benefit plan and, but for the number of persons employed by his or her employer, would have qualified for continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of the standard health questionnaire shall not be a condition of coverage if: (i) Application for coverage is made within ninety days of a qualifying event as defined in 29 U.S.C. Sec. 1163; and (ii) the person had at least twenty-four months of continuous group coverage immediately prior to the qualifying event. A health carrier shall accept an application without a standard health

questionnaire from a person with at least twenty-four months of continuous group coverage if application is made no more than ninety days prior to the date of a qualifying event and the effective date of the individual coverage applied for is the date of the qualifying event, or within ninety days thereafter.

(f) Completion of the standard health questionnaire shall not be a condition of coverage if: (i) Application for coverage is made within ninety days of disenrollment from the basic health plan under chapter 70.47 RCW; and (ii) the person had at least twenty-four months of continuous basic health plan coverage immediately prior to disenrollment. A health carrier shall accept an application without a standard health questionnaire from a person with at least twenty-four months of continuous basic health plan coverage if application is made no more than ninety days prior to the date of disenrollment and the effective date of the individual coverage applied for is the date of disenrollment, or within ninety days thereafter.

(g) If a person is seeking an individual health benefit plan following enrollment in a plan sponsored by the federal government or church or church-related organization that is exempt from continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of the standard health questionnaire shall not be a condition of coverage if: (i) Application for coverage is made within ninety days of a qualifying event as defined in 29 U.S.C. Sec. 1163; and (ii) the person had at least twenty-four months of continuous group coverage immediately prior to the qualifying event. A health carrier shall accept an application without a standard health questionnaire from a person with at least twenty-four months of continuous group coverage if application is made no more than ninety days prior to the date of a qualifying event and the effective date of the individual coverage applied for is the date of the qualifying event, or within ninety days thereafter.

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

(a) The carrier may decide not to accept the person's application for enrollment in its individual health benefit plan; and

(b) Within fifteen business days of receipt of a completed application, the carrier shall provide written notice of the decision not to accept the person's application for enrollment to both the

person and the administrator of the Washington state health insurance pool. The notice to the person shall state that the person is eligible for health insurance provided by the Washington state health insurance pool, and shall include information about the Washington state health insurance pool and an application for such coverage. If the carrier does not provide or postmark such notice within fifteen business days, the application is deemed approved.

(3) If the person applying for an individual health benefit plan: (a) Does not qualify for coverage under the Washington state health insurance pool based upon the results of the standard health questionnaire; (b) does qualify for coverage under the Washington state health insurance pool based upon the results of the standard health questionnaire and the carrier elects to accept the person for enrollment; or (c) is not required to complete the standard health questionnaire designated under this chapter under subsection (1)(a) or (b) of this section, the carrier shall accept the person for enrollment if he or she resides within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The commissioner may grant a temporary exemption from this subsection if, upon application by a health carrier, the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a health carrier is required to continue enrollment of additional eligible individuals.

Sec. 36. RCW 70.47.020 and 2005 c 188 s 2 are each amended to read as follows:

As used in this chapter:

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

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

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

(4) "Health coverage tax credit eligible enrollee" means individual workers and their qualified family members who lose their jobs due to the effects of international trade and are eligible for certain trade adjustment assistance benefits; or are eligible for benefits under the alternative trade adjustment assistance program; or are people who receive benefits from the pension benefit guaranty corporation and are at least fifty-five years old.

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

(6) "Subsidized enrollee" means:

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

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

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

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

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

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

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

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

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

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

(8) "Subsidy" means the difference between the amount of periodic payment the administrator makes to a managed health care system on behalf of a subsidized enrollee plus the administrative cost to the

plan of providing the plan to that subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

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

(10) "Rate" means the amount, negotiated by the administrator with and paid to a participating managed health care system, that is based upon the enrollment of subsidized, nonsubsidized, and health coverage tax credit eligible enrollees in the plan and in that system.

Sec. 37. RCW 70.47.060 and 2006 c 343 s 9 are each amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be necessary for basic health care. In addition, the administrator may, to the extent that funds are available, offer as basic health plan services chemical dependency services, mental health services and organ transplant services; however, no one service or any combination of these three services shall increase the actuarial value of the basic health plan benefits by more than five percent excluding inflation, as determined by the office of financial management. All subsidized and nonsubsidized enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive covered basic health care services in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care and shall include all services necessary for prenatal, postnatal, and well-child care. However, with respect to coverage for subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the

managed care provider. The schedule of services shall also include a separate schedule of basic health care services for children, eighteen years of age and younger, for those subsidized or nonsubsidized enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.47.030, and such other factors as the administrator deems appropriate.

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

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

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

((~~(c)~~)) (d) To determine the periodic premiums due the administrator from health coverage tax credit eligible enrollees. Premiums due from health coverage tax credit eligible enrollees must be in an amount equal to the cost charged by the managed health care system provider to the state for the plan, plus the administrative cost

of providing the plan to those enrollees and the premium tax under RCW 48.14.0201. The administrator will consider the impact of eligibility determination by the appropriate federal agency designated by the Trade Act of 2002 (P.L. 107-210) as well as the premium collection and remittance activities by the United States internal revenue service when determining the administrative cost charged for health coverage tax credit eligible enrollees.

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

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

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

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

(5) To design and implement a structure of enrollee cost-sharing due a managed health care system from subsidized, nonsubsidized, and health coverage tax credit eligible enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, and may utilize copayments, deductibles, and other cost-sharing

mechanisms, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(6) To limit enrollment of persons who qualify for subsidies so as to prevent an overexpenditure of appropriations for such purposes. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment until the administrator finds the danger no longer exists. Such a closure does not apply to health coverage tax credit eligible enrollees who receive a premium subsidy from the United States internal revenue service as long as the enrollees qualify for the health coverage tax credit program.

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

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

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

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

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

(12) To accept applications from business owners on behalf of themselves and their employees, spouses, and dependent children, as subsidized or nonsubsidized enrollees, who reside in an area served by the plan. The administrator may require all or the substantial majority of the eligible employees of such businesses to enroll in the plan and establish those procedures necessary to facilitate the orderly enrollment of groups in the plan and into a managed health care system. The administrator may require that a business owner pay at least an amount equal to what the employee pays after the state pays its portion of the subsidized premium cost of the plan on behalf of each employee enrolled in the plan. Enrollment is limited to those not eligible for medicare who wish to enroll in the plan and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. The administrator shall adjust the amount determined to be due on behalf of or from all such enrollees whenever the amount negotiated by the administrator with the participating managed health care system or systems is modified or the administrative cost of providing the plan to such enrollees changes.

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

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

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

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

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

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

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

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

Sec. 38. RCW 48.43.018 and 2004 c 244 s 3 are each amended to read as follows:

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

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

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

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

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

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

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

(d) If a person is seeking an individual health benefit plan or enrollment in the basic health plan as a nonsubsidized enrollee due to his or her receiving notice that his or her coverage under a conversion contract is discontinued, completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of discontinuation of eligibility under the conversion contract. A health carrier or the health care authority as administrator of basic health plan nonsubsidized coverage shall accept an application without a standard health questionnaire from a person currently covered by such conversion contract if application is made within ninety days prior to the date eligibility

under the conversion contract would be discontinued and the effective date of the individual coverage applied for is the date eligibility under the conversion contract would be discontinued, or within ninety days thereafter.

(e) If a person is seeking an individual health benefit plan or enrollment in the basic health plan as a nonsubsidized enrollee and, but for the number of persons employed by his or her employer, would have qualified for continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of the standard health questionnaire shall not be a condition of coverage if: (i) Application for coverage is made within ninety days of a qualifying event as defined in 29 U.S.C. Sec. 1163; and (ii) the person had at least twenty-four months of continuous group coverage immediately prior to the qualifying event. A health carrier or the health care authority as administrator of basic health plan nonsubsidized coverage shall accept an application without a standard health questionnaire from a person with at least twenty-four months of continuous group coverage if application is made no more than ninety days prior to the date of a qualifying event and the effective date of the individual coverage applied for is the date of the qualifying event, or within ninety days thereafter.

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

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

(b) Within fifteen business days of receipt of a completed application, the carrier or the health care authority as administrator of basic health plan nonsubsidized coverage shall provide written notice of the decision not to accept the person's application for enrollment to both the person and the administrator of the Washington state health insurance pool. The notice to the person shall state that the person is eligible for health insurance provided by the Washington state health insurance pool, and shall include information about the Washington state health insurance pool and an application for such coverage. If the carrier or the health care authority as administrator

of basic health plan nonsubsidized coverage does not provide or postmark such notice within fifteen business days, the application is deemed approved.

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

Sec. 39. RCW 43.70.670 and 2003 c 274 s 2 are each amended to read as follows:

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

(2) The department of health may pay for health insurance coverage on behalf of persons with human immunodeficiency virus, who meet department eligibility requirements, and who are eligible for

"continuation coverage" as provided by the federal consolidated omnibus budget reconciliation act of 1985, group health insurance policies, or individual policies. ((~~The number of insurance policies supported by this program in the Washington state health insurance pool as defined in RCW 48.41.030(18) shall not grow beyond the July 1, 2003, level.~~))

PREVENTION AND HEALTH PROMOTION

NEW SECTION. **Sec. 40.** (1) The Washington state health care authority, the department of social and health services, the department of labor and industries, and the department of health shall, by September 1, 2007, develop a five-year plan to integrate disease and accident prevention and health promotion into state purchased health programs that they administer by:

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

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

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

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

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

Sec. 41. RCW 41.05.540 and 2005 c 360 s 8 are each amended to read as follows:

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

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

(2) The state employee health program shall:

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 42.** A new section is added to chapter 41.05 RCW to read as follows:

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

(2) Agency demonstration project employee health programs:

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

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

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

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

(3) The state employee health program shall evaluate each of the four programs separately and compare outcomes for each of them with the entire state employee population to assess effectiveness of the programs. Specifically, the program shall measure at least the following outcomes in the demonstration population: The reduction in the percent of the population that is overweight or obese, the reduction in risk factors related to diabetes, the reduction in risk factors related to absenteeism, the reduction in tobacco consumption, and the increase in appropriate use of preventive health services. The

state employee health program shall report to the legislature in December 2008 and December 2010 on the demonstration project.

(4) This section expires June 30, 2011.

PRESCRIPTION MONITORING PROGRAM

NEW SECTION. **Sec. 43.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

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

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

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

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

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

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

NEW SECTION. **Sec. 44.** (1) To the extent that funding is available through federal or private grants, or is appropriated by the legislature, the authority shall establish and maintain a web-based interactive prescription monitoring program to monitor the prescribing and dispensing of all Schedules II, III, IV, and V controlled substances and any additional drugs identified by the board of pharmacy as demonstrating a potential for abuse by all professionals licensed to prescribe or dispense such substances in this state. The program shall be designed to improve health care quality and effectiveness by reducing abuse of controlled substances, reducing duplicative prescribing and over-prescribing of controlled substances, and improving controlled substance prescribing practices. As much as possible, the authority should establish a common database with other states.

(2) Except as provided in subsection (5) of this section, each dispenser shall submit to the authority by electronic means information

regarding each prescription dispensed for a drug included under subsection (1) of this section. Drug prescriptions for more than immediate one day use should be immediately reported. The information submitted for each prescription shall include, but not be limited to:

(a) Patient identifier;

(b) Drug dispensed;

(c) Date of dispensing;

(d) Quantity dispensed;

(e) Prescriber; and

(f) Dispenser.

(3) Each dispenser shall immediately submit the information in accordance with transmission methods established by the authority.

(4) The authority may issue a waiver to a dispenser that is unable to submit prescription information by electronic means; however, all dispensers shall be required to submit prescription information by electronic means within one year from the effective date of this section. The waiver may permit the dispenser to submit prescription information by paper form or other means, provided all information required in subsection (2) of this section is submitted in this alternative format.

(5) The data submission requirements of this section do not apply to:

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

(b) Pharmacies operated by the department of corrections for the purpose of providing medications to offenders in prison or in a work release program that is receiving pharmaceutical services from a department of corrections pharmacy.

(6) The authority shall seek federal grants to support the activities described in this act. As state and federal funds are available, the authority shall develop and implement the prescription monitoring program. The authority may not require a practitioner or a pharmacist to pay a fee or tax specifically dedicated to the operation of the system.

(7) To the extent that funding is available through federal or private grants, or is appropriated by the legislature, the authority shall submit an implementation plan to the legislature within six months of receipt of funding under this subsection that builds upon the web-based interactive prescription monitoring program established in this chapter. The plan shall expand the information included in the prescription drug monitoring program to include information related to all legend drugs, as defined in RCW 69.41.010(12), dispensed or paid for through fee-for-service or managed care contracting, on behalf of persons receiving health care services through state-purchased health care programs administered by the authority, the department of social and health services, the department of labor and industries, and the department of corrections. The implementation plan shall be designed to improve the quality of state-purchased health services by reducing legend drug abuse, reducing duplicative prescribing and over-prescribing of legend drugs, and improving legend drug prescribing practices. The implementation plan shall include mechanisms that will allow persons authorized to prescribe or dispense controlled substances to query the web-based interactive prescription monitoring program and obtain timely information regarding legend drug utilization history of persons for whom they are providing medical or pharmaceutical care when such persons are receiving health services through the programs included in this subsection.

NEW SECTION. **Sec. 45.** (1) Prescription information submitted to the authority shall be confidential, in compliance with chapter 70.02 RCW and federal health care information privacy requirements and not subject to disclosure, except as provided in subsections (3), (4), and (5) of this section.

(2) The authority shall maintain procedures to ensure that the privacy and confidentiality of patients and patient information collected, recorded, transmitted, and maintained is not disclosed to persons except as in subsections (3), (4), and (5) of this section.

(3) The authority shall review the prescription information. The authority shall notify the practitioner and allow explanation or correction of any problem. If there is reasonable cause to believe a violation of law or breach of professional standards may have occurred,

the authority shall notify the appropriate law enforcement or professional licensing, certification, or regulatory agency or entity, and provide prescription information required for an investigation.

(4) The authority may provide data in the prescription monitoring program to the following persons:

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

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

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

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

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

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

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

(h) Personnel of the department of health for purposes of administration and enforcement of this chapter or chapter 69.50 RCW.

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

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

NEW SECTION. **Sec. 46.** The authority may contract with another agency of this state or with a private vendor, as necessary, to ensure the effective operation of the prescription monitoring program. Any contractor is bound to comply with the provisions regarding confidentiality of prescription information in section 45 of this act

and is subject to the penalties specified in section 48 of this act for unlawful acts.

NEW SECTION. **Sec. 47.** The authority shall adopt rules to implement this chapter.

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

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

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

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

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

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

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

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

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

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

(ii) If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this subsection (1)(d) as exempt from disclosure;

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

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

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

(g) Complaints filed under chapter 18.130 RCW after July 27, 1997, to the extent provided in RCW 18.130.095(1)<u>; and</u>

<u>(h) Information obtained by the health care authority under chapter 41.-- RCW (sections 43 through 48 of this act)</u>.

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

STRATEGIC HEALTH PLANNING

<u>NEW SECTION.</u> **Sec. 50.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Health care provider" means an individual who holds a license issued by a disciplining authority identified in RCW 18.130.040 and who

practices his or her profession in a health care facility or provides a health service.

(2) "Health facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers, ambulatory diagnostic, treatment, or surgical facilities, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision, including a public hospital district, or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

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

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

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

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

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

(2) The office shall:

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

(b) Develop a computerized system for accessing, analyzing, and disseminating data relevant to strategic health planning

responsibilities. The office may contract with an organization to create the computerized system capable of meeting the needs of the office;

(c) Maintain access to deidentified data collected and stored by any public and private organizations as necessary to support its planning responsibilities, including state-purchased health care program data, hospital discharge data, and private efforts to collect utilization and claims-related data. The office is authorized to enter into any data sharing agreements and contractual arrangements necessary to obtain data or to distribute data. Among the sources of deidentified data that the office may access are any databases established pursuant to the recommendations of the health information infrastructure advisory board established by chapter 261, Laws of 2005. The office may store limited data sets as necessary to support its activities. Unless specifically authorized, the office shall not collect data directly from the records of health care providers and health care facilities, but shall make use of databases that have already collected such information; and

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

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

NEW SECTION. **Sec. 52.** (1) The office, in consultation with the technical advisory committee established under section 51 of this act, shall develop a statewide health resources strategy. The strategy shall establish statewide health planning policies and goals related to

the availability of health care facilities and services, quality of care, and cost of care. The strategy shall identify needs according to geographic regions suitable for comprehensive health planning as designated by the office.

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

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

(b) That the development and ongoing maintenance of current and accurate health care information and statistics related to cost and quality of health care, as well as projections of need for health facilities and services, are essential to effective strategic health planning.

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

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

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

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

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

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

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

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

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

(c) A health care data resource plan that identifies data elements necessary to properly conduct planning activities and to review certificate of need applications, including data related to inpatient and outpatient utilization and outcomes information, and financial and utilization information related to charity care, quality, and cost. The plan shall inventory existing data resources, both public and private, that store and disclose information relevant to the health planning process, including information necessary to conduct certificate of need activities pursuant to chapter 70.38 RCW. The plan shall identify any deficiencies in the inventory of existing data resources and the data necessary to conduct comprehensive health planning activities. The plan may recommend that the office be authorized to access existing data sources and conduct appropriate analyses of such data or that other agencies expand their data collection activities as statutory authority permits. The plan may identify any computing infrastructure deficiencies that impede the proper storage, transmission, and analysis of health planning data. The plan shall provide recommendations for increasing the availability of data related to health planning to provide greater community involvement in the health planning process and consistency in data used for certificate of need applications and determinations;

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

(e) A rural health resource plan to assess the availability of health resources in rural areas of the state, assess the unmet needs of these communities, and evaluate how federal and state reimbursement policies can be modified, if necessary, to more efficiently and effectively meet the health care needs of rural communities. The plan

shall consider the unique health care needs of rural communities, the adequacy of the rural health workforce, and transportation needs for accessing appropriate care.

(4) The office shall submit the initial strategy to the governor by January 1, 2010. Every two years the office shall submit an updated strategy. The health care facilities and services plan as it pertains to a distinct geographic planning region may be updated by individual categories on a rotating, biannual schedule.

(5) The office shall hold at least one public hearing and allow opportunity to submit written comments prior to the issuance of the initial strategy or an updated strategy. A public hearing shall be held prior to issuing a draft of an updated health care facilities and services plan, and another public hearing shall be held before final adoption of an updated health care facilities and services plan. Any hearing related to updating a health care facilities and services plan for a specific planning region shall be held in that region with sufficient notice to the public and an opportunity to comment.

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

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

(2) Data elements related to the identification of individual patient's, provider's, and facility's care outcomes are confidential, are exempt from RCW 42.56.030 through 42.56.570 and 42.17.350 through

42.17.450, and are not subject to discovery by subpoena or admissible as evidence.

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

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

(1) That strategic health planning ((~~to~~)) efforts must be supported by appropriately tailored regulatory activities that can effectuate the goals and principles of the statewide health resources strategy developed pursuant to chapter 43.-- RCW (sections 50 through 54 of this act). The implementation of the strategy can promote, maintain, and assure the health of all citizens in the state, ((~~to~~)) provide accessible health services, health manpower, health facilities, and other resources while controlling ((~~excessive~~)) increases in costs, and ((~~to~~)) recognize prevention as a high priority in health programs((~~, is essential to the health, safety, and welfare of the people of the state. Health planning should be responsive to changing health and social needs and conditions~~)). Involvement in health planning from both consumers and providers throughout the state should be encouraged;

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

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

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

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

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

(2) Effective January 1, 2010, for those facilities and services covered by the certificate of need programs, certificate of need determinations must be consistent with the statewide health resources strategy developed pursuant to section 52 of this act, including any health planning policies and goals identified in the statewide health resources strategy in effect at the time of application. The department may waive specific terms of the strategy if the applicant demonstrates that consistency with those terms will create an undue burden on the population that a particular project would serve, or in emergency circumstances which pose a threat to public health.

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

The secretary shall have authority to:

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

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

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

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

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

(c) Promulgate rules in implementation of the provisions of this chapter, including the establishment of procedures for public hearings

for predecisions and post-decisions on applications for certificate of need;

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

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

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

NEW SECTION. **Sec. 58.** RCW 70.38.919 (Effective date--State health plan--1989 1st ex.s. c 9) and 1989 1st ex.s. c 9 s 610 are each repealed.

NEW SECTION. **Sec. 59.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 60.** Sections 43 through 48 of this act constitute a new chapter in Title 41 RCW.

NEW SECTION. **Sec. 61.** Sections 50 through 54 of this act constitute a new chapter in Title 43 RCW.

NEW SECTION. **Sec. 62.** Subheadings used in this act are not any part of the law.

NEW SECTION. **Sec. 63.** Sections 18 through 22 of this act take effect January 1, 2008.

NEW SECTION. **Sec. 64.** If specific funding for the purposes of the following sections of this act, referencing the section of this act by

bill or chapter number and section number, is not provided by June 30, 2007, in the omnibus appropriations act, the section is null and void:

(1) Section 2 of this act;

(2) Section 9 of this act (Washington state quality forum);

(3) Section 10 of this act (health records banking pilot project);

(4) Section 14 of this act;

(5) Section 42 of this act (state employee health demonstration project);

(6) Sections 50 through 57 of this act."

Correct the title.

--- END ---