

2SSB 5930 - S AMD 131
By Senator Keiser

WITHDRAWN 03/09/2007

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

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

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

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

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

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

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

16 (5) Direct enrollees to quality care systems;

17 (6) Better support primary care and provide a medical home to all
18 enrollees; and

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

21 The plan shall identify any existing barriers and opportunities to
22 support implementation, including needed changes to state or federal
23 law and be submitted to the governor and the legislature upon
24 completion.

25 NEW SECTION. **Sec. 2.** The legislature finds that unwarranted
26 variations in health care, variations not explained by illness, patient
27 preference, or the dictates of evidence-based medicine, are a
28 significant feature of health care in Washington state. There is

1 growing evidence that, for preference-sensitive care involving elective
2 surgery, the quality of patient-practitioner communication about the
3 benefits, harms, and uncertainty of available treatment options can be
4 improved by introducing high-quality decision aids that encourage
5 shared decision making. The international patient decision aid
6 standards collaboration, a network of over one hundred researchers,
7 practitioners, patients, and policy makers from fourteen countries,
8 have developed standards for constructing high-quality decision aids.
9 The legislature declares an intent to focus on improving the quality of
10 patient-practitioner communication and on increasing the extent to
11 which patients make genuinely informed, preference-based treatment
12 decisions. Randomized clinical trial evidence indicates that effective
13 use of well designed decision aids is likely to improve the quality of
14 patient decision making, reduce unwarranted variations in health care,
15 and result in lower health care costs overall. Despite this growing
16 body of evidence, widespread use of decision aids has yet to occur.
17 Barriers include: (1) Lack of awareness of existing, appropriate,
18 high-quality decision aids; (2) poor accessibility to such decision
19 aids; (3) low practitioner acceptance of decision aids in terms of
20 compatibility with their practice, ease of use, and expense to
21 incorporate into practice; (4) lack of incentives for use, such as
22 reduced liability and reimbursement for their use; and (5) lack of a
23 process to certify that a decision aid meets the standards required of
24 a high-quality decision aid. The legislature intends to promote new
25 public/private collaborative efforts to broaden the development, use,
26 evaluation, and certification of effective decision aids and intends to
27 support the collaborative through providing new recognition of the
28 shared decision-making process and patient decision aids in the state's
29 laws on informed consent. The legislature also intends to establish a
30 process for certifying that a given decision aid meets the standards
31 required for a high-quality decision aid.

32 NEW SECTION. **Sec. 3.** The state health care authority shall work
33 in collaboration with the health professions and quality improvement
34 communities to increase awareness of appropriate, high-quality decision
35 aids, and to train physicians and other practitioners in their use.
36 The effort shall focus on one or more of the preference-sensitive
37 conditions with high rates of unwarranted variation in Washington, and

1 can include strategies such as prominent linkage to such decision aids
2 in state web sites, and training/awareness programs in conjunction with
3 professional and quality improvement groups. The state health care
4 authority shall, in consultation with the national committee for
5 quality assurance, identify a certification process for patient
6 decision aids. The state health care authority may accept donations or
7 grants to support such efforts.

8 NEW SECTION. **Sec. 4.** The state health care authority shall work
9 with contracting health carriers and health care providers, and a
10 nonproprietary public interest research group and/or university-based
11 research group, to implement practical and usable models to demonstrate
12 shared decision making in everyday clinical practice. The
13 demonstrations shall be conducted at one or more multispecialty group
14 practice sites providing state purchased health care in the state of
15 Washington, and may include other practice sites providing state
16 purchased health care. The demonstrations must include the following
17 elements: Incorporation into clinical practice of one or more decision
18 aids for one or more identified preference-sensitive care areas
19 combined with ongoing training and support of involved practitioners
20 and practice teams, preferably at sites with necessary supportive
21 health information technology. The evaluation must include the
22 following elements: (1) A comparison between the demonstration sites
23 and, if appropriate, between the demonstration sites and a control
24 group, of the impact of the shared decision-making process employing
25 the decision aids on: The use of preference-sensitive health care
26 services; and associated costs saved and/or expended; and (2) an
27 assessment of patient knowledge of the relevant health care choices,
28 benefits, harms, and uncertainties; concordance between patient values
29 and care received; and satisfaction with the decision-making process
30 and their health outcomes by patients and involved physicians and other
31 health care practitioners. The health care authority may solicit and
32 accept funding to support the demonstration and evaluation.

33 **Sec. 5.** RCW 7.70.060 and 1975-'76 2nd ex.s. c 56 s 11 are each
34 amended to read as follows:

35 (1) If a patient while legally competent, or his or her
36 representative if he or she is not competent, signs a consent form

1 which sets forth the following, the signed consent form shall
2 constitute prima facie evidence that the patient gave his or her
3 informed consent to the treatment administered and the patient has the
4 burden of rebutting this by a preponderance of the evidence:

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

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

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

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

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

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

18 (2) If a patient while legally competent, or his or her
19 representative if he or she is not competent, signs an acknowledgement
20 of shared decision making as described in subsection (3) of this
21 section, such acknowledgement shall constitute prima facie evidence
22 that the patient gave his or her informed consent to the treatment
23 administered and the patient has the burden of rebutting this by clear
24 and convincing evidence. An acknowledgement of shared decision making
25 shall include:

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

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

32 (c) A brief description of the patient decision aid or aids that
33 have been used by the patient and provider to address the needs for (i)
34 high-quality, up-to-date information about the condition, including
35 risk and benefits of available options and, if appropriate, a
36 discussion of the limits of scientific knowledge about outcomes; (ii)
37 values clarification to help patients sort out their values and

1 preferences; and (iii) guidance or coaching in deliberation, designed
2 to improve the patient's involvement in the decision process;

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

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

12 (3) "Shared decision making" means a process in which the physician
13 or other health care practitioner discusses with the patient or his or
14 her representative the information specified in subsection (1)(a) of
15 this section, with or without the use of a patient decision aid, and
16 the patient shares with the provider such relevant personal information
17 as might make one treatment or side effect more or less tolerable than
18 others. The goal of shared decision making is for the patient and
19 physician or other health care practitioner to feel they appropriately
20 understand the nature of the procedure, the risks and benefits, as well
21 as the individual values and preferences that influence the treatment
22 decision, such that both are willing to sign a statement acknowledging
23 that they have engaged in shared decision making and setting forth the
24 agreed treatment to be furnished.

25 (4) "Patient decision aid" means a written, audio-visual, or online
26 tool that provides a balanced presentation of the condition and
27 treatment options, benefits, and harms, including, if appropriate, a
28 discussion of the limits of scientific knowledge about outcomes, and
29 that is certified by one or more national certifying organizations
30 approved by the health care authority. In order to be an approved
31 national certifying organization, an organization must use a rigorous
32 evaluation process to assure that decision aids are competently
33 developed, provide a balanced presentation of treatment options,
34 benefits, and harms, and are efficacious at improving decision making.

35 (5) Failure to use a form or to engage in shared decision making,
36 with or without the use of a patient decision aid, shall not be
37 admissible as evidence of failure to obtain informed consent. There
38 shall be no liability, civil or otherwise, resulting from a health care

1 provider choosing either the signed consent form set forth in
2 subsection (1)(a) of this section or the signed acknowledgement of
3 shared decision making as set forth in subsection (2) of this section.

4 **PREVENTION AND MANAGEMENT OF CHRONIC ILLNESS**

5 NEW SECTION. **Sec. 6.** A new section is added to chapter 74.09 RCW
6 to read as follows:

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

9 (a) Design and implement medical homes for its aged, blind, and
10 disabled clients in conjunction with chronic care management programs
11 to improve health outcomes, access, and cost-effectiveness. Programs
12 must be evidence based, facilitating the use of information technology
13 to improve quality of care, and must improve coordination of primary,
14 acute, and long-term care for those clients with multiple chronic
15 conditions. The department shall consider expansion of existing
16 medical home and chronic care management programs and build on the
17 Washington state collaborative initiative. The department shall use
18 best practices in identifying those clients best served under a chronic
19 care management model using predictive modeling through claims or other
20 health risk information; and

21 (b) Contract for a study of chronic care management, to include
22 evaluation of current efforts in the health and recovery services
23 administration and the aging and disability services administration,
24 comparison to best practices, and recommendations for future efforts
25 and organizational structure to improve chronic care management.

26 (2) For purposes of this section:

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

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

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

3 (5) Produce an annual quality report detailing clinical practice
4 patterns identified to purchasers, providers, insurers, and policy
5 makers.

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

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

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

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

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

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

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

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

35 (b) Meetings of the board, stakeholder committee, and any advisory
36 group are subject to chapter 42.30 RCW, the open public meetings act,

1 including RCW 42.30.110(1)(1), which authorizes an executive session
2 during a regular or special meeting to consider proprietary or
3 confidential nonpublished information; and

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

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

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

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

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

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

24 **Sec. 10.** RCW 43.70.110 and 2006 c 72 s 3 are each amended to read
25 as follows:

26 (1) The secretary shall charge fees to the licensee for obtaining
27 a license. After June 30, 1995, municipal corporations providing
28 emergency medical care and transportation services pursuant to chapter
29 18.73 RCW shall be exempt from such fees, provided that such other
30 emergency services shall only be charged for their pro rata share of
31 the cost of licensure and inspection, if appropriate. The secretary
32 may waive the fees when, in the discretion of the secretary, the fees
33 would not be in the best interest of public health and safety, or when
34 the fees would be to the financial disadvantage of the state.

35 (2) Except as provided in (~~RCW 18.79.202, until June 30, 2013, and~~
36 ~~except for the cost of regulating retired volunteer medical workers in~~
37 ~~accordance with RCW 18.130.360~~) subsection (3) of this section, fees

1 charged shall be based on, but shall not exceed, the cost to the
2 department for the licensure of the activity or class of activities and
3 may include costs of necessary inspection.

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

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

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

12 (c) For physicians licensed under chapter 18.71 RCW, physician
13 assistants licensed under chapter 18.71A RCW, osteopathic physicians
14 licensed under chapter 18.57 RCW, osteopathic physicians' assistants
15 licensed under chapter 18.57A RCW, naturopaths licensed under chapter
16 18.36A RCW, podiatrists licensed under chapter 18.22 RCW, chiropractors
17 licensed under chapter 18.25 RCW, psychologists licensed under chapter
18 18.83 RCW, registered nurses licensed under chapter 18.79 RCW,
19 optometrists licensed under chapter 18.53 RCW, mental health counselors
20 licensed under chapter 18.225 RCW, massage therapists licensed under
21 chapter 18.108 RCW, clinical social workers licensed under chapter
22 18.225 RCW, and acupuncturists licensed under chapter 18.06 RCW, the
23 license fees shall include the cost to the department of contracting
24 with the University of Washington to allow online access to selected
25 vital clinical resources negotiated and maintained for the exclusive
26 use of the licensed health professionals included in this subsection by
27 the University of Washington health sciences library.

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

31 **REDUCING UNNECESSARY EMERGENCY ROOM USE**

32 **Sec. 11.** RCW 41.05.220 and 1998 c 245 s 38 are each amended to
33 read as follows:

34 (1) State general funds appropriated to the department of health
35 for the purposes of funding community health centers to provide primary
36 health and dental care services, migrant health services, and maternity

1 health care services shall be transferred to the state health care
2 authority. Any related administrative funds expended by the department
3 of health for this purpose shall also be transferred to the health care
4 authority. The health care authority shall exclusively expend these
5 funds through contracts with community health centers to provide
6 primary health and dental care services, migrant health services, and
7 maternity health care services. The administrator of the health care
8 authority shall establish requirements necessary to assure community
9 health centers provide quality health care services that are
10 appropriate and effective and are delivered in a cost-efficient manner.
11 The administrator shall further assure that community health centers
12 have appropriate referral arrangements for acute care and medical
13 specialty services not provided by the community health centers.

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

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

26 NEW SECTION. **Sec. 12.** The Washington state health care authority
27 and the department of social and health services shall report to the
28 legislature by December 1, 2007, on recent trends in unnecessary
29 emergency room use by enrollees in state purchased health care programs
30 and the uninsured, and then partner with community organizations and
31 local health care providers to design a demonstration pilot to reduce
32 such unnecessary visits.

33 **REDUCE HEALTH CARE ADMINISTRATIVE COSTS**

34 NEW SECTION. **Sec. 13.** By September 1, 2007, the insurance
35 commissioner shall provide a report to the governor and the legislature

1 that identifies the key contributors to health care administrative
2 costs and evaluates opportunities to reduce them, including suggested
3 changes to state law. The report shall be completed in collaboration
4 with health care providers, carriers, state health purchasing agencies,
5 the Washington healthcare forum, and other interested parties.

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

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

9 (1) Any plan offered to employees under this chapter must offer
10 each employee the option of covering any unmarried dependent of the
11 employee under the age of twenty-five who is a "qualifying child" or
12 "qualifying relative" as defined in section 152 of the internal revenue
13 code.

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

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

24 NEW SECTION. **Sec. 15.** A new section is added to chapter 48.20 RCW
25 to read as follows:

26 Any disability insurance contract that provides coverage for a
27 subscriber's dependent must offer the option of covering any unmarried
28 dependent under the age of twenty-five who is a "qualifying child" or
29 "qualifying relative" as defined in section 152 of the internal revenue
30 code.

31 NEW SECTION. **Sec. 16.** A new section is added to chapter 48.21 RCW
32 to read as follows:

33 Any group disability insurance contract or blanket disability
34 insurance contract that provides coverage for a participating member's

1 dependent must offer each participating member the option of covering
2 any unmarried dependent under the age of twenty-five who is a
3 "qualifying child" or "qualifying relative" as defined in section 152
4 of the internal revenue code.

5 NEW SECTION. **Sec. 17.** A new section is added to chapter 48.44 RCW
6 to read as follows:

7 (1) Any individual health care service plan contract that provides
8 coverage for a subscriber's dependent must offer the option of covering
9 any unmarried dependent under the age of twenty-five who is a
10 "qualifying child" or "qualifying relative" as defined in section 152
11 of the internal revenue code.

12 (2) Any group health care service plan contract that provides
13 coverage for a participating member's dependent must offer each
14 participating member the option of covering any unmarried dependent
15 under the age of twenty-five who is a "qualifying child" or "qualifying
16 relative" as defined in section 152 of the internal revenue code.

17 NEW SECTION. **Sec. 18.** A new section is added to chapter 48.46 RCW
18 to read as follows:

19 (1) Any individual health maintenance agreement that provides
20 coverage for a subscriber's dependent must offer the option of covering
21 any unmarried dependent under the age of twenty-five who is a
22 "qualifying child" or "qualifying relative" as defined in section 152
23 of the internal revenue code.

24 (2) Any group health maintenance agreement that provides coverage
25 for a participating member's dependent must offer each participating
26 member the option of covering any unmarried dependent under the age of
27 twenty-five who is a "qualifying child" or "qualifying relative" as
28 defined in section 152 of the internal revenue code.

29 **WASHINGTON HEALTH INSURANCE CONNECTOR**

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

32 (1) The authority, in collaboration with an advisory board
33 established under subsection (3) of this section, shall design a
34 Washington health insurance connector and submit implementing

1 legislation and supporting information, including funding options, to
2 the governor and the legislature by December 1, 2007. The connector
3 shall be designed to serve as a statewide, public-private partnership,
4 offering maximum value for Washington state residents, through which
5 nonlarge group health insurance may be bought and sold. It is the goal
6 of the connector to:

7 (a) Ensure that employees of small businesses and other individuals
8 can find affordable health insurance;

9 (b) Provide a mechanism for small businesses to contribute to their
10 employees' coverage without the administrative burden of directly
11 shopping or contracting for insurance;

12 (c) Ensure that individuals can access coverage as they change
13 and/or work in multiple jobs;

14 (d) Coordinate with other state agency health insurance assistance
15 programs, including the department of social and health services
16 medical assistance programs and the authority's basic health program;
17 and

18 (e) Lead the health insurance marketplace in implementation of
19 evidence-based medicine, data transparency, prevention and wellness
20 incentives, and outcome-based reimbursement.

21 (2) In designing the connector, the authority shall:

22 (a) Address all operational and governance issues;

23 (b) Consider best practices in the private and public sectors
24 regarding, but not limited to, such issues as risk and/or purchasing
25 pooling, market competition drivers, risk selection, and consumer
26 choice and responsibility incentives; and

27 (c) Address key functions of the connector, including but not
28 limited to:

29 (i) Methods for small businesses and their employees to realize tax
30 benefits from their financial contributions;

31 (ii) Options for offering choice among a broad array of affordable
32 insurance products designed to meet individual needs, including waiving
33 some current regulatory requirements. Options may include a health
34 savings account/high-deductible health plan, a comprehensive health
35 benefit plan, and other benchmark plans;

36 (iii) Benchmarking health insurance products to a reasonable
37 standard to enable individuals to make an informed choice of the
38 coverage that is right for them;

1 (iv) Aggregating premium contributions for an individual from
2 multiple sources: Employers, individuals, philanthropies, and
3 government;

4 (v) Mechanisms to collect and distribute workers' enrollment
5 information and premium payments to the health plan of their choice;

6 (vi) Mechanisms for spreading health risk widely to support health
7 insurance premiums that are more affordable;

8 (vii) Opportunities to reward carriers and consumers whose behavior
9 is consistent with quality, efficiency, and evidence-based best
10 practices;

11 (viii) Coordination of the transmission of premium assistance
12 payments with the department of social and health services for
13 individuals eligible for the department's employer-sponsored insurance
14 program.

15 (3) The authority shall appoint an advisory board and designate a
16 chair. Members of the advisory board shall receive no compensation,
17 but shall be reimbursed for expenses under RCW 43.03.050 and 43.03.060.
18 Meetings of the board are subject to chapter 42.30 RCW, the open public
19 meetings act, including RCW 42.30.110(1)(1), which authorizes an
20 executive session during a regular or special meeting to consider
21 proprietary or confidential nonpublished information.

22 (4) The authority may enter into contracts to issue, distribute,
23 and administer grants that are necessary or proper to carry out the
24 requirements of this section.

25 SUSTAINABILITY AND ACCESS TO PUBLIC PROGRAMS

26 NEW SECTION. **Sec. 20.** (1) The department of social and health
27 services shall seek necessary federal waivers and state plan amendments
28 to expand coverage and leverage federal and state resources for the
29 state's basic health program, for the medical assistance program, as
30 codified at Title XIX of the federal social security act, and the
31 state's children's health insurance program, as codified at Title XXI
32 of the federal social security act. The department shall propose
33 options including but not limited to:

34 (a) Offering alternative benefit designs to promote high quality
35 care, improve health outcomes, and encourage cost-effective treatment

1 options, including benefit designs that discourage the use of emergency
2 rooms for nonemergent care, and redirect savings to finance additional
3 coverage;

4 (b) Creation of a health opportunity account demonstration program;
5 and

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

11 (2) The department of social and health services, in collaboration
12 with the Washington state health care authority, shall ensure that
13 enrollees are not simultaneously enrolled in the state's basic health
14 program and the medical assistance program or the state's children's
15 health insurance program to ensure coverage for the maximum number of
16 people within available funds. Priority enrollment in the basic health
17 program shall be given to those who disenrolled from the program in
18 order to enroll in medicaid, and subsequently became ineligible for
19 medicaid coverage.

20 NEW SECTION. **Sec. 21.** A new section is added to chapter 48.43 RCW
21 to read as follows:

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

28 **REINSURANCE**

29 NEW SECTION. **Sec. 22.** (1) The office of financial management, in
30 collaboration with the office of the insurance commissioner, shall
31 evaluate and design a state-supported reinsurance program to address
32 the impact of high cost enrollees in the individual and small group
33 health insurance markets, and submit implementing legislation and
34 supporting information, including financing options, to the governor

1 and the legislature by December 1, 2007. In designing the program, the
2 office of financial management shall:

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

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

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

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

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

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

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

8 **THE WASHINGTON STATE HEALTH INSURANCE POOL**

9 NEW SECTION. **Sec. 23.** The legislature finds that the Washington
10 state health insurance pool is a critically important insurance option
11 for people in this state and must reflect health care provisions based
12 on the best available evidence and be financially sustainable over
13 time. The laws governing the Washington state health insurance pool
14 have been read to preclude the program from modifying contracts, and
15 yet coverage needs and options change with time. Everyone in this
16 state benefits when the Washington state health insurance pool is more
17 affordable and higher performing. Changes are needed to the Washington
18 state health insurance pool to increase affordability, offer quality
19 and cost-effective benefits, and enhance the governance and operation
20 of the pool.

21 **Sec. 24.** RCW 48.41.110 and 2001 c 196 s 4 are each amended to read
22 as follows:

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

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

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

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

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

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

25 (c) The first twenty outpatient professional visits for the
26 diagnosis or treatment of one or more mental or nervous conditions or
27 alcohol, drug, or chemical dependency or abuse rendered during a
28 calendar year by one or more physicians, psychologists, or community
29 mental health professionals, or, at the direction of a physician, by
30 other qualified licensed health care practitioners, in the case of
31 mental or nervous conditions, and rendered by a state certified
32 chemical dependency program approved under chapter 70.96A RCW, in the
33 case of alcohol, drug, or chemical dependency or abuse;

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

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

38 (f) Services of a home health agency;

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

3 (h) Oxygen;

4 (i) Anesthesia services;

5 (j) Prostheses, other than dental;

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

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

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

16 (n) Maternity care services;

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

19 (p) Hospice services;

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

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

25 ~~((4))~~ (5) The pool shall offer at least one policy which closely
26 adheres to benefits available in the private, individual market.

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

31 ~~((5))~~ (7) The pool benefit policy may contain benefit
32 limitations, exceptions, and cost shares such as copayments,
33 coinsurance, and deductibles that are consistent with managed care
34 products, except that differential cost shares may be adopted by the
35 board for nonnetwork providers under point of service plans. ((The
36 pool benefit policy cost shares and limitations must be consistent with
37 those that are generally included in health plans approved by the

1 ~~insurance commissioner; however, no limitation, exception, or reduction~~
2 ~~may be used that would exclude coverage for any disease, illness, or~~
3 ~~injury.~~

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

17 ~~((7))~~ (9)(a) Except as provided in (b) of this subsection, the
18 pool shall credit any preexisting condition waiting period in its plans
19 for a person who was enrolled at any time during the sixty-three day
20 period immediately preceding the date of application for the new pool
21 plan. For the person previously enrolled in a group health benefit
22 plan, the pool must credit the aggregate of all periods of preceding
23 coverage not separated by more than sixty-three days toward the waiting
24 period of the new health plan. For the person previously enrolled in
25 an individual health benefit plan other than a catastrophic health
26 plan, the pool must credit the period of coverage the person was
27 continuously covered under the immediately preceding health plan toward
28 the waiting period of the new health plan. For the purposes of this
29 subsection, a preceding health plan includes an employer-provided self-
30 funded health plan.

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

35 ~~((8))~~ (10) If an application is made for the pool policy as a
36 result of rejection by a carrier, then the date of application to the
37 carrier, rather than to the pool, should govern for purposes of
38 determining preexisting condition credit.

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

5 **Sec. 25.** RCW 48.41.160 and 1987 c 431 s 16 are each amended to
6 read as follows:

7 (1) A pool policy offered under this chapter prior to the effective
8 date of this section shall contain provisions under which the pool is
9 obligated to renew the policy until the day on which the individual in
10 whose name the policy is issued first becomes eligible for medicare
11 coverage. At that time, coverage of dependents shall terminate if such
12 dependents are eligible for coverage under a different health plan.
13 Dependents who become eligible for medicare prior to the individual in
14 whose name the policy is issued, shall receive benefits in accordance
15 with RCW 48.41.150.

16 (2) A pool policy offered after the effective date of this section
17 shall contain a guarantee of the individual's right to continued
18 coverage, subject to the provisions of subsections (4) and (5) of this
19 section.

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

23 (a) Nonpayment of premium;

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

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

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

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

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

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

35 (4)(a) The guarantee of continuity of coverage provided by this
36 section requires that if the pool replaces a plan, it must make the
37 replacement plan available to all individuals in the plan being

1 replaced. The replacement plan must include all of the services
2 covered under the replaced plan, and must not significantly limit
3 access to the kind of services covered under the replaced plan. The
4 pool may also allow individuals who are covered by a plan that is being
5 replaced an unrestricted right to transfer to a fully comparable plan.

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

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

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

21 (ii) Pool financing and enrollment;

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

24 (iv) The ability of carriers to offer health plans in the
25 individual market;

26 (v) Other items identified by the board.

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

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

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

34 ((+3)) (6) A pool policy offered under this chapter shall provide
35 that, upon the death of the individual in whose name the policy is
36 issued, every other individual then covered under the policy may elect,
37 within a period specified in the policy, to continue coverage under the
38 same or a different policy.

1 **Sec. 26.** RCW 48.41.200 and 2000 c 79 s 17 are each amended to read
2 as follows:

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

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

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

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

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

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

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

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

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

36 (ii) The rate for any person (~~aged fifty to sixty four~~) whose
37 current gross family income is more than two hundred fifty but less

1 than three hundred one percent of the federal poverty level shall be
2 reduced by fifteen percent from what it would otherwise be;

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

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

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

12 **Sec. 27.** RCW 48.41.037 and 2000 c 79 s 36 are each amended to read
13 as follows:

14 The Washington state health insurance pool account is created in
15 the custody of the state treasurer. All receipts from moneys
16 specifically appropriated to the account must be deposited in the
17 account. Expenditures from this account shall be used to cover
18 deficits incurred by the Washington state health insurance pool under
19 this chapter in excess of the threshold established in this section.
20 To the extent funds are available in the account, funds shall be
21 expended from the account to offset that portion of the deficit that
22 would otherwise have to be recovered by imposing an assessment on
23 members in excess of a threshold of seventy cents per insured person
24 per month. The commissioner shall authorize expenditures from the
25 account, to the extent that funds are available in the account, upon
26 certification by the pool board that assessments will exceed the
27 threshold level established in this section. The account is subject to
28 the allotment procedures under chapter 43.88 RCW, but an appropriation
29 is not required for expenditures.

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

1 **Sec. 28.** RCW 48.41.100 and 2001 c 196 s 3 are each amended to read
2 as follows:

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

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

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

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

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

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

28 (a) Any person having terminated coverage in the pool unless (i)
29 twelve months have lapsed since termination, or (ii) that person can
30 show continuous other coverage which has been involuntarily terminated
31 for any reason other than nonpayment of premiums. However, these
32 exclusions do not apply to eligible individuals as defined in section
33 2741(b) of the federal health insurance portability and accountability
34 act of 1996 (42 U.S.C. Sec. 300gg-41(b));

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

37 (c) Inmates of public institutions and persons whose benefits are
38 duplicated under public programs. However, these exclusions do not

1 apply to eligible individuals as defined in section 2741(b) of the
2 federal health insurance portability and accountability act of 1996 (42
3 U.S.C. Sec. 300gg-41(b));

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

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

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

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

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

1 (4) The board shall ensure that an independent analysis of the
2 eligibility standards is conducted, with emphasis on those populations
3 identified in subsection (2) of this section and the impacts on the
4 pool and the state budget. The board shall report the findings to the
5 legislature by December 1, 2007.

6 **Sec. 29.** RCW 48.43.005 and 2006 c 25 s 16 are each amended to read
7 as follows:

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

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

14 (2) "Basic health plan" means the plan described under chapter
15 70.47 RCW, as revised from time to time.

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

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

22 (5) "Catastrophic health plan" means:

23 (a) In the case of a contract, agreement, or policy covering a
24 single enrollee, a health benefit plan requiring a calendar year
25 deductible of, at a minimum, one thousand (~~five~~) seven hundred fifty
26 dollars and an annual out-of-pocket expense required to be paid under
27 the plan (other than for premiums) for covered benefits of at least
28 three thousand five hundred dollars; and

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

35 (c) Any health benefit plan that provides benefits for hospital
36 inpatient and outpatient services, professional and prescription drugs

1 provided in conjunction with such hospital inpatient and outpatient
2 services, and excludes or substantially limits outpatient physician
3 services and those services usually provided in an office setting.

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

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

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

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

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

33 (11) "Emergency medical condition" means the emergent and acute
34 onset of a symptom or symptoms, including severe pain, that would lead
35 a prudent layperson acting reasonably to believe that a health
36 condition exists that requires immediate medical attention, if failure
37 to provide medical attention would result in serious impairment to

1 bodily functions or serious dysfunction of a bodily organ or part, or
2 would place the person's health in serious jeopardy.

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

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

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

18 (15) "Health care facility" or "facility" means hospices licensed
19 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
20 rural health care facilities as defined in RCW 70.175.020, psychiatric
21 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
22 under chapter 18.51 RCW, community mental health centers licensed under
23 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed
24 under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical
25 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment
26 facilities licensed under chapter 70.96A RCW, and home health agencies
27 licensed under chapter 70.127 RCW, and includes such facilities if
28 owned and operated by a political subdivision or instrumentality of the
29 state and such other facilities as required by federal law and
30 implementing regulations.

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

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

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

37 (17) "Health care service" means that service offered or provided

1 by health care facilities and health care providers relating to the
2 prevention, cure, or treatment of illness, injury, or disease.

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

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

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

11 (b) Medicare supplemental health insurance governed by chapter
12 48.66 RCW;

13 (c) Coverage supplemental to the coverage provided under chapter
14 55, Title 10, United States Code;

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

17 (e) Disability income;

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

21 (g) Workers' compensation coverage;

22 (h) Accident only coverage;

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

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

26 (k) Dental only and vision only coverage; and

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

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

37 (21) "Preexisting condition" means any medical condition, illness,

1 or injury that existed any time prior to the effective date of
2 coverage.

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

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

15 (24) "Small employer" or "small group" means any person, firm,
16 corporation, partnership, association, political subdivision, sole
17 proprietor, or self-employed individual that is actively engaged in
18 business that, on at least fifty percent of its working days during the
19 preceding calendar quarter, employed at least two but no more than
20 fifty eligible employees, with a normal work week of thirty or more
21 hours, the majority of whom were employed within this state, and is not
22 formed primarily for purposes of buying health insurance and in which
23 a bona fide employer-employee relationship exists. In determining the
24 number of eligible employees, companies that are affiliated companies,
25 or that are eligible to file a combined tax return for purposes of
26 taxation by this state, shall be considered an employer. Subsequent to
27 the issuance of a health plan to a small employer and for the purpose
28 of determining eligibility, the size of a small employer shall be
29 determined annually. Except as otherwise specifically provided, a
30 small employer shall continue to be considered a small employer until
31 the plan anniversary following the date the small employer no longer
32 meets the requirements of this definition. A self-employed individual
33 or sole proprietor must derive at least seventy-five percent of his or
34 her income from a trade or business through which the individual or
35 sole proprietor has attempted to earn taxable income and for which he
36 or she has filed the appropriate internal revenue service form 1040,
37 schedule C or F, for the previous taxable year except for a self-
38 employed individual or sole proprietor in an agricultural trade or

1 business, who must derive at least fifty-one percent of his or her
2 income from the trade or business through which the individual or sole
3 proprietor has attempted to earn taxable income and for which he or she
4 has filed the appropriate internal revenue service form 1040, for the
5 previous taxable year. A self-employed individual or sole proprietor
6 who is covered as a group of one on the day prior to June 10, 2004,
7 shall also be considered a "small employer" to the extent that
8 individual or group of one is entitled to have his or her coverage
9 renewed as provided in RCW 48.43.035(6).

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

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

22 **Sec. 30.** RCW 48.41.190 and 1989 c 121 s 10 are each amended to
23 read as follows:

24 Neither the participation by members, the establishment of rates,
25 forms, or procedures for coverages issued by the pool, nor any other
26 joint or collective action required by this chapter or the state of
27 Washington shall be the basis of any legal action, civil or criminal
28 liability or penalty against the pool, any member of the board of
29 directors, or members of the pool either jointly or separately. The
30 pool, members of the pool, board directors of the pool, officers of the
31 pool, employees of the pool, the commissioner, the commissioner's
32 representatives, and the commissioner's employees shall not be civilly
33 or criminally liable and shall not have any penalty or cause of action
34 of any nature arise against them for any action taken or not taken,
35 including any discretionary decision or failure to make a discretionary
36 decision, when the action or inaction is done in good faith and in the

1 performance of the powers and duties under this chapter. Nothing in
2 this section prohibits legal actions against the pool to enforce the
3 pool's statutory or contractual duties or obligations.

4 **Sec. 31.** RCW 41.05.075 and 2006 c 103 s 3 are each amended to read
5 as follows:

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

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

12 (a) Encourages competition among insuring entities;

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

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

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

21 (3) The administrator shall establish a requirement for review of
22 utilization and financial data from participating insuring entities on
23 a quarterly basis.

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

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

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

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

1 (6) All contracts with insuring entities for the provision of
2 health care benefits shall provide that the beneficiaries of such
3 benefit plans may use on an equal participation basis the services of
4 practitioners licensed pursuant to chapters 18.22, 18.25, 18.32, 18.53,
5 18.57, 18.71, 18.74, 18.83, and 18.79 RCW, as it applies to registered
6 nurses and advanced registered nurse practitioners. However, nothing
7 in this subsection may preclude the administrator from establishing
8 appropriate utilization controls approved pursuant to RCW 41.05.065(2)
9 (a), (b), and (d).

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

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

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

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

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

29 (i) Facilitate diagnosis or treatment;

30 (ii) Reduce unnecessary duplication of medical tests;

31 (iii) Promote efficient electronic physician order entry;

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

34 (v) Improve health outcomes;

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

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

4 **STRENGTHEN THE PUBLIC HEALTH SYSTEM**

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

7 (1) By December 31, 2007, within funds specifically appropriated
8 therefor, the department shall award basic, noncategorical state public
9 health funding to local public health jurisdictions through an annual
10 contract which is based on performance measures for public health
11 improvement, and which requires regular reporting to demonstrate
12 progress toward meeting performance goals. This shall include local
13 capacity development funds and any additional funds approved by the
14 legislature to strengthen the public health system.

15 The department shall require the local health jurisdiction to
16 regularly document compliance with contract requirements, and shall
17 report to the legislature every two years on progress toward achieving
18 public health improvement goals with funds provided for this purpose.

19 (2) Each contract with a local public health jurisdiction shall
20 require reports of data on specific local public health indicators
21 published in the most recent public health improvement plan, and a
22 record of efforts to protect and improve the health of people in each
23 local jurisdiction. To establish a basis for judging progress toward
24 health goals:

25 (a) The local public health jurisdiction shall report data to
26 document trends in protecting and improving public health using the
27 local public health indicators;

28 (b) The department shall assist in assuring that needed data can be
29 obtained at the county or local jurisdiction level;

30 (c) Technical assistance and information about evidence-based
31 practice shall be provided to local jurisdictions through the efforts
32 of the department; and

33 (d) The department shall routinely publish information on
34 successful practices so that all local jurisdictions have information
35 to improve effectiveness.

1 (3) To qualify for state funding under this section, local health
2 jurisdictions must participate in demonstrating basic capacity to
3 perform expected functions described in *Standards for Public Health* and
4 published in the public health services improvement plan under RCW
5 43.70.520:

6 (a) The *Standards for Public Health* shall serve as the basic
7 framework for evaluating each local health jurisdiction's ability to
8 meet minimum expectations to perform public health functions;

9 (b) A measurement of every local jurisdiction shall be conducted no
10 less than every third year;

11 (c) The department shall participate in the standards measurement
12 process so that state-level support of the public health system is
13 demonstrated; and

14 (d) Each local jurisdiction shall develop a quality improvement
15 plan to use standards measurement results to improve capacity to meet
16 public health standards prior to the next measurement cycle.

17 PREVENTION AND HEALTH PROMOTION

18 NEW SECTION. **Sec. 33.** The Washington state health care authority,
19 the department of social and health services, the department of labor
20 and industries, and the department of health shall, by September 1,
21 2007, develop a five-year plan to integrate disease and accident
22 prevention and health promotion into state health programs by:

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

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

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

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

30 The plan shall identify any existing barriers and opportunities to
31 support implementation, including needed changes to state or federal
32 law, and be submitted to the governor and the legislature upon
33 completion. The agencies shall include health insurance carriers in
34 the development of the plan.

1 **Sec. 34.** RCW 41.05.540 and 2005 c 360 s 8 are each amended to read
2 as follows:

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

10 ~~(2) The health care authority shall report to the governor and the~~
11 ~~legislature by December 1, 2006, on progress in implementing, and~~
12 ~~evaluating the results of, the worksite health promotion program))~~
13 shall establish and maintain a state employee health program focused on
14 reducing the health risks of state employees, dependents, and retirees
15 enrolled in the public employees' benefits board. The program shall
16 use public and private sector best practices to achieve goals of
17 measurable health outcomes, measurable productivity improvements,
18 positive impact on the cost of medical care, and positive return on
19 investment.

20 (2) The state employee health program shall:

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

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

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

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

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

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

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

1 (3) The health care authority shall report to the legislature in
2 December 2008, 2009, and 2010 on outcome goals for the employee health
3 program.

4 **NEW SECTION. Sec. 35.** A new section is added to chapter 41.05 RCW
5 to read as follows:

6 (1) The health care authority through the state employee health
7 program shall create a state employee health demonstration project in
8 four state agencies: The department of health, department of
9 personnel, department of natural resources, and department of labor and
10 industries. Demonstration project agencies shall operate employee
11 health programs for their employees in collaboration with the state
12 employee health program. Agency demonstration project employee health
13 programs:

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

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

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

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

30 (2) The state employee health program shall evaluate each of the
31 four programs separately and compare outcomes for each of them with the
32 entire state employee population to assess effectiveness of the
33 programs. Specifically, the program shall measure at least the
34 following outcomes in the demonstration population: The reduction in
35 the percent of the population that is overweight or obese, the
36 reduction in risk factors related to diabetes, the reduction in risk
37 factors related to absenteeism, the reduction in tobacco consumption,

1 and the increase in appropriate use of preventive health services. The
2 state employee health program shall report to the legislature in
3 December 2008, 2009, and 2010 on the demonstration project.

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

5 NEW SECTION. **Sec. 36.** The legislature finds that prescription
6 drug abuse has been on the rise and that often dispensers and
7 prescribing providers are unaware of prescriptions provided by others
8 both in and out of state.

9 It is the intent of the legislature to establish an electronic
10 database available in real time to dispensers and prescribers of
11 controlled substances. And further, that the department in as much as
12 possible should establish a common dataset with other sets of other
13 states.

14 NEW SECTION. **Sec. 37.** The definitions in this section apply
15 throughout this chapter unless the context clearly requires otherwise.

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

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

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

22 (4) "Dispenser" means a person who delivers a Schedule II, III, IV,
23 or V controlled substance to the ultimate user, but does not include:

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

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

28 NEW SECTION. **Sec. 38.** (1) The department shall establish and
29 maintain a web-based interactive prescription monitoring program
30 available in real time to monitor the prescribing and dispensing of all
31 Schedules II, III, IV, and V controlled substances and any additional
32 drugs identified by the board of pharmacy as demonstrating a potential
33 for abuse by all professionals licensed to prescribe or dispense such
34 substances in this state. As much as possible, the department should
35 establish a common database with other states.

1 (2) Each dispenser shall submit to the department by electronic
2 means information regarding each prescription dispensed for a drug
3 included under subsection (1) of this section. Drug prescriptions for
4 more than immediate one day use should be immediately reported. The
5 information submitted for each prescription shall include, but not be
6 limited to:

- 7 (a) Patient identifier;
- 8 (b) Drug dispensed;
- 9 (c) Date of dispensing;
- 10 (d) Quantity dispensed;
- 11 (e) Prescriber; and
- 12 (f) Dispenser.

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

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

23 (5) The department shall seek federal grants to cover the costs of
24 operating the prescription monitoring program. The department may not
25 require a practitioner or a pharmacist to pay a fee or tax specifically
26 dedicated to the operation of the system.

27 (6) The department shall report to the legislature on the
28 implementation of this chapter by December 1, 2009.

29 NEW SECTION. **Sec. 39.** (1) Prescription information submitted to
30 the department shall be confidential, in compliance with the health
31 insurance portability and accountability act, and not subject to
32 disclosure, except as provided in subsections (3), (4), and (5) of this
33 section.

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

1 (3) The department shall review the prescription information. The
2 department shall notify the practitioner and allow explanation or
3 correction of any problem. If there is reasonable cause to believe a
4 violation of law or breach of professional standards may have occurred,
5 the department shall notify the appropriate law enforcement or
6 professional licensing, certification, or regulatory agency or entity,
7 and provide prescription information required for an investigation.

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

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

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

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

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

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

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

23 (g) Personnel of the department for purposes of administration and
24 enforcement of this chapter or chapter 69.50 RCW.

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

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

34 NEW SECTION. **Sec. 40.** The department may contract with another
35 agency of this state or with a private vendor, as necessary, to ensure
36 the effective operation of the prescription monitoring program. Any
37 contractor is bound to comply with the provisions regarding

1 confidentiality of prescription information in section 39 of this act
2 and is subject to the penalties specified in section 42 of this act for
3 unlawful acts.

4 NEW SECTION. **Sec. 41.** The department shall adopt rules to
5 implement this chapter.

6 NEW SECTION. **Sec. 42.** (1) A dispenser who knowingly fails to
7 submit prescription monitoring information to the department as
8 required by this chapter or knowingly submits incorrect prescription
9 information is subject to disciplinary action under chapter 18.130 RCW.

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

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

16 (4) In accordance with the health insurance portability and
17 accountability act, any physician or pharmacist authorized to access a
18 patient's prescription monitoring may discuss or release that
19 information to other health care providers involved with the patient in
20 order to provide safe and appropriate care coordination.

21 NEW SECTION. **Sec. 43.** If any provision of this act or its
22 application to any person or circumstance is held invalid, the
23 remainder of the act or the application of the provision to other
24 persons or circumstances is not affected.

25 **Sec. 44.** RCW 42.56.360 and 2006 c 209 s 9 and 2006 c 8 s 112 are
26 each reenacted and amended to read as follows:

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

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

31 (b) Information obtained by the board of pharmacy or the department
32 of health and its representatives as provided in RCW 69.41.044,
33 69.41.280, and 18.64.420;

1 (c) Information and documents created specifically for, and
2 collected and maintained by a quality improvement committee under RCW
3 43.70.510 or 70.41.200, or by a peer review committee under RCW
4 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640
5 or 18.20.390, and notifications or reports of adverse events or
6 incidents made under RCW 70.56.020 or 70.56.040, regardless of which
7 agency is in possession of the information and documents;

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

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

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

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

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

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

34 (h) Information obtained by the department of health under chapter
35 69.-- RCW (sections 36 through 43 of this act).

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

1 NEW SECTION. **Sec. 45.** Sections 36 through 43 of this act
2 constitute a new chapter in Title 69 RCW.

3 NEW SECTION. **Sec. 46.** Subheadings used in this act are not any
4 part of the law.

5 NEW SECTION. **Sec. 47.** Sections 14 through 18 of this act take
6 effect January 1, 2008.

7 NEW SECTION. **Sec. 48.** If specific funding for the purposes of the
8 following sections of this act, referencing the section of this act by
9 bill or chapter number and section number, is not provided by June 30,
10 2007, in the omnibus appropriations act, the section is null and void:

- 11 (1) Section 8 of this act (Washington state quality forum);
12 (2) Section 9 of this act (health records banking pilot project);
13 (3) Section 19 of this act (health insurance connector); and
14 (4) Section 35 of this act (state employee health demonstration
15 project).

16 NEW SECTION. **Sec. 49.** Sections 23 through 31 of this act are
17 necessary for the immediate preservation of the public peace, health,
18 or safety, or support of the state government and its existing public
19 institutions, and take effect immediately."

2SSB 5930 - S AMD
By Senator Keiser

WITHDRAWN 03/09/2007

20 On page 1, line 3 of the title, after "access;" strike the
21 remainder of the title and insert "amending RCW 7.70.060, 43.70.110,
22 41.05.220, 48.41.110, 48.41.160, 48.41.200, 48.41.037, 48.41.100,
23 48.43.005, 48.41.190, 41.05.075, and 41.05.540; reenacting and amending
24 RCW 42.56.360; adding a new section to chapter 74.09 RCW; adding new
25 sections to chapter 43.70 RCW; adding new sections to chapter 41.05
26 RCW; adding a new section to chapter 48.20 RCW; adding a new section to

1 chapter 48.21 RCW; adding a new section to chapter 48.44 RCW; adding a
2 new section to chapter 48.46 RCW; adding a new section to chapter 48.43
3 RCW; adding a new chapter to Title 69 RCW; creating new sections;
4 prescribing penalties; providing an effective date; providing an
5 expiration date; and declaring an emergency."

--- END ---