# HOUSE BILL REPORT
# E2SHB 2572

**As Amended by the Senate**

**Title**: An act relating to improving the effectiveness of health care purchasing and transforming the health care delivery system by advancing value-based purchasing, promoting community health, and providing greater integration of chronic illness care and needed social supports.

**Brief Description**: Concerning the effectiveness of health care purchasing and transforming the health care delivery system.

**Sponsors**: House Committee on Appropriations (originally sponsored by Representative Cody; by request of Governor Inslee).

**Brief History:**
**Committee Activity:**
Health Care & Wellness: 1/27/14, 2/3/14, 2/5/14 [DPS];
Appropriations: 2/10/14 [DP2S(w/o sub HCW)].
**Floor Activity:**
Passed House: 2/19/14, 55-41.
Senate Amended.
Passed Senate: 3/13/14, 32-17.


**Brief Summary of Engrossed Second Substitute Bill**

- Requires the Health Care Authority (HCA) to create a process to designate nonprofit or public-private partnerships as "accountable collaboratives for health."
- Requires the Department of Health to establish a health extension program to disseminate tools, training, and resources to providers.
- Establishes a statewide all-payer claims database and requires health carriers and employers to submit claims data to the database. Directs a lead organization selected by the Office of Financial Management to manage the database and prepare reports based on the claims data.
- Directs a stakeholder committee to identify and recommend statewide measures of health performance, and requires state agencies to use the measures to inform purchasing and set benchmarks.
- Requires the HCA and the Department of Social and Health Services to restructure Medicaid procurement of health care services and agreements with


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managed care systems to better support integration of physical health, mental health, and chemical dependency treatment.

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## HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

**Majority Report**: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 9 members: Representatives Cody, Chair; Riccelli, Vice Chair; Clibborn, Green, Jinkins, Moeller, Morrell, Tharinger and Van De Wege.

**Minority Report**: Do not pass. Signed by 8 members: Representatives Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; DeBolt, G. Hunt, Manweller, Rodne, Ross and Short.

**Staff**: Alexa Silver (786-7190).

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## HOUSE COMMITTEE ON APPROPRIATIONS

**Majority Report**: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Health Care & Wellness. Signed by 19 members: Representatives Hunter, Chair; Ormsby, Vice Chair; Carlyle, Cody, Dunshee, Green, Haigh, Hudgins, S. Hunt, Jinkins, Kagi, Lytton, Morrell, Pettigrew, Schmick, Seaquist, Springer, Sullivan and Tharinger.

**Minority Report**: Do not pass. Signed by 11 members: Representatives Chandler, Ranking Minority Member; Ross, Assistant Ranking Minority Member; Wilcox, Assistant Ranking Minority Member; Buys, Christian, Fagan, Haler, Harris, G. Hunt, Parker and Taylor.

**Staff**: Erik Cornellier (786-7116).

**Background**:

<u>Procurement of State-Purchased Health Care</u>.

The Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) purchase medical assistance, mental health services, long-term care case management services, and chemical dependency treatment services from several types of entities that coordinate with providers to deliver the services to clients.

- *Medical Assistance*. Medical assistance is available to eligible low-income state residents and their families from the HCA, primarily through the Medicaid program. Coverage is provided through fee-for-service and managed care systems. Managed care is a prepaid, comprehensive system of medical and health care delivery. Healthy Options is the HCA Medicaid managed care program for low-income people in Washington. Healthy Options offers eligible families, children under age 19, low-income adults, certain disabled individuals, and pregnant women a complete medical benefits package.

- *Regional Support Networks*. The DSHS contracts with regional support networks to oversee the delivery of mental health services for adults and children who suffer from mental illness or severe emotional disturbance. The regional support networks contract with local providers to provide an array of mental health services, monitor the activities of local providers, and oversee the distribution of funds under the state managed care plan.
- *County Chemical Dependency Programs*. The DSHS contracts with counties to provide outpatient chemical dependency treatment services, either directly or by subcontracting with certified providers. The DSHS contracts directly with providers for residential treatment services.

Several other state agencies, including the Department of Labor and Industries and the Department of Corrections, also purchase health care services.

All-Payer Claims Databases.

Several states have established all-payer claims databases to collect claims information from public and private payers. Payers may include health carriers, third-party administrators, pharmacy benefit managers, Medicaid agencies, and public employee health benefit programs. Generally, the databases collect medical, pharmacy, and dental claims data, as well as information about eligibility, benefit design, and providers. In Washington, the Washington Health Alliance maintains a voluntary all-payer claims database.

In September 2013 the Office of Financial Management received a federal grant to expand collection and analysis of medical claims data from multiple payers, complete an information technology infrastructure assessment, develop web-enabled analytic capabilities to provide access to health pricing data, and develop a state website that integrates price and quality information.

State Health Care Innovation Plan.

The Affordable Care Act established the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services to test innovative payment and service delivery models without reducing the quality of care. As part of the State Innovation Models Initiative, Washington received approximately $1 million from the CMMI to continue work on the State Health Care Innovation Plan (Innovation Plan). The Innovation Plan includes three strategies:

- encourage value-based purchasing, beginning with state-purchased health care;
- build healthy communities through prevention and early mitigation of disease; and
- improve chronic illness care through better integration of care and social supports, in particular for people with both physical and behavioral health issues.

**Summary of Engrossed Second Substitute Bill**:

State Health Care Innovation Plan.

The Health Care Authority (HCA) is responsible for coordinating, implementing, and administering interagency efforts and local collaborations to implement the State Health Care

Innovation Plan (Innovation Plan). By January 1, 2015, and each January 1 through 2019, the HCA must coordinate and issue a report to the Legislature summarizing actions taken to implement the Innovation Plan, progress toward achieving the aims of the Innovation Plan, anticipated future implementation efforts, and any recommendations for legislation.

Accountable Collaboratives for Health.

An "accountable collaborative for health" (ACH) is a regionally based collaborative designated by the HCA, the purpose of which is to align actions and initiatives of a diverse coalition of members to achieve healthy communities, improve health care quality, and lower costs. The term is used to recognize entities that are currently active or that may become active for purposes of directing funding. Designation as an ACH is not intended to create a governmental entity.

By September 1, 2014, the HCA must establish boundaries for up to nine regions for ACHs. Counties must be given the opportunity to propose the boundaries, but if the counties do not submit recommendations by July 1, 2014, the Task Force on the Adult Behavioral Health System must submit proposed boundaries by August 1, 2014. Boundaries must be based on county borders and must be consistent with Medicaid procurement regions.

The HCA must develop a process for designating an entity as an ACH. An entity is eligible to be designated if it is a nonprofit or public-private partnership, its membership includes key stakeholders, and it demonstrates an ongoing capacity to, among other things, lead health improvement activities within the region with other local systems and act in alignment with statewide health care initiatives. The HCA may designate more than one ACH in any region that consists of more than one county, but ACHs may not overlap or cross regional boundaries.

An entity designated as an ACH must convene stakeholders to:
- review existing data;
- evaluate the region's progress toward certain objectives;
- assess the region's capacity to address chronic care needs;
- review available funding and resources; and
- identify and prioritize or reaffirm regional health care needs, and develop a plan or use an existing plan to address those needs.

The HCA may award grants to support the development of ACHs. Grants may only be used for start-up costs. Criteria for awarding grants include whether the entity will provide matching funds, base decisions on public input and collaboration, and further the purposes of the state purchasing as identified in the bill. The HCA's rulemaking authority with respect to the ACHs extends only to those rules necessary to implement the provisions in the bill related to the ACHs.

An entity designated as an ACH must submit a report to the Legislature and the HCA by December 1, 2015, and each year through 2019. The report must describe regional needs, plans developed, actions taken, and any measurable progress. It must also identify grant funds received and, for the final report, demonstrate capability for sustainability.

The sections related to ACHs expire July 1, 2020.

Health Extension Program.

The Department of Health (DOH), subject to amounts appropriated, must establish a health extension program to provide training, tools, and technical assistance to health care providers. The program must emphasize high quality preventive, chronic disease, and behavioral health care that is comprehensive and evidence-based. The program must coordinate dissemination of resources that promote, among other things, integration of physical and behavioral health, reports of the Robert Bree collaborative, and practice transformation. The DOH may adopt rules necessary to implement the program, but may not adopt rules, policies, or procedures beyond the identified scope of authority. If the DOH contracts for services, it may only contract with an organization with a demonstrated ability to provide educational services to providers, clinics, and hospitals.

Statewide All-Payer Health Care Claims Database and Performance Measures.

The Office of Financial Management (OFM) must establish a statewide all-payer health care claims database. The database must support transparent public reporting of health care information to: assist patients, providers, and hospitals to make informed choices about care; enable providers, hospitals, and communities to benchmark their performance; enable purchasers to identify value, build expectations into their purchasing strategies, and reward improvements over time; and promote competition based on quality and cost. The Legislature finds that the benefit of collaboration among purchasers and providers, together with active state supervision, outweighs potential adverse impacts. Therefore, the Legislature intends to exempt and provide immunity from antitrust laws for certain activities undertaken, reviewed, and approved by the OFM.

*Lead Organization*. The OFM Director selects a lead organization to coordinate and manage the database, and the lead organization is responsible for collecting claims data and reporting performance on cost and quality. At the direction of the OFM, the lead organization must:

- be responsible for internal governance, management, funding, and operations;
- design collection mechanisms with consideration for time, cost, and benefits;
- ensure protection of collected data;
- make information from the database available as a resource;
- develop policies to ensure quality of data releases;
- develop a plan for financial sustainability and charge fees up to $5,000, with any fees comparable across data requests and users and approved by the OFM; and
- appoint advisory committees on data policy and the data release process.

*Submissions to Database*. Data suppliers must submit claims data to the database within the time frames established by the Director of the OFM an in accordance with procedures established by the lead organization. "Data supplier" is defined as a health carrier or an employer that provides health insurance to its employees. "Data supplier" does not include any entity, other than a state or local governmental entity, that is self-insured. "Claims data" include claims data for fully insured plans and claims data related to health care coverage and services funded, in whole or in part, in the operating budget, including coverage and services funded by appropriated and non-appropriated state and federal moneys. An entity that is not

a data supplier but that chooses to participate in the database must require any third-party administrator to release, at no additional cost, any claims data related to persons receiving health coverage from the entity's plan.

Data suppliers must submit an annual status report to the OFM regarding their compliance, and this information must be included in the report to the Legislature.

*Performance Measures.* A performance measures committee is established to identify and recommend standard statewide measures of health performance to inform healthcare purchasers and set benchmarks. The committee must coordinate with the lead organization. Members of the committee must represent state agencies, employers, health plans, patient groups, consumers, academic experts, hospitals, physicians, and other providers. Members must represent diverse geographic locations and rural and urban communities. The Governor appoints members to the committee, except that statewide associations representing hospitals and physicians appoint those members. The chief executive officer of the lead organization also serves on the committee. The committee is chaired by the director of the HCA.

The committee must develop a transparent process to select performance measures, including an opportunity for public comment. By January 1, 2015, the committee must submit the measures to the HCA. The measures must include dimensions of prevention and screening, effective management of chronic conditions, key health outcomes, care coordination and patient safety, and use of the lowest cost, highest quality care for acute conditions.

The committee must develop a measure set that:

- is of a manageable size;
- is based on readily available claims and clinical data;
- gives preference to nationally reported measures and, when those may not be appropriate, measures used by the Health Benefit Exchange and state agencies;
- focuses on overall performance of the system;
- is aligned with the Governor's performance management system measures and common measure requirements specific to Medicaid delivery systems;
- considers needs of different stakeholders and populations; and
- is usable by multiple payers, providers, purchasers, and communities.

State agencies must use the measure set to inform purchasing decisions and set benchmarks. The committee must establish a public process to periodically evaluate and make additions or changes to the measure set.

*Reports.* Under the supervision of the OFM, the lead organization must use the measure set and the database to prepare health care data reports. Prior to releasing reports that use claims data, the lead organization must submit the reports to the OFM for review and approval. Reports must assist the Legislature and the public by reporting on whether providers and systems deliver efficient, high-quality care and geographic and other variations in care and costs.

Measures in the report should be stratified to identify disparities and efforts to reduce disparities, and comparisons of costs among systems must account for differences in acuity

of patients, the cost impact of subsidization, and teaching expenses when feasible with available data.

The lead organization may not publish data or reports that directly or indirectly identify patients or disclose specific reimbursement arrangements between a provider and a payer. The OFM and the lead organization may use claims data to identify and make available information on payers, providers, and facilities, but may not use claims data to recommend or incentivize direct contracting. The lead organization may not release a report comparing or identifying providers, hospitals, or data suppliers unless it allows them to verify the accuracy of the information and submit corrections within 45 days and unless it corrects errors.

The lead organization must ensure that no individual data supplier comprises more than 25 percent of the claims data used in any report or other analysis generated from the database. For this purpose, "data supplier" means a carrier and any self-insured employer that uses the carrier's provider contracts.

*Use of Data*. Data provided to the database, the database itself, and raw data received from the database are not public records within the meaning of the Public Records Act and are exempt from public disclosure. Data obtained through activities related to the database and performance measures are not subject to subpoena in a civil, criminal, judicial, or administrative proceeding, and a person with access to the data may not be compelled to testify.

The OFM must direct the lead organization to maintain the confidentiality of the data it collects for the database that include direct or indirect patient identifiers. Any agency, researcher, or other person who receives data with patient identifiers must also maintain confidentiality and may not release the information except as consistent with the requirements of the bill.

Data must be made available within a reasonable time after request. Data with direct or indirect patient identifiers, as specifically defined in rule, may be released to: (1) federal, state, and local government agencies upon receipt of a signed data use agreement; and (2) researchers with approval of an institutional review board upon receipt of a signed confidentiality agreement. Data with indirect patient identifiers may be released to an agency, researcher, and other person upon receipt of a signed data use agreement. Data that do not contain direct or indirect patient identifiers may be released upon request. "Direct patient identifier" means information that identifies a patient, and "indirect patient identifier" means information that may identify a patient when combined with other information.

Recipients of data with patient identifiers must agree in a data use agreement and confidentiality agreement to, at a minimum, take steps to protect patient identifying information and not re-disclose the data except as authorized in the agreement or as otherwise required by law. Recipients of data may not attempt to determine patients' identity or use the data in a manner that identifies the individuals or their families.

The Insurance Commissioner may not use data acquired from the database for purposes of reviewing insurance rates, but the Insurance Commissioner's authority to access data from

any other source for rate review is not otherwise curtailed, even if that data may have been separately submitted to the database.

*Administration.* The OFM may adopt rules as necessary to implement and enforce requirements related to the database and the performance measures, including:

- definitions of claim and data files that data suppliers must submit (including: files for covered medical services, pharmacy claims, and dental claims; member eligibility and enrollment data; and provider data);
- deadlines for submitting claim files and penalties for failure to submit claim files;
- procedures for ensuring data are securely collected and stored in compliance with law; and
- procedures for ensuring compliance with privacy laws.

<u>Medicaid Procurement</u>.

The HCA and the DSHS must restructure Medicaid procurement of health care services and agreements with managed care systems on a phased basis to better support integrated physical health, mental health, and chemical dependency treatment. By January 1, 2019, Medicaid services must be fully integrated in a managed health care system that provides mental health, chemical dependency, and medical care services to Medicaid clients. The HCA and the DSHS must develop and use innovative mechanisms to promote and sustain integrated clinical models of physical and behavioral health care.

The agencies must incorporate specified principles into their Medicaid procurement efforts, including:

- Facilitating equitable access to effective behavioral health services for adults and children is a state priority.
- Delivery of better integrated, person-centered care is a shared responsibility of regional support networks, managed health care systems, service providers, hospitals, the state, and communities.
- Medicaid purchasing must support delivery of integrated care that addresses the spectrum of individuals' health needs in the context of their communities and with the availability of care continuity as their health needs change.

The principles are not intended to create an individual entitlement to services.

**EFFECT OF SENATE AMENDMENT(S)**:

<u>With respect to coordination of the State Health Care Innovation Plan (Innovation Plan), the Senate amendment requires that the Health Care Authority (HCA), prior to submitting a grant application, consult a neutral actuarial firm that is not currently contracted with the agency to review the estimated savings in the Innovation Plan. Prior to submitting the grant application, the HCA must also present the actuarial information and the plan to the Joint Select Committee on Health Care Oversight (Joint Select Committee). The Joint Select Committee must review the application in a timely fashion to enable the application, if approved, to be submitted within the required time frame. The grant application may not commit the state to financial obligations beyond the grant amount. Any federally required</u>

reporting related to the grant must be shared with the Joint Select Committee when it is submitted to the federal government.

The Joint Select Committee is established in statute, with an expiration date of December 31, 2022. Membership consists of the chairs of the health care committees, four additional members of the Senate, and four additional members of the House of Representatives. The Governor may appoint a nonvoting member to act as a liaison. The Joint Select Committee must provide oversight between the HCA, the Health Benefit Exchange (Exchange), the Office of the Insurance Commissioner, the Department of Health (DOH), and the Department of Social and Health Services (DSHS) and must propose legislation and budget recommendations to aid in the coordination of activities and achieve better quality and cost savings.

With respect to the accountable collaboratives for health, the Senate amendment:
- deletes the provisions creating regions and requiring the accountable collaboratives for health to undertake certain activities;
- renames "accountable collaboratives for health" as "communities of health;"
- requires the HCA to award grants for two pilot projects;
- modifies eligibility to include public-private partnerships led by a local public health agency;
- deletes the requirements that the HCA consider the extent to which an applicant will further the purposes of state health care purchasing, that performance requirements be aligned with the purposes of state health care purchasing, and that the organization submit annual reports to the Legislature and HCA; and
- grants the HCA rulemaking authority but prohibit the HCA from adopting rules, policies, or procedures beyond the scope of authority granted.

The Senate amendment modifies the health extension program by:
- deleting the requirement that any organizations with which the DOH contracts have the ability to provide educational services to providers, clinics, and hospitals;
- deleting the requirement that the program disseminate tools that promote clinical information systems and practice transformation; and
- adding a requirement that the program disseminate tools that promote identification of evidence-based models to effectively treat depression and other conditions in primary care settings.

The Senate amendment modifies the section creating a performance measures committee by:
- requiring the committee to propose (instead of set) benchmarks;
- deleting the requirement that the committee coordinate with the lead organization;
- adding federally recognized tribes to the committee membership;
- requiring the measures to include use of the lowest cost, highest quality care for preventive care and chronic conditions in addition to acute conditions;
- requiring the measure set to give preference to measures used by state agencies or commercial health plans (instead of the Exchange) if nationally reported measures are not appropriate; and
- requiring agencies to use the measure set to inform and set benchmarks for purchasing (rather than inform purchasing and set benchmarks).

The Senate amendment permits (instead of requires) the HCA and the DSHS to restructure Medicaid procurement to support integration, develop and use innovative mechanisms, and incorporate specified principles in Medicaid procurement efforts aimed at integration. The requirement that Medicaid services be fully integrated by January 1, 2019 is deleted. Restructuring of procurement must be consistent with the assumptions in 2SSB 6312 and the recommendations of the Behavioral Health Task Force. Examples of innovative mechanisms to promote and sustain integration are deleted. Principles stating that facilitation of equitable access to behavioral health is a state priority and that integration is a shared responsibility are deleted. The HCA must increase the use of value based contracting, alternative quality contracting, and other payment incentives for Medicaid and public employee purchasing and must implement additional chronic disease management techniques.

With respect to the all-payer claims database, the Senate amendment deletes the definition of "data supplier" (which included carriers and employers). The definition of "claims data," which must be submitted to the database, is modified to: remove reference to claims data for fully insured plans; include claims data related to coverage and services funded in the budget only for Medicaid programs and Public Employee Benefits Board programs; include claims data voluntarily provided by other data suppliers, such as carriers and self-funded employers; and provide that the definition "includes" (rather than "includes but is not limited to") the specified categories of data. The lead organization's governance structure and advisory committees must include representation of the third-party administrator of the Uniform Medical Plan. Only payers, health maintenance organizations, and third-party administrators that are data suppliers may be represented on the lead organization's governance structure and advisory committees. The lead organization may exceed the cap on fees for reports and data files if the fees are otherwise negotiated. The prohibition on a third-party administrator imposing an additional cost to release a voluntary data supplier’s claims is deleted. The lead organization may not compare performance in a report generated for the general public that includes a provider in a practice with fewer than five providers.

The Senate amendment modifies the intent section by deleting examples of how the state has an opportunity to transform the health delivery system and by deleting and rephrasing identified drivers of health transformation.

**Appropriation**: None.

**Fiscal Note**: Available.

**Effective Date**: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

**Staff Summary of Public Testimony** (Health Care & Wellness):

(In support) This bill represents a year-long process of vetting ideas statewide. State-purchased health care must be the first mover, because the way the state pays for health care will improve the quality and cost of health care for residents. Whole-person care is needed for the Medicaid population. This bill requires a phased approach to procurement to deliver integrated physical, mental, and substance use treatment.

Local communities have begun collaborating, knowing that good health occurs when communities come together to address health care and other health essentials, especially for vulnerable populations. There are currently 11 collaboratives in various stages of development. Members include business partnerships, public health districts, and behavioral health organizations, among others. The collaborative approach gets the community engaged in determining metrics and prevents unnecessary hospitalization and incarceration. Many cost, quality, and access problems are a function of people getting lost in the intersections between different organizations. It is vital for successful reform that rural and urban communities work side by side. The ACHs need access to data to make informed decisions.

Transparency is a key driver for improvement. Creating the all-payer claims database is necessary to provide transparent information to patients and employer purchasers with respect to price, quality, and utilization. In recent surveys, Washington was rated an "A" for physician transparency but an "F" for price transparency because of the lack of access to pricing data for medical claims. Vast pricing variation exists across hospital delivery systems. The voluntary approach for pricing data has not worked. The Office of Financial Management has received a grant to increase price transparency, but enabling legislation is necessary. There are concerns about privacy with the database, because data sets about collusion are not addressed. There must be a comprehensive solution for all health plans, because cost transparency is difficult to tackle as a single health plan. Cost calculators for patients are helpful but do not deal with the real cost of care. One reason cost varies is because quality of care varies. Common state performance measures will ensure consistent health improvement efforts.

(In support with amendments) The all-payer claims database provisions in the bill impact small business. Consumers need better information to make better purchasing decisions, and this bill represents a step forward in that process. It will allow consumers access to real-time or recent data on important cost and quality measures. When trying to decide which clinic, hospital, or other facility to use, the database will help get the best quality coverage for an affordable price. Provider data should be confidential. Physicians want equal access to data and representation on advisory committees. The concepts in the bill must be implemented in a staged approach so changes can be handled at the local level. The extension program looks creatively at options for delivering care on the ground.

(In support with concerns) It is important to work at the local level, and many communities are already doing that. Hospitals are looking for better information on cost and quality of health care. The administrative burden associated with additional data requests should be streamlined. The accountable collaboratives for health should not be involved in Medicaid contracting.

(Opposed) Legislatively mandated all-payer claims databases have not been proven to improve quality or reduce cost, even after significant initial investments. They pose a serious problem for competition. Most carriers are moving toward a value-based payment model. Aggregated data that a consumer might access would not apply to the consumer's plan and benefits. Tools currently offered provide meaningful and personalized cost information to make price and quality shopping decisions across a range of providers and provider types. The database will require providers to make substantial investments in order to submit data.

**Staff Summary of Public Testimony** (Appropriations):

(In support) None.

(Commented) Anything that is done to increase health care purchasing efficiency makes sense and this bill does that. There are concerns about privacy and the administering of health care generally. People would heal more quickly if the state ensured access to all types of healing. People need health, not health care, and there are things happening in the allopathic health care system that are harming health.

(Opposed) None.

**Persons Testifying** (Health Care & Wellness): (In support) Dr. Bob Crittenden, Office of the Governor; Dorothy Teeter, Health Care Authority; John Wiesman, Department of Health; Mary McWilliams, Washington Health Alliance; Eric Schinfeld, Seattle Metropolitan Chamber of Commerce; Larry Thompson, Whatcom Alliance; Jesus Hernandez, Community Choice; Sue Dietz, Critical Access Hospital Network; Reese Edwards, United Health; and David Grossman, Group Health.

(In support with amendments) Patrick Connor, National Federation of Independent Business; and Katie Kolan, Washington State Medical Association.

(In support with concerns) Claudia Sanders, Washington State Hospital Association.

(Opposed) Chris Bandoli, Regence Blue Shield; and Len Sorrin, Premera Blue Cross.

**Persons Testifying** (Appropriations): Lucy Luddington.

**Persons Signed In To Testify But Not Testifying** (Health Care & Wellness): Mary Clogston, American Association of Retired Persons; Len McComb, Community Health Network of Washington; Joe Avalos, Thurston County; Lindsey Grad, Service Employees International Union 1199 NW; Lisa Thatcher, GlaxoSmithKline; and Michael Shaw, King County.

**Persons Signed In To Testify But Not Testifying** (Appropriations): None.