H-4150.3

SECOND SUBSTITUTE HOUSE BILL 2572

State of Washington **63rd Legislature** **2014 Regular Session**

By House Appropriations (originally sponsored by Representative Cody; by request of Governor Inslee)

READ FIRST TIME 02/11/14.

1 AN ACT Relating to improving the effectiveness of health care
2 purchasing and transforming the health care delivery system by
3 advancing value-based purchasing, promoting community health, and
4 providing greater integration of chronic illness care and needed social
5 supports; amending RCW 42.56.360 and 70.02.045; adding new sections to
6 chapter 41.05 RCW; adding a new section to chapter 43.70 RCW; adding a
7 new section to chapter 74.09 RCW; adding a new chapter to Title 43 RCW;
8 creating new sections; and providing an expiration date.

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

10 NEW SECTION. **Sec. 1.** (1) The legislature finds that the state of
11 Washington has an unprecedented opportunity to implement a five-year
12 state health care innovation plan developed through the center for
13 medicare and medicaid innovation state innovation model program. The
14 innovation plan describes the state's strategy to transform its health
15 care delivery system through multipayer payment reform, the development
16 of a statewide comprehensive prevention framework, and other state-led
17 initiatives.
18 (2) The state health care innovation plan establishes the following

1 primary drivers of health transformation, each with individual key
2 actions that are necessary to achieve the objective:
3 (a) Improve health overall by building healthy communities and
4 people through prevention and early mitigation of disease throughout
5 the lifespan;
6 (b) Improve chronic illness care through better integration and
7 strengthening of linkages between the health care delivery system and
8 community, particularly for individuals with physical and behavioral
9 comorbidities; and
10 (c) Advance value-based purchasing across the community, and lead
11 by example in transforming how the state purchases health care
12 services.
13 (3) The legislature intends to facilitate the implementation of the
14 state health care innovation plan by:
15 (a) Establishing an all-payer claims database that improves
16 transparency for patients, providers, hospitals, and purchasers;
17 (b) Developing standard statewide performance and quality measures
18 to inform purchasing and set benchmarks;
19 (c) Supporting the initiatives of regional collaboratives to
20 achieve healthy communities and populations, improve health care
21 quality, and lower costs;
22 (d) Disseminating evidence-based training, tools, and other
23 resources to providers and hospitals; and
24 (e) Supporting integration of services for physical health,
25 behavioral health, and chemical dependency by restructuring medicaid
26 procurement.

27 NEW SECTION. **Sec. 2.** (1) The health care authority is responsible
28 for coordination, implementation, and administration of interagency
29 efforts and local collaborations of public and private organizations to
30 implement the state health care innovation plan.
31 (2) By January 1, 2015, and January 1st of each year through
32 January 1, 2019, the health care authority shall coordinate and submit
33 a status report to the appropriate committees of the legislature
34 regarding implementation of the innovation plan. The report must
35 summarize any actions taken to implement the innovation plan, progress
36 toward achieving the aims of the innovation plan, and anticipated

future implementation efforts. In addition, the health care authority shall submit any recommendations for legislation necessary to implement the innovation plan.

NEW SECTION. **Sec. 3.** A new section is added to chapter 41.05 RCW to read as follows:

(1) An accountable collaborative for health is a regionally based, voluntary collaborative designated by the authority, the purpose of which is to align actions and initiatives of a diverse coalition of members to achieve healthy communities and populations, improve health care quality, and lower costs. "Accountable collaborative for health" is a term used to recognize entities that are currently active and those that may become active that perform the functions described in this section. This term is used only to assist in directing funding or other support that may be available to these local entities. The designation of an entity as an accountable collaborative for health is not intended to create an additional government entity.

(2) By September 1, 2014, the authority shall establish boundaries for up to nine regions for accountable collaboratives for health as provided in this subsection. Counties, through the Washington state association of counties, must be given the opportunity to propose the boundaries of the regions. If counties do not submit proposed boundaries for the regions by July 1, 2014, the task force on the adult behavioral health system created by section 1, chapter 338, Laws of 2013 shall submit proposed boundaries to the authority by August 1, 2014. The boundaries must be based on county borders and must be consistent with medicaid procurement regions.

(3) The authority shall develop a process for designating an entity as an accountable collaborative for health. An entity seeking designation is eligible if:

(a) It is a nonprofit or public-private partnership;

(b) Its membership is broad and incorporates key stakeholders, such as the long-term care system, the health care delivery system, behavioral health, social supports and services, primary care and specialty providers, hospitals, consumers, small and large employers, health plans, and public health, with no single entity or organizational cohort serving in a majority capacity; and

(c) It demonstrates an ongoing capacity to:

1 (i) Lead health improvement activities within the region with other
2 local systems to improve health outcomes and the overall health of the
3 community, improve health care quality, and lower costs;
4 (ii) Distribute tools and resources from the health extension
5 program created in section 6 of this act; and
6 (iii) Act in alignment with statewide health care initiatives by
7 using the statewide all-payer health care claims database created in
8 section 9 of this act, the statewide health performance and quality
9 measures developed pursuant to section 12 of this act, and outcome
10 measures reflecting local health needs as identified by the accountable
11 collaborative for health.
12 (4) The authority may designate more than one accountable
13 collaborative for health in any region that consists of more than one
14 county, but an accountable collaborative for health may not cross the
15 regional boundaries defined by the authority or overlap with another
16 accountable collaborative for health.
17 (5) An entity designated by the authority as an accountable
18 collaborative for health must convene key stakeholders to:
19 (a) Review existing data, including data collected through the
20 community health assessment process;
21 (b) Evaluate the region's progress toward the objectives of the
22 national healthy people 2020 initiative and the priorities identified
23 in community health assessments and community health improvement plans;
24 (c) Assess the region's capacity to address chronic care needs,
25 including the needs of persons with co-occurring disorders;
26 (d) Review available funding and resources; and
27 (e) Identify and prioritize or reaffirm regional health care needs
28 and prevention strategies and develop a plan or use an existing plan to
29 address those needs.
30 (6) For purposes of this section and section 4 of this act, the
31 authority may only adopt rules that are necessary to implement this
32 section and section 4 of this act.

33 NEW SECTION. **Sec. 4.** A new section is added to chapter 41.05 RCW
34 to read as follows:
35 (1) The authority shall, subject to the availability of amounts
36 appropriated for this specific purpose, award grants to support the

development of accountable collaboratives for health. Grants may only be used for start-up costs. The authority may not award more than one grant per region.

(2) An entity may be eligible for a grant under this section if it has been designated as an accountable collaborative for health under section 3 of this act. A grant application must, at a minimum:

(a) Identify the geographic region served by the applicant;

(b) Demonstrate how the applicant's structure and operation reflect the interests of and are accountable to the region and the state for health improvement; and

(c) Indicate the size of the grant being requested and describe how the money will be spent.

(3) In awarding grants under this section, the authority shall consider the extent to which the applicant will:

(a) Further the purposes of the state health care innovation plan and section 3 of this act;

(b) Base decisions on public input and an active collaboration among key community partners, including, but not limited to, local governments, school districts, early learning regional coalitions, large and small businesses, labor organizations, health and human service organizations, tribal governments, health carriers, providers, hospitals, public health agencies, and consumers;

(c) Match the grant funding with funds from other sources; and

(d) Demonstrate capability for sustainability without reliance on state general fund appropriations.

(4) The authority may prioritize applications that commit to providing at least one dollar in matching funds for each grant dollar awarded.

(5) Before grant funds are disbursed, the authority and the applicant must agree on performance requirements and the consequences for failing to meet those requirements. The performance requirements must be aligned with the purposes of the state health care innovation plan.

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

Any entity designated as an accountable collaborative for health pursuant to section 3 of this act shall submit a report to the governor

1 and the appropriate committees of the legislature beginning December 1,
2 2015, and December 1st of each year through December 1, 2019. The
3 report must:
4 (1) Describe the regional health care needs identified by the
5 entity and key stakeholders to date, the plan developed to address
6 those needs, any actions taken by the entity and other stakeholders
7 pursuant to the plan, and any measurable progress toward meeting those
8 needs;
9 (2) Identify any grant funds received by the entity pursuant to
10 section 4 of this act; and
11 (3) For the final report, demonstrate the entity's capability for
12 sustainability without reliance on state general fund appropriations.

13 NEW SECTION. **Sec. 6.** A new section is added to chapter 43.70 RCW
14 to read as follows:
15 (1) Subject to the availability of amounts appropriated for this
16 specific purpose, the department shall establish a health extension
17 program to provide training, tools, and technical assistance to primary
18 care, behavioral health, and other providers. The program must
19 emphasize high quality preventive, chronic disease, and behavioral
20 health care that is comprehensive and evidence-based. If the
21 department contracts for services under this section, it may only
22 contract with an organization that has demonstrated the ability to
23 provide educational services to providers, clinics, and hospitals on
24 the topics listed in subsection (2) of this section.
25 (2) The health extension program must coordinate dissemination of
26 evidence-based tools and resources that promote:
27 (a) Integration of physical and behavioral health;
28 (b) Clinical information systems with sharing and organization of
29 patient data;
30 (c) Clinical decision support to promote evidence-based care;
31 (d) Reports of the Robert Bree collaborative created by RCW
32 70.250.050 and findings of health technology assessments under RCW
33 70.14.080 through 70.14.130;
34 (e) Methods of formal assessment;
35 (f) Support for patients managing their own conditions;
36 (g) Identification and use of resources that are available in the

community for patients and their families, including community health workers; and

(h) Practice transformation, including, but not limited to, team-based care, shared decision making, use of population level health data and management, and quality improvement linked to common statewide performance measures.

(3) The department may adopt rules necessary to implement this section, but may not adopt rules, policies, or procedures beyond the scope of authority granted in this section.

NEW SECTION. **Sec. 7.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Carrier" and "health carrier" have the same meaning as in RCW 48.43.005.

(2) "Claims data" means the data required by section 10 of this act to be submitted to the database, as defined by the director in rule. "Claims data" includes, but is not limited to:

(a) Claims data for fully insured plans; and

(b) Claims data related to health care coverage and services funded, in whole or in part, in the omnibus appropriations act, including coverage and services funded by appropriated and nonappropriated state and federal moneys.

(3) "Data supplier" means a health carrier or an employer that provides health insurance to its employees. It does not include any entity, other than a state or local governmental entity, that is self-insured.

(4) "Database" means the statewide all-payer health care claims database established in section 9 of this act.

(5) "Director" means the director of financial management.

(6) "Lead organization" means the organization selected under section 9 of this act.

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

NEW SECTION. **Sec. 8.** The legislature finds that:

(1) The activities authorized by this chapter will require collaboration among state agencies and local governments that purchase health care, private health carriers, third-party purchasers, health care providers, and hospitals. These activities will identify

strategies to increase the quality and effectiveness of health care delivered in Washington state and are therefore in the best interest of the public.

(2) The benefits of collaboration, together with active state supervision, outweigh potential adverse impacts. Therefore, the legislature, through the state action doctrine, intends to exempt and provide immunity from state and federal antitrust laws for activities directed, reviewed, and approved by the office pursuant to this chapter that might otherwise be constrained by such laws when the activities are directed, reviewed, and approved by the office. The legislature does not intend for the office to approve activities that would constitute per se violations of state and federal antitrust laws.

NEW SECTION. **Sec. 9.** (1) The office shall establish a statewide all-payer health care claims database to support transparent public reporting of health care information. The database must improve transparency to: Assist patients, providers, and hospitals to make informed choices about care; enable providers, hospitals, and communities to improve by benchmarking their performance against that of others by focusing on best practices; enable purchasers to identify value, build expectations into their purchasing strategy, and reward improvements over time; and promote competition based on quality and cost.

(2) The director shall select a lead organization to coordinate and manage the database. The lead organization is responsible for internal governance, management, funding, and operations of the database. At the direction of the office, the lead organization shall:

(a) Collect claims data from data suppliers as provided in section 10 of this act;

(b) Design data collection mechanisms with consideration for the time and cost involved in collection and the benefits that measurement would achieve;

(c) Ensure protection of collected data and store and use any data with patient-specific information in a manner that protects patient privacy;

(d) Consistent with the requirements of this chapter, make information from the database available as a resource for public and

1 private entities, including carriers, employers, providers, hospitals,
2 and purchasers of health care;
3 (e) Report performance on cost and quality pursuant to section 13
4 of this act using, but not limited to, the performance measures
5 developed under section 12 of this act;
6 (f) Develop protocols and policies to ensure the quality of data
7 releases;
8 (g) Develop a plan for the financial sustainability of the database
9 and charge fees not to exceed five thousand dollars for reports and
10 data files as needed to fund the database. Any fees must be approved
11 by the office and must be comparable across data requesters and users;
12 and
13 (h) Convene advisory committees with the approval and participation
14 of the office, including: (i) A committee on data policy development;
15 and (ii) a committee to establish a data release process consistent
16 with the requirements of this chapter and to provide advice regarding
17 formal data release requests. The advisory committees must include
18 representation from key provider, hospital, payer, public health,
19 health maintenance organization, purchaser, and consumer organizations.

20 NEW SECTION. **Sec. 10.** (1) Data suppliers must submit claims data
21 to the database within the time frames established by the director in
22 rule and in accordance with procedures established by the lead
23 organization.
24 (2) An entity that is not a data supplier but that chooses to
25 participate in the database shall require any third-party administrator
26 utilized by the entity's plan to release, at no additional cost, any
27 claims data related to persons receiving health coverage from the plan.
28 (3) Each data supplier shall submit an annual status report to the
29 office regarding its compliance with this section. The report to the
30 legislature required by section 2 of this act must include a summary of
31 these status reports.

32 NEW SECTION. **Sec. 11.** (1) The claims data provided to the
33 database, the database itself, including the data compilation, and any
34 raw data received from the database are not public records and are
35 exempt from public disclosure under chapter 42.56 RCW.

(2) Claims data received by the lead organization or the office pursuant to this chapter are strictly confidential, and any use, release, or publication of claims data must be done in such a way that no person is directly or indirectly identifiable.

(3) Claims data obtained in the course of activities undertaken pursuant to or supported under this chapter are not subject to subpoena or similar compulsory process in any civil or criminal, judicial, or administrative proceeding, nor may any individual or organization with lawful access to data under this chapter be compelled to testify with regard to such data, except that data pertaining to a party in litigation may be subject to subpoena or similar compulsory process in an action brought by or on behalf of such individual to enforce any liability arising under this chapter.

NEW SECTION. **Sec. 12.** (1) There is created a performance measures committee, the purpose of which is to develop and recommend standard statewide measures of health performance to inform state purchasing of health care and set benchmarks to track costs and improvements in health outcomes.

(2) Members of the committee must include representation from state agencies, small and large employers, health plans, patient groups, consumers, academic experts on health care measurement, hospitals, physicians, and other providers. The governor shall appoint the members of the committee, except that a statewide association representing hospitals may appoint a member representing hospitals and a statewide association representing physicians may appoint a member representing physicians. The governor shall ensure that members represent diverse geographic locations and both rural and urban communities. The chief executive officer of the lead organization must also serve on the committee.

(3) The committee shall develop a transparent process for selecting performance measures, and the process must include opportunities for public comment.

(4) By January 1, 2015, the committee shall submit the performance measures to the office and the lead organization. The measures must include dimensions of:

(a) Prevention and screening;

(b) Effective management of chronic conditions;

(c) Key health outcomes;

(d) Care coordination and patient safety; and

(e) Use of the lowest cost, highest quality care for acute conditions.

(5) The lead organization shall develop a measure set based on the recommendations of the committee. The measure set must:

(a) Be of manageable size;

(b) Be based on readily available claims and clinical data;

(c) Give preference to nationally reported measures and measures used by the health benefit exchange and state agencies that purchase health care;

(d) Focus on the overall performance of the system, including outcomes and total cost;

(e) Be aligned with the governor's performance management system measures and common measure requirements specific to medicaid delivery systems under RCW 70.320.020 and 43.20A.895;

(f) Consider the needs of different stakeholders and the populations served; and

(g) Be usable by multiple payers, providers, hospitals, purchasers, public health, and communities as part of health improvement, care improvement, provider payment systems, benefit design, and administrative simplification for providers and hospitals.

(6) The committee shall terminate on January 31, 2015.

(7) State agencies shall use the measure set developed under this section to inform purchasing decisions and set benchmarks.

(8) The lead organization shall establish a public process to periodically evaluate the measure set and make necessary additions or changes to the measure set.

NEW SECTION. **Sec. 13.** (1) Under the supervision of the office, the lead organization shall prepare health care data reports using the database and the statewide health performance and quality measure set, including only those measures that can be completed with readily available claims data. Prior to releasing any health care data reports that use claims data, the lead organization must submit the reports to the office for review and approval.

(2)(a) Health care data reports prepared by the lead organization

1 that use claims data must assist the legislature and the public with
2 awareness and promotion of transparency in the health care market by
3 reporting on:
4 (i) Whether providers and health systems deliver efficient, high
5 quality care;
6 (ii) Geographic and other variations in medical care and costs as
7 demonstrated by data available to the lead organization; and
8 (iii) Rate and price increases by health care providers that exceed
9 the consumer price index - medical care as compiled by the bureau of
10 labor statistics of the United States department of labor.
11 (b) Measures in the health care data reports should be stratified
12 by demography, income, language, health status, and geography when
13 feasible with available data to identify disparities in care and
14 successful efforts to reduce disparities.
15 (c) Comparisons of costs among providers and health care systems
16 must account for differences in acuity of patients, as appropriate and
17 feasible, and must take into consideration the cost impact of
18 subsidization for uninsured and governmental patients, as well as
19 teaching expenses, when feasible with available data.
20 (3) The lead organization may not publish any data or health care
21 data reports that:
22 (a) Directly or indirectly identify patients; or
23 (b) Disclose specific terms of contracts, discounts, or fixed
24 reimbursement arrangements or other specific reimbursement arrangements
25 between an individual provider and a specific payer.
26 (4) The lead organization may not release a report that compares
27 and identifies providers or data suppliers unless it:
28 (a) Allows the data supplier or the provider to verify the accuracy
29 of the information submitted to the lead organization and submit to the
30 lead organization any corrections of errors with supporting evidence
31 and comments within forty-five days of receipt of the report;
32 (b) Corrects data found to be in error within a reasonable amount
33 of time; and
34 (c) Allows the data supplier a reasonable amount of time prior to
35 publication to review the lead organization's interpretation of the
36 data and prepare a response.
37 (5) The office and the lead organization may use claims data to
38 identify and compare payers, providers, and facilities, but may not use

1 claims data to recommend that consumers or payers direct business to or
2 avoid directing business to a single provider or facility or a group of
3 providers or facilities.

4 NEW SECTION. **Sec. 14.** (1) The director shall adopt any rules
5 necessary to implement this chapter, including:
6 (a) Definitions of claim and data files that data suppliers must
7 submit to the database, including: Files for covered medical services,
8 pharmacy claims, and dental claims; member eligibility and enrollment
9 data; and provider data with necessary identifiers;
10 (b) Deadlines for submission of claim files;
11 (c) Penalties for failure to submit claim files as required;
12 (d) Procedures for ensuring that all data received from data
13 suppliers are securely collected and stored in compliance with state
14 and federal law; and
15 (e) Procedures for ensuring compliance with state and federal
16 privacy laws.
17 (2) The director may not adopt rules, policies, or procedures
18 beyond the authority granted in this chapter.

19 NEW SECTION. **Sec. 15.** A new section is added to chapter 74.09 RCW
20 to read as follows:
21 (1) Consistent with the implementation of the state health care
22 innovation plan and the provisions of RCW 70.320.020, the authority and
23 the department shall restructure medicaid procurement of health care
24 services and agreements with managed care systems on a phased basis to
25 better support integrated physical health, mental health, and chemical
26 dependency treatment. The authority and the department shall develop
27 and utilize innovative mechanisms to promote and sustain integrated
28 clinical models of physical and behavioral health care such as:
29 Practice transformation support and resources; workforce capacity and
30 flexibility; shared clinical information sharing, tools, resources, and
31 training; and outcome-based payments to providers and hospitals.
32 (2) The authority and the department shall incorporate the
33 following principles into future medicaid procurement efforts aimed at
34 integrating the delivery of physical and behavioral health services:
35 (a) Facilitating equitable access to effective behavioral health
36 services for adults and children is a state priority;

1 (b) Recognition that the delivery of better integrated, person-
2 centered care to meet enrollees' physical and behavioral health care
3 needs is a shared responsibility of contracted regional support
4 networks, managed health care systems, service providers, hospitals,
5 the state, and communities;
6 (c) Medicaid purchasing must support delivery of integrated,
7 person-centered care that addresses the spectrum of individuals' health
8 needs in the context of the communities in which they live and with the
9 availability of care continuity as their health needs change;
10 (d) Accountability for the client outcomes established in RCW
11 43.20A.895 and 71.36.025 and performance measures linked to those
12 outcomes;
13 (e) Medicaid benefit design must recognize that adequate preventive
14 care, crisis intervention, and support services promote a recovery-
15 focused approach;
16 (f) Evidence-based care interventions and continuous quality
17 improvement must be enforced through contract specifications and
18 performance measures, including the statewide measure set under section
19 12 of this act, that provide meaningful integration at the patient care
20 level with broadly distributed accountability for results;
21 (g) Active purchasing and oversight of medicaid managed care
22 contracts is a state responsibility;
23 (h) A deliberate and flexible system change plan with identified
24 benchmarks and periodic readiness reviews will promote system
25 stability, provide continuity of treatment for patients, and protect
26 essential existing behavioral health system infrastructure and
27 capacity; and
28 (i) Community and organizational readiness are key determinants of
29 implementation timing; a phased approach is therefore desirable.
30 (3) The principles identified in subsection (2) of this section are
31 not intended to create an individual entitlement to services.

32 **Sec. 16.** RCW 42.56.360 and 2013 c 19 s 47 are each amended to read
33 as follows:
34 (1) The following health care information is exempt from disclosure
35 under this chapter:
36 (a) Information obtained by the pharmacy quality assurance
37 commission as provided in RCW 69.45.090;

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

(c) Information and documents created specifically for, and collected and maintained by a quality improvement committee under RCW 43.70.510, 70.230.080, or 70.41.200, or by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640 or 18.20.390, or by a hospital, as defined in RCW 43.70.056, for reporting of health care-associated infections under RCW 43.70.056, a notification of an incident under RCW 70.56.040(5), and reports regarding adverse events under RCW 70.56.020(2)(b), regardless of which agency is in possession of the information and documents;

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

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

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

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

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

(g) Information obtained by the department of health under chapter 70.225 RCW;

(h) Information collected by the department of health under chapter 70.245 RCW except as provided in RCW 70.245.150;

(i) Cardiac and stroke system performance data submitted to

1 national, state, or local data collection systems under RCW
2 70.168.150(2)(b); ((~~and~~))
3 (j) All documents, including completed forms, received pursuant to
4 a wellness program under RCW 41.04.362, but not statistical reports
5 that do not identify an individual; and
6 (k) Data and information exempt from disclosure under section 11 of
7 this act.
8 (2) Chapter 70.02 RCW applies to public inspection and copying of
9 health care information of patients.
10 (3)(a) Documents related to infant mortality reviews conducted
11 pursuant to RCW 70.05.170 are exempt from disclosure as provided for in
12 RCW 70.05.170(3).
13 (b)(i) If an agency provides copies of public records to another
14 agency that are exempt from public disclosure under this subsection
15 (3), those records remain exempt to the same extent the records were
16 exempt in the possession of the originating entity.
17 (ii) For notice purposes only, agencies providing exempt records
18 under this subsection (3) to other agencies may mark any exempt records
19 as "exempt" so that the receiving agency is aware of the exemption,
20 however whether or not a record is marked exempt does not affect
21 whether the record is actually exempt from disclosure.

22 **Sec. 17.** RCW 70.02.045 and 2000 c 5 s 2 are each amended to read
23 as follows:
24 Third-party payors shall not release health care information
25 disclosed under this chapter, except as required by chapter 43.--- RCW
26 (the new chapter created in section 19 of this act) and to the extent
27 that health care providers are authorized to do so under RCW 70.02.050.

28 NEW SECTION. **Sec. 18.** If any provision of this act or its
29 application to any person or circumstance is held invalid, the
30 remainder of the act or the application of the provision to other
31 persons or circumstances is not affected.

32 NEW SECTION. **Sec. 19.** Sections 7 through 14 of this act
33 constitute a new chapter in Title 43 RCW.

1 NEW SECTION. **Sec. 20.** Sections 3 through 5 of this act expire
2 July 1, 2020.

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