ENGROSSED SECOND SUBSTITUTE SENATE BILL 5930

State of Washington 60th Legislature 2007 Regular Session

By Senate Committee on Ways & Means (originally sponsored by Senators Keiser, Kohl-Welles, Shin and Rasmussen; by request of Governor Gregoire)

READ FIRST TIME 03/05/07.

AN ACT Relating to providing high quality, affordable health care to Washingtonians based on the recommendations of the blue ribbon commission on health care costs and access; amending RCW 7.70.060, 43.70.110, 41.05.220, 48.41.110, 48.41.160, 48.41.200, 48.41.037, 48.41.100, 48.41.120, 48.43.005, 48.41.190, 41.05.075, 41.05.540, 41.05.540, 70.47A.040, 48.21.045, 48.44.023, 48.46.066, 48.21.047, 48.43.028, 48.44.024, and 48.46.068; reenacting and amending RCW 42.56.360; adding a new section to chapter 74.09 RCW; adding new sections to chapter 43.70 RCW; adding new sections to chapter 41.05 RCW; adding a new section to chapter 48.20 RCW; adding a new section to chapter 48.21 RCW; adding a new section to chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; adding a new section to chapter 48.43 RCW; adding a new chapter to Title 69 RCW; creating new sections; prescribing penalties; providing an effective date; providing an expiration date; and declaring an emergency.

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

USE STATE PURCHASING TO IMPROVE HEALTH CARE QUALITY

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

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

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

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

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

(5) Direct enrollees to quality care systems;

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

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

The plan shall identify any existing barriers and opportunities to support implementation, including needed changes to state or federal law and be submitted to the governor and the legislature upon completion. The agencies shall report annually to the legislature beginning September 2007, and September of each year thereafter, initially on what the targets are; and in the years to follow, the effectiveness and efficiency with which each strategy in the plan has achieved the goals of reducing the cost of health care for individuals, improving people's health, and achieving the goals set for this section.

NEW SECTION. **Sec. 2.** The legislature finds that unwarranted variations in health care, variations not explained by illness, patient preference, or the dictates of evidence-based medicine, are a significant feature of health care in Washington state. There is growing evidence that, for preference-sensitive care involving elective surgery, the quality of patient-practitioner communication about the benefits, harms, and uncertainty of available treatment options can be improved by introducing high-quality decision aids that encourage shared decision making. The international patient decision aid standards collaboration, a network of over one hundred researchers,

practitioners, patients, and policy makers from fourteen countries, have developed standards for constructing high-quality decision aids. The legislature declares an intent to focus on improving the quality of patient-practitioner communication and on increasing the extent to which patients make genuinely informed, preference-based treatment decisions. Randomized clinical trial evidence indicates that effective use of well designed decision aids is likely to improve the quality of patient decision making, reduce unwarranted variations in health care, and result in lower health care costs overall. Despite this growing body of evidence, widespread use of decision aids has yet to occur. Barriers include: (1) Lack of awareness of existing, appropriate, high-quality decision aids; (2) poor accessibility to such decision aids; (3) low practitioner acceptance of decision aids in terms of compatibility with their practice, ease of use, and expense to incorporate into practice; (4) lack of incentives for use, such as reduced liability and reimbursement for their use; and (5) lack of a process to certify that a decision aid meets the standards required of a high-quality decision aid. The legislature intends to promote new public/private collaborative efforts to broaden the development, use, evaluation, and certification of effective decision aids and intends to support the collaborative through providing new recognition of the shared decision-making process and patient decision aids in the state's laws on informed consent. The legislature also intends to establish a process for certifying that a given decision aid meets the standards required for a high-quality decision aid.

NEW SECTION. **Sec. 3.** The state health care authority shall work in collaboration with the health professions and quality improvement communities to increase awareness of appropriate, high-quality decision aids, and to train physicians and other practitioners in their use. The effort shall focus on one or more of the preference-sensitive conditions with high rates of unwarranted variation in Washington, and can include strategies such as prominent linkage to such decision aids in state web sites, and training/awareness programs in conjunction with professional and quality improvement groups. The state health care authority shall, in consultation with the national committee for quality assurance, identify a certification process for patient

decision aids. The state health care authority may accept donations or grants to support such efforts.

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) A statement that the patient or his or her representative understands: The risk or seriousness of the disease or condition to be

prevented or treated; the available treatment alternatives, including nontreatment; and the risks, benefits, and uncertainties of the treatment alternatives, including nontreatment; and

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

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

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

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

PREVENTION AND MANAGEMENT OF CHRONIC ILLNESS

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

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

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

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

(2) For purposes of this section:

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

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

NEW SECTION. **Sec. 7.** A new section is added to chapter 43.70 RCW to read as follows:

(1) The department shall conduct a program of training and technical assistance regarding care of people with chronic conditions

for providers of primary care. The program shall emphasize evidence-based high quality preventive and chronic disease care. The department may designate one or more chronic conditions to be the subject of the program.

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

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

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

(c) Clinical delivery system design;

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

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

(3) In selecting primary care providers to participate in the program, the department shall consider the number and type of patients with chronic conditions the provider serves, and the provider's participation in the medicaid and medicare programs.

COST AND QUALITY INFORMATION FOR CONSUMERS AND PROVIDERS

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

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

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

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

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

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

(5) Produce an annual quality report detailing clinical practice patterns identified to purchasers, providers, insurers, and policy makers. The agencies shall report annually to the legislature

beginning September 2007, and September of each year thereafter, initially on what the targets are; and in the years to follow, the effectiveness and efficiency with which each strategy in the plan has achieved the goals of reducing the cost of health care for individuals, improving people's health, and achieving the goals set for this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REDUCING UNNECESSARY EMERGENCY ROOM USE

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

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

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

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

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

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

The agencies shall design a plan to require hospitals serving patients enrolled in their state financed health plans to effectively link or refer nonemergent patients seeking care in hospital emergency rooms to twenty-four hour clinics located in the community. The clinic must be reasonably accessible and available to the patient. The

agencies shall design a plan to provide all enrollees, beneficiaries, and participants in their health coverage access to a twenty-four hour, seven day a week, nurse hotline that is accessible via the two-one-one system. The agencies shall develop technical service agreements to secure public service announcements through television, radio, and print media to inform the public of access to the nurse hotline.

REDUCE HEALTH CARE ADMINISTRATIVE COSTS

NEW SECTION. **Sec. 13.** By September 1, 2007, the insurance commissioner shall provide a report to the governor and the legislature that identifies the key contributors to health care administrative costs and evaluates opportunities to reduce them, including suggested changes to state law. The report shall be completed in collaboration with health care providers, carriers, state health purchasing agencies, the Washington healthcare forum, and other interested parties. In developing the report, the insurance commissioner shall work with health insurance carriers to develop a plan to implement the recommendations from the 2003-2004 health insurance regulation review and streamlining work group.

COVERAGE FOR DEPENDENTS TO AGE TWENTY-FIVE

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

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

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

(3) Any employee choosing under subsection (1) of this section to cover a dependent with disabilities, developmental disabilities, mental

illness, or mental retardation, who is incapable of self-support, may continue enrollment under the same premium and payment structure as for dependents under the age of twenty, irrespective of age.

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

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

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

Any group disability insurance contract or blanket disability insurance contract that provides coverage for a participating member's dependent must offer each participating member the option of covering any unmarried dependent under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

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

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

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

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

(1) Any individual health maintenance agreement that provides coverage for a subscriber's dependent must offer the option of covering

any unmarried dependent under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

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

WASHINGTON HEALTH INSURANCE CONNECTOR

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

(1) The authority, in collaboration with an advisory board established under subsection (3) of this section, shall design a Washington health insurance connector and submit implementing legislation and supporting information, including funding options, to the governor and the legislature by December 1, 2007. The connector shall be designed to serve as a statewide, public-private partnership, offering maximum value for Washington state residents, through which nonlarge group health insurance may be bought and sold. It is the goal of the connector to:

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

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

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

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

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

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

(a) Address all operational and governance issues;

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

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

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

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

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

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

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

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

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

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

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

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

SUSTAINABILITY AND ACCESS TO PUBLIC PROGRAMS

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

(a) Offering alternative benefit designs to promote high quality care, improve health outcomes, and encourage cost-effective treatment options, including benefit designs that discourage the use of emergency rooms for nonemergent care, and redirect savings to finance additional coverage;

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

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

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

(3) In coordination with the health care authority, the departments shall design and implement a medical home for chronically ill state employees enrolled in the state's self-insured uniform medical plan.

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

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

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

REINSURANCE

NEW SECTION. **Sec. 22.** (1) The office of financial management, in collaboration with the office of the insurance commissioner, shall evaluate and design a state-supported reinsurance program to address the impact of high cost enrollees in the individual and small group health insurance markets, and submit implementing legislation and supporting information, including financing options, to the governor and the legislature by December 1, 2007. In designing the program, the office of financial management shall:

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

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

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

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

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

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

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

THE WASHINGTON STATE HEALTH INSURANCE POOL

NEW SECTION. **Sec. 23.** The legislature finds that the Washington state health insurance pool is a critically important insurance option

for people in this state and must reflect health care provisions based on the best available evidence and be financially sustainable over time. The laws governing the Washington state health insurance pool have been read to preclude the program from modifying contracts, and yet coverage needs and options change with time. Everyone in this state benefits when the Washington state health insurance pool is more affordable and higher performing. Changes are needed to the Washington state health insurance pool to increase affordability, offer quality and cost-effective benefits, and enhance the governance and operation of the pool.

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

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

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

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

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

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

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

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

(d) Drugs and contraceptive devices requiring a prescription;

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

(f) Services of a home health agency;

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

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

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

(l) Diagnostic x-rays and laboratory tests;

(m) Oral surgery limited to the following: Fractures of facial bones; excisions of mandibular joints, lesions of the mouth, lip, or tongue, tumors, or cysts excluding treatment for temporomandibular joints; incision of accessory sinuses, mouth salivary glands or ducts;

dislocations of the jaw; plastic reconstruction or repair of traumatic injuries occurring while covered under the pool; and excision of impacted wisdom teeth;

(n) Maternity care services;

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

(p) Hospice services;

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

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

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

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

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

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

through the creation of a new rate classification or the modification of an existing rate classification. Credit against the waiting period shall be as provided in subsection ((~~(7)~~)) (9) of this section.

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

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

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

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

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

(1) A pool policy offered under this chapter prior to the effective date of this section shall contain provisions under which the pool is obligated to renew the policy until the day on which the individual in whose name the policy is issued first becomes eligible for medicare coverage. At that time, coverage of dependents shall terminate if such dependents are eligible for coverage under a different health plan.

Dependents who become eligible for medicare prior to the individual in whose name the policy is issued, shall receive benefits in accordance with RCW 48.41.150.

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

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

(a) Nonpayment of premium;

(b) Violation of published policies of the pool;

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

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

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

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

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

(4)(a) The guarantee of continuity of coverage provided by this section requires that if the pool replaces a plan, it must make the replacement plan available to all individuals in the plan being replaced. The replacement plan must include all of the services covered under the replaced plan, and must not significantly limit access to the kind of services covered under the replaced plan. The pool may also allow individuals who are covered by a plan that is being replaced an unrestricted right to transfer to a fully comparable plan.

(b) The guarantee of continuity of coverage provided by this section requires that if the pool discontinues offering a plan: (i) The pool must provide notice to each individual of the discontinuation at least ninety days prior to the date of the discontinuation; (ii) the pool must offer to each individual provided coverage under the discontinued plan the option to enroll in any other plan currently offered by the pool for which the individual is otherwise eligible; and (iii) in exercising the option to discontinue a plan and in offering

the option of coverage under (b)(ii) of this subsection, the pool must act uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for this coverage.

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

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

(ii) Pool financing and enrollment;

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

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

(v) Other items identified by the board.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 29. RCW 48.41.120 and 2000 c 79 s 14 are each amended to read as follows:

(1) Subject to the limitation provided in subsection ((~~(3)~~)) (2) of this section, a pool policy offered in accordance with RCW 48.41.110(3) shall impose a deductible. Deductibles of five hundred dollars and one thousand dollars on a per person per calendar year basis shall

initially be offered. The board may authorize deductibles in other amounts. The deductible shall be applied to the first five hundred dollars, one thousand dollars, or other authorized amount of eligible expenses incurred by the covered person.

(2) ((~~Subject to the limitations provided in subsection (3) of this section, a mandatory coinsurance requirement shall be imposed at the rate of twenty percent of eligible expenses in excess of the mandatory deductible.~~

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

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

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

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

((~~(4)~~)) (3) Eligible expenses incurred by a covered person in the last three months of a calendar year, and applied toward a deductible, shall also be applied toward the deductible amount in the next calendar year.

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

Sec. 30. RCW 48.43.005 and 2006 c 25 s 16 are each amended to read as follows:

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

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

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

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

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

(5) "Catastrophic health plan" means:

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

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

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

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

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

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

(9) "Dependent" means, at a minimum, the enrollee's legal spouse

and unmarried dependent children who qualify for coverage under the enrollee's health benefit plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage; and

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

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

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

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

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

(24) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the

preceding calendar quarter, employed at least two but no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor must derive at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year except for a self-employed individual or sole proprietor in an agricultural trade or business, who must derive at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year. A self-employed individual or sole proprietor who is covered as a group of one on the day prior to June 10, 2004, shall also be considered a "small employer" to the extent that individual or group of one is entitled to have his or her coverage renewed as provided in RCW 48.43.035(6).

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

(26) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle

safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

Sec. 31. RCW 48.41.190 and 1989 c 121 s 10 are each amended to read as follows:

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

Sec. 32. RCW 41.05.075 and 2006 c 103 s 3 are each amended to read as follows:

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

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

(a) Encourages competition among insuring entities;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Facilitate diagnosis or treatment;

(ii) Reduce unnecessary duplication of medical tests;

(iii) Promote efficient electronic physician order entry;

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

(v) Improve health outcomes;

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

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

STRENGTHEN THE PUBLIC HEALTH SYSTEM

NEW SECTION. **Sec. 33.** A new section is added to chapter 43.70 RCW to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

PREVENTION AND HEALTH PROMOTION

NEW SECTION. **Sec. 34.** The Washington state health care authority, the department of social and health services, the department of labor

and industries, and the department of health shall, by September 1, 2007, develop a five-year plan to integrate disease and accident prevention and health promotion into state health programs by:

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

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

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

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

The plan shall identify any existing barriers and opportunities to support implementation, including needed changes to state or federal law, and be submitted to the governor and the legislature upon completion. The agencies shall report annually to the legislature beginning September 2007, and September of each year thereafter, initially on what the targets are; and in the years to follow, the effectiveness and efficiency with which each strategy in the plan has achieved the goals of reducing the cost of health care for individuals, improving people's health, and achieving the goals set for this section. The agencies shall include health insurance carriers in the development of the plan.

Sec. 35. RCW 41.05.540 and 2005 c 360 s 8 are each amended to read as follows:

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

~~(2) The health care authority shall report to the governor and the legislature by December 1, 2006, on progress in implementing, and evaluating the results of, the worksite health promotion program~~)) shall establish and maintain a state employee health program focused on reducing the health risks of state employees, dependents, and retirees enrolled in the public employees' benefits board. The program shall use public and private sector best practices to achieve goals of

measurable health outcomes, measurable productivity improvements, positive impact on the cost of medical care, and positive return on investment.

(2) The state employee health program shall:

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 36.** A new section is added to chapter 41.05 RCW to read as follows:

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

(a) Shall include but are not limited to the following key elements: Outreach to all staff with efforts made to reach the largest

percentage of employees possible; awareness-building information that promotes health; motivational opportunities that encourage employees to improve their health; behavior change opportunities that demonstrate and support behavior change; and tools to improve employee health care decisions;

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

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

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

(2) The state employee health program shall evaluate each of the four programs separately and compare outcomes for each of them with the entire state employee population to assess effectiveness of the programs. Specifically, the program shall measure at least the following outcomes in the demonstration population: The reduction in the percent of the population that is overweight or obese, the reduction in risk factors related to diabetes, the reduction in risk factors related to absenteeism, the reduction in tobacco consumption, and the increase in appropriate use of preventive health services. The state employee health program shall report to the legislature in December 2008, 2009, and 2010 on the demonstration project.

(3) This section expires June 30, 2011.

NEW SECTION. **Sec. 37.** The legislature finds that prescription drug abuse has been on the rise and that often dispensers and prescribing providers are unaware of prescriptions provided by others both in and out of state.

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

NEW SECTION. **Sec. 38.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

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

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

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

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

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

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

NEW SECTION. **Sec. 39.** (1) The department shall establish and maintain a web-based interactive prescription monitoring program available is real time to monitor the prescribing and dispensing of all Schedules II, III, IV, and V controlled substances and any additional drugs identified by the board of pharmacy as demonstrating a potential for abuse by all professionals licensed to prescribe or dispense such substances in this state. As much as possible, the department should establish a common database with other states.

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

(a) Patient identifier;

(b) Drug dispensed;

(c) Date of dispensing;

(d) Quantity dispensed;

(e) Prescriber; and

(f) Dispenser.

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

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

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

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

NEW SECTION. **Sec. 40.** (1) Prescription information submitted to the department shall be confidential, in compliance with the health insurance portability and accountability act, and not subject to disclosure, except as provided in subsections (3), (4), and (5) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 41.** The department may contract with another agency of this state or with a private vendor, as necessary, to ensure the effective operation of the prescription monitoring program. Any contractor is bound to comply with the provisions regarding confidentiality of prescription information in section 40 of this act and is subject to the penalties specified in section 43 of this act for unlawful acts.

NEW SECTION. **Sec. 42.** The department shall adopt rules to implement this chapter.

NEW SECTION. **Sec. 43.** (1) A dispenser who knowingly fails to submit prescription monitoring information to the department as required by this chapter or knowingly submits incorrect prescription information is subject to disciplinary action under chapter 18.130 RCW.

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

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

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

NEW SECTION. **Sec. 44.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

Sec. 45. RCW 42.56.360 and 2006 c 209 s 9 and 2006 c 8 s 112 are each reenacted and amended to read as follows:

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

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

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

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

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

(ii) If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of

receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this subsection (1)(d) as exempt from disclosure;

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

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

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

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

<u>(h) Information obtained by the department of health under chapter 69.-- RCW (sections 37 through 44 of this act)</u>.

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

<u>NEW SECTION.</u> **Sec. 46.** The legislature finds that many small employers struggle with the cost of providing employer-sponsored health insurance coverage to their employees, while others are unable to offer coverage due to its high cost. It is the intent of the legislature to encourage the availability of less expensive health insurance plans, and expand the flexibility of small employers to purchase less expensive products.

Sec. 47. RCW 70.47A.040 and 2006 c 255 s 4 are each amended to read as follows:

(1) Beginning July 1, 2007, the administrator shall accept applications from eligible employees, on behalf of themselves, their spouses, and their dependent children, to receive premium subsidies through the small employer health insurance partnership program.

(2) Premium subsidy payments may be provided to eligible employees ((~~if:~~)) or participating carriers on behalf of employees.

(a) The eligible employee ((~~is~~)) must be employed by a small employer((~~:~~)).

(b) ((~~The actuarial value of the health benefit plan offered by the small employer is at least equivalent to that of the basic health plan benefit offered under chapter 70.47 RCW. The office of the insurance commissioner under Title 48 RCW shall certify those small employer health benefit plans that are at least actuarially equivalent to the basic health plan benefit; and~~)) Small employers may offer any available health benefit plan including health savings accounts. Health savings account subsidy payments may be provided to eligible employees if the eligible employee participates in an employer-sponsored high deductible health plan and health savings account that conforms to the requirements of the United States internal revenue service.

(c) The small employer will pay at least forty percent of the monthly premium cost for health benefit plan coverage of the eligible employee.

(3) The amount of an eligible employee's premium subsidy shall be determined by applying the sliding scale subsidy schedule developed for subsidized basic health plan enrollees under RCW 70.47.060 to the employee's premium obligation for his or her employer's health benefit plan.

(4) After an eligible individual has enrolled in the program, the program shall issue subsidies in an amount determined pursuant to subsection (3) of this section to either the eligible employee or to the carrier designated by the eligible employee.

(5) An eligible employee must agree to provide verification of continued enrollment in his or her small employer's health benefit plan on a semiannual basis or to notify the administrator whenever his or her enrollment status changes, whichever is earlier. Verification or notification may be made directly by the employee, or through his or her employer or the carrier providing the small employer health benefit plan. When necessary, the administrator has the authority to perform retrospective audits on premium subsidy accounts. The administrator may suspend or terminate an employee's participation in the program and seek repayment of any subsidy amounts paid due to the omission or

misrepresentation of an applicant or enrolled employee. The administrator shall adopt rules to define the appropriate application of these sanctions and the processes to implement the sanctions provided in this subsection, within available resources.

Sec. 48. RCW 48.21.045 and 2004 c 244 s 1 are each amended to read as follows:

(1)(((~~(a)~~)) An insurer offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer ((~~a~~)) no more than one health benefit plan featuring a limited schedule of covered health care services. ((~~Nothing in this subsection shall preclude an insurer from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. An insurer offering a health benefit plan under this subsection shall clearly disclose all covered benefits to the small employer in a brochure filed with the commissioner.~~

~~(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240, 48.21.244, 48.21.250, 48.21.300, 48.21.310, or 48.21.320.~~

~~(2)~~)) (a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to, comply with: RCW 48.21.130 through 48.21.240, 48.21.244 through 48.21.280, 48.21.300 through 48.21.320, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

(b) In offering the plan under this subsection, the insurer must offer the small employer the option of permitting every category of health care provider to provide health services or care for conditions covered by the plan pursuant to RCW 48.43.045(1).

(2) An insurer offering the plan under subsection (1) of this

section must also offer and actively market to the small employer at least one additional health benefit plan.

(3) Nothing in this section shall prohibit an insurer from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

((~~(3)~~)) (4) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The insurer shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The insurer shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection ((~~(3)~~)) (4).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs ((~~due to network provider reimbursement schedules or type of network~~)) for a plan. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account defined by the United States internal revenue service, adjusted community rates established under this section shall pool the medical experience of all small groups purchasing coverage. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus ((~~four~~)) eight percentage points from the overall adjustment of a carrier's entire small group pool, ((~~such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal~~)) if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue

neutral effect on the carrier's small group pool. Variations of greater than eight percentage points are subject to review by the commissioner and must be approved or denied within thirty days of submittal. A variation that is not denied within ((~~sixty~~)) thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ((~~within thirty days~~)) at the time of the denial.

((~~(4)~~)) (5) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

((~~(5)~~)) (6)(a) Except as provided in this subsection, requirements used by an insurer in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) An insurer shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) An insurer may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

((~~(6)~~)) (7) An insurer must offer coverage to all eligible employees of a small employer and their dependents. An insurer may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. An insurer may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

((~~(7)~~)) (8) As used in this section, "health benefit plan," "small

employer," "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005.

Sec. 49. RCW 48.44.023 and 2004 c 244 s 7 are each amended to read as follows:

(1)(((~~(a)~~)) A health care services contractor offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer ((~~a~~)) no more than one health benefit plan featuring a limited schedule of covered health care services. ((~~Nothing in this subsection shall preclude a contractor from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A contractor offering a health benefit plan under this subsection shall clearly disclose all covered benefits to the small employer in a brochure filed with the commissioner.~~

~~(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460.~~

~~(2)~~)) (a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to, comply with: RCW 48.44.210, 48.44.212, 48.44.225, 48.44.240 through 48.44.245, 48.44.290 through 48.44.340, 48.44.344, 48.44.360 through 48.44.380, 48.44.400, 48.44.420, 48.44.440 through 48.44.460, 48.44.500, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

(b) In offering the plan under this subsection, the health care service contractor must offer the small employer the option of permitting every category of health care provider to provide health services or care for conditions covered by the plan pursuant to RCW 48.43.045(1).

(2) A health care service contractor offering the plan under subsection (1) of this section must also offer and actively market to the small employer at least one additional health benefit plan.

(3) Nothing in this section shall prohibit a health care service contractor from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

((~~(3)~~)) (4) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The contractor shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The contractor shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection ((~~(3)~~)) (4).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs ((~~due to network provider reimbursement schedules or type of network~~)) for a plan. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus ((~~four~~)) eight percentage points from the overall adjustment of a carrier's entire small group pool((~~, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal~~)) if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, or provider network characteristics; and (ii) for a rate renewal period, the projected

weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than eight percentage points are subject to review by the commissioner and must be approved or denied within thirty days of submittal. A variation that is not denied within ((~~sixty~~)) thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ((~~within thirty days~~)) at the time of the denial.

((~~(4)~~)) (5) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

((~~(5)~~)) (6)(a) Except as provided in this subsection, requirements used by a contractor in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A contractor shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A contractor may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

((~~(6)~~)) (7) A contractor must offer coverage to all eligible employees of a small employer and their dependents. A contractor may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A contractor may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 50. RCW 48.46.066 and 2004 c 244 s 9 are each amended to read as follows:

(1)((~~(a)~~)) A health maintenance organization offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer ((~~a~~)) no more than one health benefit plan featuring a limited schedule of covered health care services. ((~~Nothing in this subsection shall preclude a health maintenance organization from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A health maintenance organization offering a health benefit plan under this subsection shall clearly disclose all the covered benefits to the small employer in a brochure filed with the commissioner.~~

~~(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530.~~

~~(2)~~)) (a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to, comply with: RCW 48.46.250, 48.46.272 through 48.46.290, 48.46.320, 48.46.350, 48.46.375, 48.46.440 through 48.46.460, 48.46.480. 48.46.490, 48.46.510, 48.46.520, 48.46.530, 48.46.565, 48.46.570, 48.46.575, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

(b) In offering the plan under this subsection, the health maintenance organization must offer the small employer the option of permitting every category of health care provider to provide health services or care for conditions covered by the plan pursuant to RCW 48.43.045(1).

(2) A health maintenance organization offering the plan under subsection (1) of this section must also offer and actively market to the small employer at least one additional health benefit plan.

(3) Nothing in this section shall prohibit a health maintenance organization from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

((~~(3)~~)) (4) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The health maintenance organization shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection ((~~(3)~~)) (4).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs ((~~due to network provider reimbursement schedules or type of network~~)) for a plan. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus ((~~four~~)) eight percentage points from the overall adjustment of a carrier's entire small group pool((~~, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal~~)) if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the health maintenance organization's small group

pool. Variations of greater than eight percentage points are subject to review by the commissioner and must be approved or denied within thirty days of submittal. A variation that is not denied within ((~~sixty~~)) thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ((~~within thirty days~~)) at the time of the denial.

((~~(4)~~)) (5) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

((~~(5)~~)) (6)(a) Except as provided in this subsection, requirements used by a health maintenance organization in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A health maintenance organization shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A health maintenance organization may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

((~~(6)~~)) (7) A health maintenance organization must offer coverage to all eligible employees of a small employer and their dependents. A health maintenance organization may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A health maintenance organization may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 51. RCW 48.21.047 and 2005 c 223 s 11 are each amended to read as follows:

(1) An insurer may not offer any health benefit plan to any small employer without complying with RCW 48.21.045((~~(3)~~)) (4).

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and the plans are not subject to RCW 48.21.045((~~(3)~~)) (4).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

Sec. 52. RCW 48.43.028 and 2001 c 196 s 10 are each amended to read as follows:

To the extent required of the federal health insurance portability and accountability act of 1996, the eligibility of an employer or group to purchase a health benefit plan set forth in RCW 48.21.045(1)((~~(b)~~)), 48.44.023(1)((~~(b)~~)), and 48.46.066(1)((~~(b)~~)) must be extended to all small employers and small groups as defined in RCW 48.43.005.

Sec. 53. RCW 48.44.024 and 2003 c 248 s 15 are each amended to read as follows:

(1) A health care service contractor may not offer any health benefit plan to any small employer without complying with RCW 48.44.023((~~(3)~~)) (4).

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and the plans are not subject to RCW 48.44.023((~~(3)~~)) (4).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

Sec. 54. RCW 48.46.068 and 2003 c 248 s 16 are each amended to read as follows:

(1) A health maintenance organization may not offer any health benefit plan to any small employer without complying with RCW 48.46.066((~~(3)~~)) (4).

(2) Employers purchasing health plans provided through associations

or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and are not subject to RCW 48.46.066((~~(3)~~)) (4).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

NEW SECTION. **Sec. 55.** Sections 37 through 44 of this act constitute a new chapter in Title 69 RCW.

NEW SECTION. **Sec. 56.** Subheadings used in this act are not any part of the law.

NEW SECTION. **Sec. 57.** Sections 14 through 18 of this act take effect January 1, 2008.

NEW SECTION. **Sec. 58.** If specific funding for the purposes of the following sections of this act, referencing the section of this act by bill or chapter number and section number, is not provided by June 30, 2007, in the omnibus appropriations act, the section is null and void:

(1) Section 8 of this act (Washington state quality forum);

(2) Section 9 of this act (health records banking pilot project);

(3) Section 19 of this act (health insurance connector); and

(4) Section 36 of this act (state employee health demonstration project).

NEW SECTION. **Sec. 59.** Sections 23 through 32 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect immediately.

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