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HOUSE BILL 1046

State of Washington 54th Legislature 1995 Regular Session

By Representatives Dyer, Carlson, Kremen, Cooke, Horn, Schoesler, Buck, Johnson, Thompson, Beeksma, B. Thomas, Radcliff, Hickel, Chandler, Backlund, Mastin, Mitchell, Foreman, Sehlin, Ballasiotes, Clements, Campbell, Sheldon, L. Thomas, Huff, Mielke, Talcott, McMahan, Stevens and Lisk

Prefiled 01/06/95. Read first time 01/09/95. Referred to Committee on Health Care.

AN ACT Relating to health care reform improvement; amending RCW 18.130.330, 28A.400.200, 28A.400.350, 41.05.011, 41.05.021, 41.05.022, 41.05.055, 41.05.065, 41.05.200, 43.72.005, 43.72.010, 43.72.020, 43.72.070, 43.72.080, 43.72.090, 43.72.100, 43.72.130, 43.72.160, 43.72.170, 43.72.300, 43.72.310, 43.72.800, 43.72.810, 43.72.830, 43.72.860, 43.72.910, 47.64.270, 48.43.150, 48.41.110, 48.43.160, 48.43.170, 48.70.040, 48.70.900, 48.85.010, 48.85.020, 48.85.030, 48.85.040, 48.85.050, 70.47.060, 51.14.010, 51.16.060, 51.16.140, and 70.170.100; amending 1993 c 492 s 279 (uncodified); reenacting and amending RCW 41.05.075; adding a new section to chapter 4.24 RCW; adding new sections to chapter 7.70 RCW; adding a new section to chapter 28A.400 RCW; adding new sections to chapter 48.43 RCW; adding a new section to chapter 41.05 RCW; adding a new section to chapter 44.44 RCW; adding a new section to chapter 43.70 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 48.36A 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 51.16 RCW; adding a new section to chapter 82.04 RCW; adding a new chapter to Title 48 RCW; creating new sections; recodifying RCW 51.14.010, 43.72.005, 43.72.010, 43.72.070, 43.72.080, 43.72.090, 43.72.100, 43.72.130, 43.72.160, 43.72.170, 43.72.200,

43.72.300, 43.72.310, 43.72.800, 43.72.810, 43.72.830, 43.72.840, 43.72.850, 43.72.860, 43.72.900, 43.72.902, 43.72.904, 43.72.906, and 43.72.910; repealing RCW 41.05.170, 41.05.180, 48.20.390, 48.20.393, 48.20.395, 48.20.397, 48.20.410, 48.20.411, 48.20.412, 48.20.414, 48.20.416, 48.20.520, 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.144, 48.21.146, 48.21.160, 48.21.180, 48.21.190, 48.21.195, 48.21.197, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240, 48.21.300, 48.21.310, 48.21.320, 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.309, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.440, 48.44.450, 48.44.460, 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355, 48.46.510, 48.46.520, 48.46.530, 49.64.040, 43.72.030, 43.72.040, 43.72.050, 43.72.060, 43.72.110, 43.72.120, 43.72.140, 43.72.150, 43.72.180, 43.72.190, 43.72.210, 43.72.220, 43.72.230, 43.72.225, 43.72.240, 43.72.820, 43.72.870, 48.43.010, 48.43.020, 48.43.030, 48.43.040, 48.43.050, 48.43.060, 48.43.070, 48.43.080, 48.43.090, 48.43.100, 48.43.110, 48.43.120, 48.43.130, 48.01.210, 48.20.540, 48.21.340, 48.44.480, 48.46.550, 48.42.060, 48.42.070, 48.42.080, 70.170.110, 70.170.120, 70.170.130, and 70.170.140; providing effective dates; providing an expiration date; and providing for submission of this act to a vote of the people.

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

NEW SECTION. **Sec. 1.** A new section is added to chapter 4.24 RCW to read as follows:

LIABILITY REFORM. (1) The claimant’s attorney shall file the certificate specified in subsection (2) of this section within thirty days of filing or service, whichever occurs later, any action for damages arising out of the professional negligence of a person licensed, registered, or certified under Title 18 RCW.

(2) The certificate issued by the claimant’s attorney shall declare:

(a) That the attorney has reviewed the facts of the case;

(b) That the attorney has consulted with at least one qualified expert who holds a license, certificate, or registration issued by this state or another state in the same profession as that of the defendant, who practices in the same specialty or subspecialty as the defendant,

and who the attorney reasonably believes is knowledgeable in the relevant issues involved in the particular action;

(c) The identity of the expert and the expert's license, certification, or registration;

(d) That the expert is willing and available to testify to admissible facts or opinions; and

(e) That the attorney has concluded on the basis of such review and consultation that there is reasonable and meritorious cause for the filing of such action.

(3) Where a certificate is required under this section, and where there are multiple defendants, the certificate or certificates must state the attorney's conclusion that on the basis of review and expert consultation, there is reasonable and meritorious cause for the filing of such action as to each defendant.

(4) The provisions of this section shall not be applicable to a plaintiff who is not represented by an attorney.

(5) Violation of this section shall be grounds for either dismissal of the case or sanctions against the attorney, or both, as the court deems appropriate.

NEW SECTION. **Sec. 2.** Section 1 of this act applies to all actions for damages arising out of professional negligence filed on or after the effective date of this section.

NEW SECTION. **Sec. 3.** A new section is added to chapter 7.70 RCW to read as follows:

A health care provider, as defined in chapter 48.43 RCW, shall not be liable for the decision of a third party payer or others not to pay for or provide reimbursement for health care services recommended by the health care provider, provided:

(1) The health care provider complies with any formal or informal avenues of appeal made available by the third party payer or others under a health plan, as defined in chapter 48.43 RCW, or under any other contract or policy providing or paying for health care benefits or services; and

(2) The health care provider advises the patient to obtain the recommended care, even if not covered by the third party payer, and informs the patient of the potential risks in not obtaining the recommended health care services.

NEW SECTION. **Sec. 4.** A new section is added to chapter 7.70 RCW to read as follows:

(1) Even when the physician-patient privilege is waived, defendant, including defendant's counsel, shall not engage in ex parte contact with health care providers that have provided health care services to the plaintiff. Once the action is commenced under chapter 4.28 RCW, the plaintiff, including plaintiff's attorney, also shall not engage in ex parte contact with health care providers regarding the health care provided to plaintiff that is related to the cause of action.

(2) This section does not apply to actions under Title 51 RCW.

Sec. 5. RCW 18.130.330 and 1994 c 102 s 1 are each amended to read as follows:

(1) Except to the extent that liability insurance is not available, every licensed, certified, or registered health care practitioner whose services are included in the ((~~uniform~~)) standard benefits package, as determined by RCW 43.72.130, and whose scope of practice includes independent practice, shall, as a condition of licensure and relicensure, be required to provide evidence of a minimum level of malpractice insurance coverage of a type satisfactory to the department before ((~~July 1, 1995~~)) January 1, 1996.

The department shall designate by rule:

(a) Those health professions whose scope of practice includes independent practice;

(b) For each health profession whose scope of practice includes independent practice, whether malpractice insurance is available;

(c) If such insurance is available, the appropriate minimum level of mandated coverage; and

(d) The types of malpractice insurance coverage that will satisfy the requirements of this section.

(2) By December 1, 1994, the department of health shall submit recommendations to appropriate committees of the legislature regarding implementation of this section. The report shall address at least the following issues:

(a) Whether exemption of a health care practitioner from the requirements of this section, including but not limited to health care practitioners employed by the federal government and retired health care practitioners, is appropriate; and

(b) Whether malpractice coverage provided by an employer should be recognized as satisfying the requirements of this section.

Sec. 6. RCW 28A.400.200 and 1993 c 492 s 225 are each amended to read as follows:

SCHOOL EMPLOYEE BENEFIT. (1) Every school district board of directors shall fix, alter, allow, and order paid salaries and compensation for all district employees in conformance with this section.

(2)(a) Salaries for certificated instructional staff shall not be less than the salary provided in the appropriations act in the state-wide salary allocation schedule for an employee with a baccalaureate degree and zero years of service; and

(b) Salaries for certificated instructional staff with a masters degree shall not be less than the salary provided in the appropriations act in the state-wide salary allocation schedule for an employee with a masters degree and zero years of service((~~;~~)).

(3)(a) The actual average salary paid to basic education certificated instructional staff shall not exceed the district's average basic education certificated instructional staff salary used for the state basic education allocations for that school year as determined pursuant to RCW 28A.150.410.

(b) Fringe benefit contributions for basic education certificated instructional staff shall be included as salary under (a) of this subsection ((~~only~~)) to the extent that the district's actual average benefit contribution exceeds the ((~~amount of the insurance benefits allocation~~)) greater of: (i) The formula amount for insurance benefits provided per certificated instructional staff unit in the state operating appropriations act in effect at the time the compensation is payable; or (ii) the actual average amount provided by the school district in the 1986-87 school year. For purposes of this section, fringe benefits shall not include payment for unused leave for illness or injury under RCW 28A.400.210; or employer contributions for old age survivors insurance, workers' compensation, unemployment compensation, and retirement benefits under the Washington state retirement system((~~; or employer contributions for health benefits in excess of the insurance benefits allocation provided per certificated instructional staff unit in the state operating appropriations act in effect at the time the compensation is payable. A school district may not use state~~

~~funds to provide employer contributions for such excess health benefits~~)).

(c) Salary and benefits for certificated instructional staff in programs other than basic education shall be consistent with the salary and benefits paid to certificated instructional staff in the basic education program.

(4) Salaries and benefits for certificated instructional staff may exceed the limitations in subsection (3) of this section only by separate contract for additional time, additional responsibilities, or incentives. Supplemental contracts shall not cause the state to incur any present or future funding obligation. Supplemental contracts shall be subject to the collective bargaining provisions of chapter 41.59 RCW and the provisions of RCW 28A.405.240, shall not exceed one year, and if not renewed shall not constitute adverse change in accordance with RCW 28A.405.300 through 28A.405.380. No district may enter into a supplemental contract under this subsection for the provision of services which are a part of the basic education program required by Article IX, section 3 of the state Constitution.

(5) Employee benefit plans offered by any district shall comply with RCW 28A.400.350 and 28A.400.275 and 28A.400.280.

Sec. 7. RCW 28A.400.350 and 1993 c 492 s 226 are each amended to read as follows:

(1) The board of directors of any of the state's school districts may make available liability, life, health, health care, accident, disability and salary protection or insurance or any one of, or a combination of the enumerated types of insurance, or any other type of insurance or protection, for the members of the boards of directors, the students, and employees of the school district, and their dependents. Such coverage may be provided by contracts with private carriers, with the state health care authority after July 1, 1990, pursuant to the approval of the authority administrator, or through self-insurance or self-funding pursuant to chapter 48.62 RCW, or in any other manner authorized by law. ((~~Except for health benefits purchased with nonstate funds as provided in RCW 28A.400.200, effective on and after October 1, 1995, health care coverage, life insurance, liability insurance, accidental death and dismemberment insurance, and disability income insurance shall be provided only by contracts with the state health care authority.~~))

(2) Whenever funds are available for these purposes the board of directors of the school district may contribute all or a part of the cost of such protection or insurance for the employees of their respective school districts and their dependents. The premiums on such liability insurance shall be borne by the school district.

After October 1, 1990, school districts may not contribute to any employee protection or insurance other than liability insurance unless the district's employee benefit plan conforms to RCW 28A.400.275 and 28A.400.280.

(3) For school board members and students, the premiums due on such protection or insurance shall be borne by the assenting school board member or student. The school district may contribute all or part of the costs, including the premiums, of life, health, health care, accident or disability insurance which shall be offered to all students participating in interschool activities on the behalf of or as representative of their school or school district. The school district board of directors may require any student participating in extracurricular interschool activities to, as a condition of participation, document evidence of insurance or purchase insurance that will provide adequate coverage, as determined by the school district board of directors, for medical expenses incurred as a result of injury sustained while participating in the extracurricular activity. In establishing such a requirement, the district shall adopt regulations for waiving or reducing the premiums of such coverage as may be offered through the school district to students participating in extracurricular activities, for those students whose families, by reason of their low income, would have difficulty paying the entire amount of such insurance premiums. The district board shall adopt regulations for waiving or reducing the insurance coverage requirements for low-income students in order to assure such students are not prohibited from participating in extracurricular interschool activities.

((~~(4) All contracts for insurance or protection written to take advantage of the provisions of this section shall provide that the beneficiaries of such contracts may utilize on an equal participation basis the services of those practitioners licensed pursuant to chapters 18.22, 18.25, 18.53, 18.57, and 18.71 RCW.~~))

NEW SECTION. **Sec. 8.** A new section is added to chapter 28A.400 RCW to read as follows:

(1) In a manner prescribed by the state health care authority, school districts and educational service districts shall remit to the health care authority for deposit in the public employees' and retirees' insurance account established in RCW 41.05.120:

(a) For each full-time employee of the district, an amount equal to four and seven-tenths percent multiplied by the insurance benefit allocation rate in the appropriations act for a certificated or classified staff, for each month of the school year;

(b) For each part-time employee of the district who, at the time of the remittance, is employed in an eligible position as defined in RCW 41.32.010 or 41.40.010 and is eligible for employer fringe benefit contributions for basic benefits as defined in RCW 28A.400.270, an amount equal to four and seven-tenths percent multiplied by the insurance benefit allocation rate in the appropriations act for a certificated or classified staff, for each month of the school year, prorated by the proportion of employer fringe benefit contributions for a full-time employee that the part-time employee receives.

(2) The legislature reserves the right to increase or decrease the percent or amount required to be remitted in this section.

Sec. 9. RCW 41.05.011 and 1994 c 153 s 2 are each amended to read as follows:

Unless the context clearly requires otherwise, the definitions in this section shall apply throughout this chapter.

(1) "Administrator" means the administrator of the authority.

(2) "State purchased health care" or "health care" means medical and health care, pharmaceuticals, and medical equipment purchased with state and federal funds by the department of social and health services, the department of health, the basic health plan, the state health care authority, the department of labor and industries, the department of corrections, the department of veterans affairs, and local school districts.

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

(4) "Insuring entity" means an insurer as defined in chapter 48.01 RCW, a health care service contractor as defined in chapter 48.44 RCW, or a health maintenance organization as defined in chapter 48.46 RCW. On and after ((~~July 1, 1995~~)) January 1, 1996, "insuring entity" means

a ((~~certified health plan~~)) health carrier, as defined in RCW 43.72.010 (as recodified by this act).

(5) "Flexible benefit plan" means a benefit plan that allows employees to choose the level of health care coverage provided and the amount of employee contributions from among a range of choices offered by the authority.

(6) "Employee" includes all full-time and career seasonal employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; and includes any or all part-time and temporary employees under the terms and conditions established under this chapter by the authority; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature or of the legislative authority of any county, city, or town who are elected to office after February 20, 1970. "Employee" also includes((~~: (a) By October 1, 1995, all employees of school districts and educational service districts. Between October 1, 1994, and September 30, 1995, "employee" includes employees of those school districts and educational service districts for whom the authority has undertaken the purchase of insurance benefits. The transition to insurance benefits purchasing by the authority may not disrupt existing insurance contracts between school district or educational service district employees and insurers. However, except to the extent provided in RCW 28A.400.200, any such contract that provides for health insurance benefits coverage after October 1, 1995, shall be void as of that date if the contract was entered into, renewed, or extended after July 1, 1993. Prior to October 1, 1994, "employee" includes employees of a school district if the board of directors of the school district seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority; (b)~~)) employees of a county, municipality, or other political subdivision of the state if the legislative authority of the county, municipality, or other political subdivision of the state seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205((~~; (c) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school~~

~~districts for the purpose of purchasing insurance benefits, at the option of each such employee organization~~)), and employees of a school district if the board of directors of the school district seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority as provided in RCW 28A.400.350.

(7) "Board" means the public employees' benefits board established under RCW 41.05.055.

(8) "Retired or disabled school employee" means:

(a) Persons who separated from employment with a school district or educational service district and are receiving a retirement allowance under chapter 41.32 or 41.40 RCW as of September 30, 1993;

(b) Persons who separate from employment with a school district or educational service district on or after October 1, 1993, and immediately upon separation receive a retirement allowance under chapter 41.32 or 41.40 RCW;

(c) Persons who separate from employment with a school district or educational service district due to a total and permanent disability, and are eligible to receive a deferred retirement allowance under chapter 41.32 or 41.40 RCW.

Sec. 10. RCW 41.05.021 and 1994 c 309 s 1 are each amended to read as follows:

(1) The Washington state health care authority is created within the executive branch. The authority shall have an administrator appointed by the governor, with the consent of the senate. The administrator shall serve at the pleasure of the governor. The administrator may employ up to seven staff members, who shall be exempt from chapter 41.06 RCW, and any additional staff members as are necessary to administer this chapter. The administrator may delegate any power or duty vested in him or her by this chapter, including authority to make final decisions and enter final orders in hearings conducted under chapter 34.05 RCW. The primary duties of the authority shall be to administer state employees' insurance benefits and retired or disabled school employees' insurance benefits, study state-purchased health care programs in order to maximize cost containment in these programs while ensuring access to quality health care, and implement state initiatives, joint purchasing strategies, and techniques for efficient administration that have potential application to all state-

purchased health services. The authority's duties include, but are not limited to, the following:

(a) To administer health care benefit programs for employees and retired or disabled school employees as specifically authorized in RCW 41.05.065 and in accordance with the methods described in RCW 41.05.075, 41.05.140, and other provisions of this chapter;

(b) To analyze state-purchased health care programs and to explore options for cost containment and delivery alternatives for those programs that are consistent with the purposes of those programs, including, but not limited to:

(i) Creation of economic incentives for the persons for whom the state purchases health care to appropriately utilize and purchase health care services, including the development of flexible benefit plans to offset increases in individual financial responsibility;

(ii) Utilization of provider arrangements that encourage cost containment, including but not limited to prepaid delivery systems, utilization review, and prospective payment methods, and that ensure access to quality care, including assuring reasonable access to local providers, especially for employees residing in rural areas;

(iii) Coordination of state agency efforts to purchase drugs effectively as provided in RCW 70.14.050;

(iv) Development of recommendations and methods for purchasing medical equipment and supporting services on a volume discount basis; and

(v) Development of data systems to obtain utilization data from state-purchased health care programs in order to identify cost centers, utilization patterns, provider and hospital practice patterns, and procedure costs, utilizing the information obtained pursuant to RCW 41.05.031;

(c) To analyze areas of public and private health care interaction;

(d) To provide information and technical and administrative assistance to the board;

(e) To review and approve or deny applications from counties, municipalities, and other political subdivisions of the state to provide state-sponsored insurance or self-insurance programs to their employees in accordance with the provisions of RCW 41.04.205, setting the premium contribution for approved groups as outlined in RCW 41.05.050;

(f) To appoint a health care policy technical advisory committee as required by RCW 41.05.150;

(g) To establish billing procedures and collect funds from school districts and educational service districts under RCW 28A.400.400 in a way that minimizes the administrative burden on districts; and

(h) To promulgate and adopt rules consistent with this chapter as described in RCW 41.05.160.

(2) ((~~After July 1, 1995~~,)) The public employees' benefits board ((~~shall~~)) may implement strategies to promote ((~~managed~~)) competition among employee health benefit plans ((~~in accordance with the Washington health services commission schedule of employer requirements. Strategies may include~~)) including but ((~~are~~)) not limited to:

(a) Standardizing the benefit package;

(b) Soliciting competitive bids for the benefit package;

(c) Limiting the state's contribution to a percent of the lowest priced qualified plan within a geographical area. If the state's contribution is less than one hundred percent of the lowest priced qualified bid, employee financial contributions shall be structured on a sliding-scale basis related to household income;

(d) Monitoring the impact of the approach under this subsection with regards to: Efficiencies in health service delivery, cost shifts to subscribers, access to and choice of ((~~managed care~~)) plans state-wide, and quality of health services. ((~~The health care authority shall also advise on the value of administering a benchmark employer-managed plan to promote competition among managed care plans.~~)) The health care authority shall report its findings and recommendations to the legislature by January 1, 1997.

(3) The health care authority shall, no later than July 1, 1996, submit to the appropriate committees of the legislature, proposed methods whereby, through the use of a voucher-type process, state employees may enroll with any health carrier to receive employee benefits. Such methods shall include the employee option of participating in a health care savings account, as set forth in sections 32 through 37 of this act.

(4) The joint committee on health systems oversight shall study the necessity and desirability of the health care authority continuing as a self-insuring entity and make recommendations to the appropriate committees of the legislature by December 1, 1996.

Sec. 11. RCW 41.05.022 and 1994 c 153 s 3 are each amended to read as follows:

(1) The health care authority is hereby designated as the single state agent for purchasing health services.

(2) On and after January 1, 1995, at least the following state-purchased health services programs shall be merged into a single, community-rated risk pool: Health benefits for employees of school districts and educational service districts that voluntarily purchase health benefits as provided in RCW 41.05.011; health benefits for state employees; health benefits for eligible retired or disabled school employees not eligible for parts A and B of medicare; and health benefits for eligible state retirees not eligible for parts A and B of medicare. Beginning ((~~July 1, 1995~~)) January 1, 1996, the basic health plan shall be included in the risk pool. The administrator may develop mechanisms to ensure that the cost of comparable benefits packages does not vary widely across the risk pools before they are merged. At the earliest opportunity the governor shall seek necessary federal waivers and state legislation to place the medical and acute care components of the medical assistance program, the limited casualty program, and the medical care services program of the department of social and health services in this single risk pool. ((~~Long-term care services that are provided under the medical assistance program shall not be placed in the single risk pool until such services have been added to the uniform benefits package.~~)) On or before January 1, 1997, the governor shall submit necessary legislation to place the purchasing of health benefits for persons incarcerated in institutions administered by the department of corrections into the single community-rated risk pool effective on and after July 1, 1997.

(3) At a minimum, and regardless of other legislative enactments, the state health services purchasing agent shall:

(a) Require that a public agency that provides subsidies for a substantial portion of services now covered under the basic health plan or a ((~~uniform~~)) standard benefits package ((~~as adopted by the Washington health services commission~~)) as provided in RCW 43.72.130 (as recodified by this act), use uniform eligibility processes, insofar as may be possible, and ensure that multiple eligibility determinations are not required;

(b) Require that a health care provider or a health care facility that receives funds from a public program provide care to state

residents receiving a state subsidy who may wish to receive care from them consistent with the provisions of chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act), and that a health maintenance organization, health care service contractor, insurer, or ((~~certified health plan~~)) health carrier that receives funds from a public program accept enrollment from state residents receiving a state subsidy who may wish to enroll with them under the provisions of chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act);

(c) Strive to integrate purchasing for all publicly sponsored health services in order to maximize the cost control potential and promote the most efficient methods of financing and coordinating services;

(d) Annually suggest changes in state and federal law and rules to bring all publicly funded health programs in compliance with the goals and intent of chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act);

(e) Consult regularly with the governor, the legislature, and state agency directors whose operations are affected by the implementation of this section.

Sec. 12. RCW 41.05.055 and 1994 c 36 s 1 are each amended to read as follows:

(1) The public employees' benefits board is created within the authority. The function of the board is to design and approve insurance benefit plans for state employees ((~~and school district employees~~)).

(2) The board shall be composed of ((~~nine~~)) seven members appointed by the governor as follows:

(a) Two representatives of state employees, one of whom shall represent an employee union certified as exclusive representative of at least one bargaining unit of classified employees, and one of whom is retired, is covered by a program under the jurisdiction of the board, and represents an organized group of retired public employees;

(b) ((~~Two~~)) One representative((~~s~~)) of ((~~school district employees, one of whom shall represent an association of school employees and one of whom is retired, and represents~~)) an organized group of retired school employees;

(c) ((~~Four~~)) Three members with experience in health benefit management and cost containment; and

(d) The administrator.

(3) The governor shall appoint the initial members of the board to staggered terms not to exceed four years. Members appointed thereafter shall serve two-year terms. Members of the board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060. The board shall prescribe rules for the conduct of its business. The administrator shall serve as chair of the board. Meetings of the board shall be at the call of the chair.

Sec. 13. RCW 41.05.065 and 1994 c 153 s 5 are each amended to read as follows:

(1) The board shall study all matters connected with the provision of health care coverage, life insurance, liability insurance, accidental death and dismemberment insurance, and disability income insurance or any of, or a combination of, the enumerated types of insurance for employees and their dependents on the best basis possible with relation both to the welfare of the employees and to the state, however liability insurance shall not be made available to dependents.

(2) The public employees' benefits board shall develop employee benefit plans that include comprehensive health care benefits for all employees. In developing these plans, the board shall consider the following elements:

(a) Methods of maximizing cost containment while ensuring access to quality health care;

(b) Development of provider arrangements that encourage cost containment and ensure access to quality care, including but not limited to prepaid delivery systems and prospective payment methods;

(c) Wellness incentives that focus on proven strategies, 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;

(d) Utilization review procedures including, but not limited to a cost-efficient method for prior authorization of services, hospital inpatient length of stay review, requirements for use of outpatient surgeries ((~~and second opinions for surgeries~~)), review of invoices or

claims submitted by service providers, and performance audit of providers;

(e) Effective coordination of benefits;

(f) Minimum standards for insuring entities; and

(g) Minimum scope and content of ((~~standard~~)) public employee benefit plans to be offered to enrollees participating in the employee health benefit plans. On and after ((~~July 1, 1995~~)) January 1, 1996, the ((~~uniform~~)) standard benefits package shall constitute the minimum level of health benefits offered to employees. ((~~To maintain the comprehensive nature of employee health care benefits, employee eligibility criteria related to the number of hours worked and the benefits provided to employees shall be substantially equivalent to the state employees' health benefits plan and eligibility criteria in effect on January 1, 1993.~~))

(3) The board shall design benefits and determine the terms and conditions of employee participation and coverage, including establishment of eligibility criteria.

(4) ((~~The board shall attempt to achieve enrollment of all employees and retirees in managed health care systems by July 1994.~~))

The board may authorize premium contributions for an employee and the employee's dependents in a manner that encourages the use of cost-efficient ((~~managed~~)) health care systems.

(5) Employees shall choose participation in one of the health care benefit plans developed by the board.

(6) The board shall review plans proposed by insurance carriers that desire to offer property insurance and/or accident and casualty insurance to state employees through payroll deduction. The board may approve any such plan for payroll deduction by carriers holding a valid certificate of authority in the state of Washington and which the board determines to be in the best interests of employees and the state. The board shall promulgate rules setting forth criteria by which it shall evaluate the plans.

Sec. 14. RCW 41.05.075 and 1994 sp.s. c 9 s 724, 1994 c 309 s 3, and 1994 c 153 s 6 are each reenacted and 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 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.

(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)~~)) Beginning in January 1990, and each January thereafter until January 1996, the administrator shall publish and distribute to each school district a description of health care benefit plans available through the authority and the estimated cost if school district employees were enrolled.

Sec. 15. RCW 41.05.200 and 1993 c 492 s 228 are each amended to read as follows:

(1) The Washington state group purchasing association is established for the purpose of coordinating and enhancing the health care purchasing power of the groups identified in subsection (2) of this section. The purchasing association shall be administered by the administrator.

(2) The following organizations or entities may seek the approval of the administrator for membership in the purchasing association:

(a) Private nonprofit human services provider organizations under contract with state agencies, on behalf of their employees and their employees' spouses and dependent children;

(b) Individuals providing in-home long-term care services to persons whose care is financed in whole or in part through the medical assistance personal care or community options program entry system program as provided in chapter 74.09 RCW, or the chore services program, as provided in chapter 74.08 RCW, on behalf of themselves and their spouses and dependent children;

(c) Owners and operators of child day care centers and family child care homes licensed under chapter 74.15 RCW and of preschool or other child care programs exempted from licensing under chapter 74.15 RCW on behalf of themselves and their employees and employees' spouses and dependent children; and

(d) Foster parents contracting with the department of social and health services under chapter 74.13 RCW and licensed under chapter 74.15 RCW on behalf of themselves and their spouses and dependent children.

(3) In administering the purchasing association, the administrator shall:

(a) Negotiate and enter into contracts on behalf of the purchasing association's members in conjunction with its contracting and purchasing activities for employee benefits plans under RCW 41.05.075. In negotiating and contracting with insuring entities on behalf of employees and purchasing association members, two distinct pools shall be maintained.

(b) Review and approve or deny applications from entities seeking membership in the purchasing association:

(i) The administrator may require all or the substantial majority of the employees of the organizations or entities listed in subsection (2) of this section to enroll in the purchasing association.

(ii) The administrator shall require, that as a condition of membership in the purchasing association, an entity or organization listed in subsection (2) of this section that employs individuals pay at least fifty percent of the cost of the health insurance coverage for each employee enrolled in the purchasing association.

(iii) In offering and administering the purchasing association, the administrator may not discriminate against individuals or groups based on age, gender, geographic area, industry, or medical history.

(4) On and after ((~~July 1, 1995~~)) January 1, 1996, the ((~~uniform~~)) standard benefits package and schedule of premiums and point of service cost-sharing adopted and from time to time revised by the health services commission pursuant to chapter 492, Laws of 1993 shall be applicable to the association.

(5) The administrator shall adopt preexisting condition coverage provisions for the association as provided in RCW 48.20.540, 48.21.340, 48.44.480, and 48.46.550.

(6) Premiums charged to purchasing association members shall include the authority's reasonable administrative and marketing costs. Purchasing association members may not receive any subsidy from the state for the purchase of health insurance coverage through the association.

(7)(a) The Washington state group purchasing association account is established in the custody of the state treasurer, to be used by the administrator for the deposit of premium payments from individuals and entities described in subsection (2) of this section, and for payment of premiums for benefit contracts entered into on behalf of the purchasing association's participants and operating expenses incurred by the authority in the administration of benefit contracts under this section. Moneys from the account shall be disbursed by the state treasurer by warrants on vouchers duly authorized by the administrator.

(b) Disbursements from the account are not subject to appropriations, but shall be subject to the allotment procedure provided under chapter 43.88 RCW.

Sec. 16. RCW 43.72.005 and 1993 c 492 s 401 are each amended to read as follows:

(1) The legislature intends that ((~~chapter 492, Laws of 1993 establish structures, processes, and specific financial limits to stabilize the overall cost of health services within the economy, reduce the demand for unneeded health services, provide access to essential health services, improve public health, and ensure that health system costs do not undermine the financial viability of nonhealth care businesses.~~)) state government policy stabilize health services costs, reform the health insurance market, actively address the health care needs of all citizens of the state, improve the public's health, and reduce unwarranted health services costs to preserve the viability of nonhealth care businesses.

(2) The legislature intends that:

(a) State residents be enrolled in the health care plan of their choice that meets state standards regarding affordability, accessibility, cost-effectiveness, and clinical quality;

(b) State residents be able to choose health services from the full range of health care providers, in a manner consistent with good health services management, quality assurance, and cost-effectiveness;

(c) Individuals and businesses have the option to purchase any health services they may choose in addition to those included in the standard benefits package;

(d) These goals be accomplished within a reformed system using health service providers and facilities in a way that allows consumers to choose among competing plans operating within regulations that promote the public good; and

(e) A policy of coordinating the delivery, purchase, and provision of health services among the federal, state, local, and tribal governments be encouraged and accomplished by chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act).

NEW SECTION. **Sec. 17.** A new section is added to chapter 48.43 RCW to read as follows:

HEALTH REFORM IMPROVEMENT. The legislature finds that our health and financial security are at risk as a result of certain aspects of our health insurance and health service delivery system. Correcting these problems can only be accomplished successfully through incremental changes that provide access to essential health care services, freedom of choice of providers and insurance plans, and choice of affordable financing mechanisms for individual and group

purchasers. This must be accomplished within a reformed and efficient system acceptable to individual purchasers, employers, insurance, and providers of health care.

The legislature finds that encouraging the individual and small group insurance market, maintaining effective price competition, creating provider incentives for cost reductions, and pooling small businesses and individuals through purchasing arrangements where prices can be negotiated are effective means for making health insurance more available and affordable for small businesses and individuals.

Sec. 18. RCW 43.72.010 and 1994 c 4 s 1 are each amended to read as follows:

In this chapter, unless the context otherwise requires:

(1) "((~~Certified health plan~~)) Health carrier" or "((~~plan~~)) carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, fraternal benefit societies regulated under chapter 48.36A.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((~~, or an entity certified in accordance with RCW 48.43.020 through 48.43.120~~)).

(2) ((~~"Chair" means the presiding officer of the Washington health services commission.~~

~~(3) "Commission" or "health services commission" means the Washington health services commission.~~

~~(4) "Community~~)) "Standardized rate" means the rating method used to establish the premium for the ((~~uniform~~)) standard benefits package adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region ((~~and~~)), age, family size, and employer use of wellness programs as determined by the ((~~commission~~)) commissioner under RCW 43.72.170 (as recodified by this act).

((~~(5)~~)) (3) "Continuous quality improvement and total quality management" means a continuous process to improve health services while reducing costs.

((~~(6)~~)) (4) "Employee" means a resident who is in the employment of an employer, as defined by chapter 50.04 RCW.

((~~(7)~~)) (5) "Enrollee" means any person who is a Washington resident enrolled ((~~in a certified health plan~~)) with a health carrier.

((~~(8)~~)) (6) "Enrollee point of service cost-sharing" means amounts paid to ((~~certified health plans~~)) a health carrier directly providing services, health care providers, or health care facilities by enrollees for receipt of specific ((~~uniform~~)) standard benefits package services, and may include copayments, coinsurance, or deductibles((~~, that together must be actuarially equivalent across plans and within overall limits established by the commission~~)).

((~~(9)~~)) (7) "Enrollee premium sharing" means that portion of the premium that is paid by enrollees or their family members.

((~~(10)~~)) (8) "Federal poverty level" means the federal poverty guidelines determined annually by the United States department of health and human services or successor agency.

((~~(11)~~)) (9) "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, but does not include Christian Science sanatoriums operated, listed, or certified by the First Church of Christ Scientist, Boston, Massachusetts.

((~~(12)~~)) (10) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW and 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.

((~~(13)~~)) (11) "((~~Health insurance purchasing cooperative" or "cooperative~~)) Subscriber-purchasing group" means a member-owned and governed nonprofit organization certified in accordance with RCW 43.72.080 (as recodified by this act) and 48.43.160.

((~~(14)~~)) (12) "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 including but not limited to medical, surgical, chiropractic, physical therapy, speech and hearing services, speech pathology, audiology, mental health, dental, hospital, and vision care.

(13) "Health plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service 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) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

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

(f) Workers' compensation coverage unless workers' compensation coverage is provided under an employer's election permitted by RCW 51.14.010 (as recodified by this act);

(g) Accident only coverage; and

(h) Specific disease, hospital confinement indemnity, or limited benefit health insurance, where such policies are not offered or marketed to groups or individuals who are covered by a standard benefits package.

(14) "Long-term care" means institutional, residential, outpatient, or community-based services that meet the individual needs of persons of all ages who are limited in their functional capacities or have disabilities and require assistance with performing two or more activities of daily living for an extended or indefinite period of time. These services include case management, protective supervision, in-home care, nursing services, convalescent, custodial, chronic, and terminally ill care.

(15) ((~~"Major capital expenditure" means any project or expenditure for capital construction, renovations, or acquisition, including medical technological equipment, as defined by the commission, costing more than one million dollars.~~

~~(16) "Managed care" means an integrated system of insurance, financing, and health services delivery functions that: (a) Assumes financial risk for delivery of health services and uses a defined~~

~~network of providers; or (b) assumes financial risk for delivery of health services and promotes the efficient delivery of health services through provider assumption of some financial risk including capitation, prospective payment, resource-based relative value scales, fee schedules, or similar method of limiting payments to health care providers.~~

~~(17) "Maximum enrollee financial participation" means the income-related total annual payments that may be required of an enrollee per family who chooses one of the three lowest priced uniform benefits packages offered by plans in a geographic region including both premium sharing and enrollee point of service cost-sharing.~~

~~(18) "Persons of color" means Asians/Pacific Islanders, African, Hispanic, and Native Americans.~~

~~(19)~~)) (16) "Premium" means all sums charged, received, or deposited by a ((~~certified health plan~~)) health carrier as consideration for a ((~~uniform~~)) standard benefits package or the continuance of a ((~~uniform~~)) standard benefits package. Any assessment((~~,~~)) or any "membership," "policy," "contract," "service," or similar fee or charge made by ((~~the certified health plan~~)) a health carrier in consideration for the ((~~uniform~~)) standard benefits package is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point of service cost-sharing.

(((~~(20) "Qualified employee" means an employee who is employed at least thirty hours during a week or one hundred twenty hours during a calendar month.~~

~~(21) "Registered employer health plan" means a health plan established by a private employer of more than seven thousand active employees in this state solely for the benefit of such employees and their dependents and that meets the requirements of RCW 43.72.120. Nothing contained in this subsection shall be deemed to preclude the plan from providing benefits to retirees of the employer.~~

~~(22) "Supplemental benefits" means those appropriate and effective health services that are not included in the uniform benefits package or that expand the type or level of health services available under the uniform benefits package and that are offered to all residents in accordance with the provisions of RCW 43.72.160 and 43.72.170.~~

~~(23) "Technology" means the drugs, devices, equipment, and medical or surgical procedures used in the delivery of health services, and the organizational or supportive systems within which such services are~~

~~provided. It also means sophisticated and complicated machinery developed as a result of ongoing research in the basic biological and physical sciences, clinical medicine, electronics, and computer sciences, as well as specialized professionals, medical equipment, procedures, and chemical formulations used for both diagnostic and therapeutic purposes.~~

~~(24) "Uniform~~)) (17) "Standard benefits package" or "package" means those ((~~appropriate and effective~~)) health services((~~, defined by the commission under RCW 43.72.130, that must be offered to all Washington residents through certified health plans~~)) determined under RCW 43.72.130 (as recodified by this act).

(((~~(25) "Washington resident" or "resident" means a person who intends to reside in the state permanently or indefinitely and who did not move to Washington for the primary purpose of securing health services under RCW 43.72.090 through 43.72.240, 43.72.300, 43.72.310, 43.72.800, and chapters 48.43 and 48.85 RCW. "Washington resident" also includes people and their accompanying family members who are residing in the state for the purpose of engaging in employment for at least one month, who did not enter the state for the primary purpose of obtaining health services. The confinement of a person in a nursing home, hospital, or other medical institution in the state shall not by itself be sufficient to qualify such person as a resident.~~))

(18) "Wellness program" means an explicit program of 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. 19. RCW 43.72.020 and 1994 c 154 s 311 are each amended to read as follows:

(1) There is created an agency of state government to be known as the Washington health services commission. The commission shall consist of five members reflecting ethnic and racial diversity, appointed by the governor, with the consent of the senate. One member shall be designated by the governor as chair and shall serve at the pleasure of the governor. The insurance commissioner shall serve as an additional nonvoting member. Of the initial members, one shall be

appointed to a term of three years, two shall be appointed to a term of four years, and two shall be appointed to a term of five years. Thereafter, members shall be appointed to five-year terms. Vacancies shall be filled by appointment for the remainder of the unexpired term of the position being vacated.

(2) Members of the commission shall have no pecuniary interest in any business subject to regulation by the commission and shall be subject to chapter 42.52 RCW.

(3) Members of the commission shall occupy their positions on a full-time basis and are exempt from the provisions of chapter 41.06 RCW. Commission members and the professional commission staff are subject to the public disclosure provisions of chapter 42.17 RCW. Members shall be paid a salary to be fixed by the governor in accordance with RCW 43.03.040. A majority of the members of the commission constitutes a quorum for the conduct of business.

(4) The Washington health services commission is terminated on January 1, 1996. The commission's powers and duties are transferred pursuant to sections 20 through 24 of this act.

NEW SECTION. **Sec. 20.** WASHINGTON HEALTH SERVICES COMMISSION--TRANSFERRED POWERS AND DUTIES. Effective January 1, 1996, the powers and duties of the Washington health services commission not repealed by chapter . . ., Laws of 1995 (this act), are transferred as follows:

(1) To the Washington health care authority:

(a) Standard benefits package provisions, under RCW 43.72.130 (as recodified by this act);

(b) Standard point-of-service cost-sharing provisions.

(2) To the department of health:

(a) Health data provisions;

(b) Quality assurance provisions;

(c) Credentialing provisions;

(d) Conflict of interest by health care providers provisions;

(e) Provision relating to funding of medical research and health professions training activities;

(f) Duty to evaluate the effect of reforms under chapter . . ., Laws of 1995 (this act) on access to appropriate care in rural areas.

(3) To the office of insurance commissioner:

(a) Health carrier provisions and related insurance provisions;

(b) Antitrust provisions;

(c) Standardized rating provisions.

(4) To the joint committee on health systems oversight:

(a) Provisions relating to the general oversight of the implementation of chapter . . ., Laws of 1995 (this act);

(b) Provisions relating to monitoring the actual growth in total annual health services costs.

NEW SECTION. **Sec. 21.** TRANSFER OF RECORDS, EQUIPMENT, FUNDS. All reports, documents, surveys, books, records, files, papers, or written material in the possession of the Washington health services commission shall be allocated in a manner prescribed by the office of financial management. All cabinets, furniture, office equipment, motor vehicles, and other tangible property used by the Washington health services commission shall be allocated in a manner prescribed by the office of financial management. All funds, credits, or other assets held by the Washington health services commission shall be allocated in a manner prescribed by the office of financial management.

Any appropriations made to the Washington health services commission shall, on the effective date of this section, be allocated in a manner prescribed by the legislature.

Whenever any question arises as to the transfer of any personnel, funds, books, documents, records, papers, files, equipment, or other tangible property used or held in the exercise of the powers and the performance of the duties and functions transferred, the director of financial management shall make a determination as to the proper allocation and certify the same to the state agencies concerned.

NEW SECTION. **Sec. 22.** TRANSFER OR EMPLOYEES. All employees of the Washington health services commission are transferred in the manner prescribed by the office of financial management.

NEW SECTION. **Sec. 23.** RULES AND BUSINESS. All rules and all pending business before the Washington health services commission shall be continued consistent with the authority transferred. All existing contracts and obligations shall remain in full force and shall be performed by the agency to which the related authority was transferred.

NEW SECTION. **Sec. 24.** VALIDITY OF PRIOR ACTS. The transfer of the powers, duties, functions, and personnel of the Washington health services commission shall not affect the validity of any act performed prior to the effective date of this section.

NEW SECTION. **Sec. 25.** A new section is added to chapter 41.05 RCW to read as follows:

The administrator of the health care authority shall appoint a seasonal employment advisory committee composed of equal numbers of seasonal employee and employer representatives to assist the administrator in development of mechanisms to facilitate coverage for seasonal employees.

Members of the committee shall serve without compensation for their services but shall be reimbursed for their expenses while attending meetings on behalf of the administrator in accordance with RCW 43.03.050 and 43.03.060.

NEW SECTION. **Sec. 26.** A new section is added to chapter 44.44 RCW to read as follows:

JOINT COMMITTEE ON HEALTH SYSTEMS OVERSIGHT--MEMBERSHIP, TERMS, LEADERSHIP. (1) There is hereby created a joint committee on health systems oversight. The committee shall consist of: (a) Four members of the senate appointed by the president of the senate, two of whom shall be members of the majority party and two of whom shall be members of the minority party; and (b) four members of the house of representatives appointed by the speaker of the house of representatives, two of whom shall be members of the majority party and two of whom shall be members of the minority party. Members of the committee shall be appointed before the close of each regular session during an odd-numbered year.

(2) Each member’s term of office shall run from the close of the session in which the member was appointed until the close of the next regular session held in an odd-numbered year. If a successor is not appointed during a session, the member’s term shall continue until the member is reappointed or a successor is appointed. The term of office for a committee member who does not continue as a member of the senate or house of representatives shall cease upon the convening of the next session of the legislature during an odd-numbered year after the member’s appointment, or upon the member’s resignation, whichever is

earlier. Vacancies on the committee shall be filled by appointment in the same manner as described in subsection (1) of this section. All such vacancies shall be filled from the same political party and from the same house as the member whose seat was vacated.

(3) The committee shall elect a chair and a vice-chair. The chair shall be a member of the senate in even-numbered years and a member of the house of representatives in odd-numbered years.

(4) The committee shall have the following powers and duties:

(a) Oversee the implementation of chapter . . ., Laws of 1995 (this act) and related chapters of the Revised Code of Washington;

(b) Periodically make recommendations to the appropriate committees of the legislature and the governor regarding the standard benefits package;

(c) Comply with other specified provisions of chapter . . ., Laws of 1995 (this act);

(d) Consistent with funds appropriated from the health services account established by RCW 43.72.902: Hire staff, who shall have extensive experience in health reform activities in Washington state; conduct or cause to be conducted appropriate studies and review; and make necessary recommendations to the legislature;

(e) Administer oaths, issue subpoenas, and compel the attendance of witnesses and the production of materials relevant to the committee's duties; and

(f) Review rules prepared by the insurance commissioner, health care authority, and department of health where appropriate to ensure consistency with the policies of this act.

(5) In January 1998 the legislative budget committee shall commence a study of the necessity of the existence of the committee and report its recommendation to the appropriate committee of the legislature by December 1, 1998.

NEW SECTION. **Sec. 27.** A new section is added to chapter 43.70 RCW to read as follows:

The secretary of health shall appoint a five-member health services effectiveness committee whose members possess a breadth of experience and knowledge in the treatment, research, and public and private funding of health care services. The committee shall have the following responsibilities:

(1) Advise the health care authority and joint committee on health systems oversight on the content of the standard benefits package and related matters;

(2) Determine that a particular procedure, treatment, drug, or other health care service is no longer experimental or investigative. Such determination shall be specific and binding to named procedures, treatments, drugs, or health services and shall apply without variation or modification to all carriers. Every health plan issued or renewed on or after the date upon which the health services effectiveness committee makes a determination that a particular procedure, treatment, drug, or other health care service is no longer experimental or investigative shall be interpreted in a manner consistent with the committee's determination. Carriers may appear before the committee, but shall have no appeal rights to the secretary. The office of the insurance commissioner may adopt rules enforcing the findings of the committee. The secretary shall adopt rules on these requirements no later than July 1, 1996; and

(3) Establish guidelines for providers dealing with terminal or static conditions, taking into consideration the ethics of providers, patient and family wishes, costs, and survival possibilities.

Sec. 28. RCW 43.72.070 and 1993 c 492 s 409 are each amended to read as follows:

To ensure the highest quality health services at the lowest total cost, the ((~~commission~~)) secretary of health shall establish a total quality management system of continuous quality improvement. Such endeavor shall be based upon the recognized quality science for continuous quality improvement. The ((~~commission~~)) secretary of health shall impanel a committee composed of persons from the private sector and related sciences who have broad knowledge and successful experiences in continuous quality improvement and total quality management applications to provide appropriate advice. ((~~It shall be the responsibility of the committee to develop standards for a Washington state health services supplier certification process and recommend such standards to the commission for review and adoption. Once adopted, the commission shall establish a schedule, with full compliance no later than July 1, 1996, whereby all health service providers and health service facilities shall be certified prior to providing uniform benefits package services.~~))

Sec. 29. RCW 43.72.080 and 1993 c 492 s 425 are each amended to read as follows:

(1) ((~~The commission shall designate four geographic regions within the state in which health insurance purchasing cooperatives may operate, based upon population, assuming that each cooperative must serve no less than one hundred fifty thousand persons; geographic factors; market conditions; and other factors deemed appropriate by the commission. The commission shall designate one health insurance purchasing cooperative per region.~~

~~(2) In coordination with the commission and consistent with the provisions of chapter 70.170 RCW, the department of health shall establish an information clearinghouse for the collection and dissemination of information necessary for the efficient operation of cooperatives, including the establishment of a risk profile information system related to certified health plan enrollees that would permit the equitable distribution of losses among plans in accordance with RCW 43.72.040(7).~~

~~(3)~~)) Every ((~~health insurance purchasing cooperative~~)) subscriber-purchasing group shall:

(a) Admit all individuals, employers, or other groups wishing to participate ((~~in the cooperative~~)) that meet individual purchasing group requirements;

(b) ((~~Make available for purchase by cooperative members every health care program offered by every certified health plan operating within the cooperative's region;~~

~~(c)~~)) Be operated as a member-governed and owned, nonprofit ((~~cooperative~~)) organization in which no ((~~certified health plan, health maintenance organization, health care service contractor~~)) health carrier, independent practice association, independent physician organization, or any individual with a pecuniary interest in any such organization, shall have any pecuniary interest in or management control of the ((~~cooperative~~)) organization;

((~~(d)~~)) (c) Be authorized to provide for ((~~centralized~~)) enrollment and premium collection and distribution among ((~~certified health plans~~)) health carriers; and

((~~(e)~~)) (d) Serve as an ombudsman for its members to resolve inquiries, complaints, or other concerns with ((~~certified health plans~~)) health carriers.

((~~(4) Every health insurance purchasing cooperative shall assist members in selecting certified health plans and for this purpose may devise a rating system or similar system to judge the quality and cost-effectiveness of certified health plans consistent with guidelines established by the commission. For this purpose, each cooperative and directors, officers, and other employees of the cooperative are immune from liability in any civil action or suit arising from the publication of any report, brochure, or guide, or dissemination of information related to the services, quality, price, or cost-effectiveness of certified plans unless actual malice, fraud, or bad faith is shown. Such immunity is in addition to any common law or statutory privilege or immunity enjoyed by such person, and nothing in this section is intended to abrogate or modify in any way such common law or statutory privilege or immunity.~~

~~(5) Every health insurance purchasing cooperative shall bear the full cost of its operations, including the costs of participating in the information clearinghouse, through assessments upon its members. Such assessments shall be billed and accounted for separately from premiums collected and distributed for the purchase of the uniform benefits package or any other supplemental insurance or health services program.~~

~~(6)~~)) (2) No health insurance purchasing cooperative may bear any financial risk for the delivery of ((~~uniform~~)) standard benefits package services, or for any other ((~~supplemental~~)) insurance or health services program.

((~~(7) No health insurance purchasing cooperative may directly broker, sell, contract for, or provide any insurance or health services program. However, nothing contained in this section shall be deemed to prohibit the use or employment of insurance agents or brokers by the cooperative for other purposes or to prohibit the facilitation of the sale and purchase by members of supplemental insurance or health services programs.~~

~~(8)~~)) (3) Every subscriber-purchasing group shall offer members the standard benefit package as the minimum available health plan. The purchasing group may negotiate with health carriers the standard benefit package premium to be paid by members, but the rate must be filed and approved by the commissioner. Premium negotiation may not result in an experience-rated standard benefit package for the subscriber-purchasing group.

(4) When more than one carrier's standard benefit package is offered by the purchasing group, every subscriber-purchasing group shall assist members in selecting health plans and for this purpose may devise a rating system or similar system to judge the quality and cost-effectiveness of health carriers. Each purchasing group and directors, officers, and other employees of the group are immune from liability in any civil action or suit arising from the publication of any report, brochure, or guide, or dissemination of information related to the services, quality, price, or cost-effectiveness of health carriers unless actual malice, fraud, or bad faith is shown. Such immunity is in addition to any common law or statutory privilege or immunity enjoyed by such person, and nothing in this section is intended to abrogate or modify in any way such common law or statutory privilege or immunity.

(5) Every subscriber-purchasing group shall employ or contract for the services of an insurance agent or broker licensed under chapter 48.17 RCW appropriate to the insurance products and programs made available through the group.

(6) The ((~~commission~~)) commissioner may adopt rules necessary for the implementation of this section ((~~including rules governing charter and bylaw provisions of cooperatives and may adopt rules prohibiting or permitting other activities by cooperatives~~)) subject to the review of the joint committee on health systems oversight.

((~~(9)~~)) (7) The ((~~commission shall consider~~)) commissioner may recommend to interested parties ways in which ((~~cooperatives~~)) purchasing groups can develop, encourage, and provide incentives for employee wellness programs.

Sec. 30. RCW 43.72.090 and 1993 c 492 s 427 are each amended to read as follows:

((~~(1) On and after July 1, 1995, no person or entity in this state shall provide the uniform benefits package and supplemental benefits as defined in RCW 43.72.010 without being certified as a certified health plan by the insurance commissioner.~~

~~(2)~~)) On and after ((~~July 1, 1995~~)) January 1, 1996, ((~~no certified health plan may offer less than the uniform~~)) every health carrier offering health plans must offer the standard benefits package to residents of this state ((~~and no registered employer health plan may~~

~~provide less than the uniform benefits package to its employees and their dependents~~)) as the minimum level of coverage.

Sec. 31. RCW 43.72.100 and 1993 c 492 s 428 are each amended to read as follows:

((~~A certified~~)) Beginning January 1, 1996, a health ((~~plan~~)) carrier offering health plans shall:

(1) Provide the benefits included in the ((~~uniform~~)) standard benefits package to enrolled Washington residents ((~~for a prepaid per capita community-rated premium not to exceed the maximum premium established by the commission and provide such benefits through managed care in accordance with rules adopted by the commission~~)) on a standardized rate basis;

(2) ((~~Offer supplemental benefits to enrolled Washington residents for a prepaid per capita community-rated premium and provide such benefits through managed care in accordance with rules adopted by the commission;~~

~~(3)~~)) Accept for enrollment any state resident within the ((~~plan's~~)) carrier's service area and provide or assure the provision of all services within the ((~~uniform~~)) standard benefits package ((~~and offer supplemental benefits~~)) regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The insurance commissioner may grant a temporary exemption from this subsection, if, upon application by a ((~~certified health plan~~)) health carrier, the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a ((~~certified health plan~~)) health carrier is required to continue enrollment of additional eligible individuals;

((~~(4)~~)) (3) If the ((~~plan~~)) health carrier provides benefits through contracts with, ownership of, or management of health care facilities and contracts with or employs health care providers, demonstrate to the satisfaction of the insurance commissioner in consultation with the department of health ((~~and the commission~~)) that its facilities and personnel are adequate to provide the benefits prescribed in the ((~~uniform benefits package and offer supplemental benefits~~)) health plans to enrolled Washington residents, and that it is financially capable of providing such residents with, or has made

adequate contractual arrangements with health care providers and facilities to provide enrollees with such benefits;

((~~(5) Comply with portability of benefits requirements prescribed by the commission;~~

~~(6) Comply with administrative rules prescribed by the commission, the insurance commissioner, and other state agencies governing certified health plans;~~

~~(7)~~)) (4) Provide all enrollees with standardized and uniform instructions and informational materials, designed by the department of health by January 1, 1996, to increase individual and family awareness of injury and illness prevention; encourage assumption of personal responsibility for protecting personal health; and stimulate discussion about the use and limits of medical care in improving the health of individuals and communities;

((~~(8)~~)) (5) Disclose to enrollees the charity care requirements under chapter 70.170 RCW;

((~~(9)~~)) (6) Include in all of its contracts with health care providers and health care facilities a provision prohibiting such providers and facilities from billing enrollees for any amounts in excess of applicable enrollee point of service cost-sharing obligations for services ((~~included in the uniform benefits package and supplemental benefits~~)) covered by the carrier;

((~~(10)~~)) (7) Include in all of its contracts issued for ((~~uniform benefits package and supplemental benefits~~)) health plans coverage a subrogation provision that allows the ((~~certified health plan~~)) health carrier to recover the costs of ((~~uniform benefits package and supplemental benefits~~)) health plans services incurred to care for an enrollee injured by a negligent third party. The costs recovered shall be limited to:

(a) If the ((~~certified health plan~~)) health carrier has not intervened in the action by an injured enrollee against a negligent third party, then the amount of costs the ((~~certified health plan~~)) health carrier can recover shall be limited to the excess remaining after the enrollee has been fully compensated for his or her loss minus a proportionate share of the enrollee's costs and fees in bringing the action. The proportionate share shall be determined by:

(i) The fees and costs approved by the court in which the action was initiated; or

(ii) The written agreement between the attorney and client that established fees and costs when fees and costs are not addressed by the court.

When fees and costs have been approved by a court, after notice to the ((~~certified health plan~~)) health carrier, the ((~~certified health plan~~)) health carrier shall have the right to be heard on the matter of attorneys' fees and costs or its proportionate share;

(b) If the ((~~certified health plan~~)) health carrier has intervened in the action by an injured enrollee against a negligent third party, then the amount of costs the ((~~certified health plan~~)) health carrier can recover shall be the excess remaining after the enrollee has been fully compensated for his or her loss or the amount of the ((~~plan's~~)) carrier's incurred costs, whichever is less;

((~~(11)~~)) (8) Establish and maintain a grievance procedure approved by the commissioner, to provide a reasonable and effective resolution of complaints initiated by enrollees concerning any matter relating to the provision of benefits under the ((~~uniform benefits package and supplemental benefits~~)) health plans, access to health care services, and quality of services. Each ((~~certified health plan~~)) health carrier shall respond to complaints filed with the insurance commissioner within fifteen working days. The insurance commissioner ((~~in consultation with the commission~~)) shall establish standards for resolution of grievances;

((~~(12)~~)) (9) Comply with the provisions of chapter 48.30 RCW prohibiting unfair and deceptive acts and practices to the extent such provisions are not specifically modified or superseded by the provisions of chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act) and be prohibited from offering or supplying incentives that would have the effect of avoiding the requirements of subsection ((~~(3)~~)) (2) of this section;

((~~(13)~~)) (10) Have standardized and uniform culturally sensitive health promotion programs, designed by the department of health by January 1, 1996, that include approaches ((~~that are specifically effective for persons of color and accommodating~~)) to accommodate different cultural value systems, gender, and age;

((~~(14)~~)) (11) Permit every category of health care provider to provide health services or care for conditions included in the ((~~uniform~~)) standard benefits package to the extent that:

(a) The provision of such health services or care is within the health care providers' permitted scope of practice; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of health services;

(ii) Management and administrative procedures; and

(iii) Provision of cost-effective and clinically efficacious health services;

((~~(15)~~)) (12) Establish the geographic ((~~boundaries~~)) areas in which they will obligate themselves to deliver the services required under the ((~~uniform~~)) standard benefits package ((~~and include such information in their application for certification, but~~)). The commissioner shall review such ((~~boundaries~~)) areas and may disapprove((~~, in conformance with guidelines adopted by the commission,~~)) those that have been clearly ((~~drawn~~)) designed to be exclusionary ((~~within a health care catchment area~~));

((~~(16)~~)) (13) Annually report the names and addresses of all officers, directors, or trustees of the ((~~certified health plan~~)) health carrier during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals;

((~~(17)~~)) (14) Annually report the number of residents enrolled and terminated during the previous year. Additional information regarding the enrollment and termination pattern for a ((~~certified health plan~~)) health carrier may be required by the commissioner to determine compliance with the open enrollment and free access requirements of chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act); and

((~~(18)~~)) (15) Disclose any financial interests held by officers and directors in any facilities associated with or operated by the ((~~certified health plan~~)) health carrier.

NEW SECTION. **Sec. 32.** HEALTH CARE SAVING ACCOUNTS. This chapter shall be known as the health care savings account act.

(1) The legislature recognizes that:

(a) The costs of health care are increasing rapidly and most individuals are removed from participating in the purchase of their health care.

(b) As the population ages, there will be an ever-increasing demand on the state to provide long-term care for those individuals with

functional disabilities who need medical care and assistance with activities of daily living.

(2) As a result, it becomes critical to encourage and support solutions to alleviate the demand for diminishing state resources. In response to these increasing costs in health care spending, health care savings accounts and qualified higher deductible health plans may be offered as health benefit options to all residents as incentives to reduce unnecessary health services utilization, administration, and paperwork, and to encourage individuals to be in charge of and participate directly in their use of services and health care spending. To alleviate the possible impoverishment of residents requiring long-term care, health care savings accounts may promote savings for long-term care and provide incentives for individuals to protect themselves from financial hardship due to a long-term health care need.

(3) By authorizing health care savings account programs:

(a) Residents can insure routine first dollar and major expenditures for health and medical services and long-term care through employer sponsored or individual-funded health care savings account program arrangements.

(b) Employees and individuals can change jobs and maintain their health care savings accounts and insurance using funds from these personally owned accounts to pay for health services and insurance for themselves and their families.

(c) Individuals and families may continue to choose among available health insurance plans and health services providers.

(d) Retirees may have moneys saved to continue preferred health coverage.

(e) Health care costs and spending increases may be reduced favorably by increased consumer sensitivity to and interest in the cost and quality of health services and health plans.

(f) The problem of long-term care financing may be alleviated by encouraging and enabling residents and individuals to save for their future needs.

NEW SECTION. **Sec. 33.** As used in sections 34 through 37 of this act:

(1) "Account administrator" means:

(a) A state-chartered bank, federal bank, savings and loan association, credit union, or trust company authorized to act as

fiduciary and under supervision of the department of financial institutions or a national banking association or federal savings and loan association or credit union authorized to act as fiduciary in this state;

(b) A health carrier authorized to do business in this state pursuant to Title 48 RCW, third party administrator, health care corporation, or health care services contractor;

(c) A broker-dealer, commodity issuer, or investment advisor regulated by the department of financial institutions or federal investment company registered under the investment company act of 1940, Title 1, chapter 686, 54 Stat. 789, 15 U.S.C. 80a-1 to 80a-64;

(d) A certified public accountant or certified public accounting firm licensed to practice pursuant to Title 18 RCW;

(e) A public, municipal, or private sector employer if the employer offers a self-insured health plan under ERISA or under state law and rules; or

(f) A public, municipal, or private sector employer that offers employees a health care savings account program.

(2) "Account holder" means the resident individual, employee, or self-employed individual who establishes a health care savings account or for whose benefit a health care savings account is established.

(3) "Deductible" means the total deductible prior to health insurance paying eligible health expenses for covered individuals or employees and all dependents for a calendar or plan year.

(4) "Dependent child" means an individual’s unmarried natural child, stepchild, or legally adopted child, who is either (a) younger than age nineteen, or (b) younger than age twenty-three, and (i) is a full-time student at an educational organization that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on, or (ii) is pursuing a full-time course of institutional on-farm training under the supervision of an educational organization described in (b)(i) of this subsection.

(5) "Family" means an individual or an individual and the individual’s spouse, if not legally separated, and the individual’s dependent children. For purposes of eligibility determination and enrollment in the health plan, an individual cannot be a member of more than one family.

(6) "Family dependent" means an enrollee’s legal spouse, if not legally separated, or the enrollee’s dependent child, who meets all eligibility requirements, is enrolled in the health plan, and for whom the applicable premium has been paid.

(7) "Eligible health expense" means an expense paid by the taxpayer for health care described in section 213(d) of the internal revenue code as in existence on the effective date of this section.

(8) "ERISA" means the employee retirement income security act of 1974, P.L. 93-406, 88 Stat. 829.

(9) "Higher deductible" means a deductible of not less than one thousand dollars for an individual and not less than two thousand dollars for a family for 1995.

(10) "Health care savings account" or "account" means an interest-bearing account established in this state pursuant to a health care savings account program to pay eligible health expenses of an account holder and his or her covered dependents.

(11) "Health care savings account program" or "program" means one of the following programs:

(a) A health benefit program offered by an employer that may or may not have previously provided health benefits, a health coverage policy, plan, certificate, or contract that includes all of the following:

(i) The purchase by an employer on behalf of an employee of a qualified higher deductible health plan for the benefit of an employee and covered dependents;

(ii) The contribution into a health care savings account by the employer on behalf of an employee of the premium differential based on the purchase of a qualified higher deductible health plan. In addition to the employer’s contribution, the employee may contribute into the account all or part of the difference between the employer’s contribution and the maximum contribution as determined pursuant to this subsection (11)(a)(ii). Total contributions into health care savings accounts shall not exceed three thousand dollars for the account holder and not more than one thousand dollars each for his or her additional covered dependents up to a maximum of two. The maximum contribution to the account shall be adjusted to reflect increases in the implicit price deflator for the United States as defined and officially reported by the United States department of labor.

(b) A health benefit program established by an individual as an account holder that includes all of the following:

(i) The purchase by the account holder of a qualified higher deductible health plan for the benefit of the account holder and his or her covered dependents.

(ii) A contribution into a health care savings account by the account holder may not exceed three thousand dollars for the account holder and not more than one thousand dollars each for his or her additional covered dependents up to a maximum of two. The maximum contribution shall be adjusted to reflect increases in the implicit price deflator for the United States as defined and officially reported by the United States department of labor.

(12) "Qualified higher deductible health plan" means a health coverage policy, health plan, certificate, or contract that provides for payments for covered services that exceed the deductible and that is purchased by an account holder or by an employer on behalf of an employee and dependents.

NEW SECTION. **Sec. 34.** (1) For taxes assessed in 1995 and thereafter, the following apply:

(a) An employer, except as otherwise provided by statute, contract, or a collective bargaining agreement, may offer a health care savings account program to its employees.

(b) A resident individual may establish a health care savings account program for himself or herself and for his or her dependents.

(2) An employer that offers or fiduciary that administers a health care savings account before making any contributions shall inform all employees in writing of the federal and state tax status of account contributions made pursuant to sections 33 through 37 of this act.

(3) Upon agreement between an employer and account holder, the employer may contribute money into the account holder’s account up to the annual maximum limits established for each account.

NEW SECTION. **Sec. 35.** (1) An account administrator shall administer the health care savings account from which the payment of or reimbursement of paid claims is made and has a fiduciary duty to the person for whose benefit the account administrator administers an account.

(2) The account administrator shall utilize the funds held in a health care savings account for the purpose of paying the health expenses of the account holder or his or her dependents or to purchase

a health coverage policy, certificate, or contract. Funds held in a health care savings account shall not be used to pay health expenses of the account holder or his or her dependents that are otherwise reimbursable including but not limited to health expenses payable pursuant to an automobile insurance policy, worker's compensation insurance policy or self-insured plan, or another health coverage policy, certificate, or contract.

(3) The account holder may submit documentation for eligible health or other expenses under section 36 of this act to the account administrator, and the account administrator may reimburse or pay the account holder from the account holder's health care savings account.

(4) If an employer makes contributions to a health care savings account program on a periodic installment basis, the employer may advance to an employee, interest free, an amount necessary to cover eligible health expenses incurred that exceed the amount in the employee's health care savings account at the time the expense is incurred if the employee agrees to repay the advance from future installments or when he or she ceases to be an employee of the employer.

NEW SECTION. **Sec. 36.** (1) Funds in an account holder's health care savings account may only be used to pay internal revenue code eligible health expenses for the covered account holder and dependents; or:

(a) Pay some or all tuition at a two-year or four-year accredited college or university for the account holder or the account holder's dependents; or

(b) Pay toward purchase of the account holder's first home; or

(c) Contribute to qualified IRAs, retirement plans, or deferred annuities; or

(d) Pay for some or all of the premium for long-term insurance; or

(e) Taken as regular income subject to federal income tax.

(2) Withdrawals from health care savings accounts for other than eligible health expenses shall not reduce account balances below a sum equal to the account holder's health plan annual deductible.

NEW SECTION. **Sec. 37.** (1) Contributions to and interest earned on a health care savings account are deemed income subject to federal income tax until such laws change.

(2) The amount of a disbursement of any assets of a health care savings account pursuant to a filing for protection under 11 U.S.C. Secs. 101 through 1330 by an account holder is not considered a withdrawal for purposes of this section.

(3) Upon the death of the account holder, the account administrator shall distribute the principal and accumulated interest of the health care savings account to the account holder's estate from which eligible health expenses may be paid or reimbursed to the estate.

(4) If an employee is no longer employed by an employer that participates in the health care savings account program and the employee, not more than sixty days after his or her final day of employment, transfers the account to a new account administrator or requests in writing to the former employer account administrator that the account remain with the administrator and that account administrator agrees to retain the account, the money in the health care savings account may be utilized for the benefit of the employee or his or her dependents subject to sections 33 through 37 of this act and remains exempt from taxation pursuant to sections 33 through 37 of this act. Not more than thirty days after the expiration of the sixty days, if an account administrator has not accepted the former employee's account, the employer shall mail a check to the former employee at the employee's last known address equal to the amount in the account on that day. Such withdrawals are not subject to withdrawal penalties. If an employee becomes self-employed or employed with a different employer that participates in a health care savings account program, the employee may transfer his or her health care savings account to that new employer's account administrator.

NEW SECTION. **Sec. 38.** (1) The governor and responsible state agencies shall work with the legislature to implement sections 32 through 37 of this act as soon as practical after the effective date of this section.

(2) The governor and responsible agencies shall take the following steps in an effort to receive waivers or exemptions from federal statutes necessary to fully implement sections 32 through 37 of this act to include, but not be limited to:

(a) Request that the United States congress amend the internal revenue code to treat premiums and contributions to health benefits plans, such as health care savings account programs, basic health

plans, conventional and standard health plans offered through a health carrier, by employers, self-employed persons, and individuals, as fully excluded employer expenses and deductible from individual adjusted gross income for federal tax purposes.

(b) Request that the United States congress amend the internal revenue code to exempt from federal income tax interest that accrues in health care savings accounts until such money is withdrawn for expenditures other than eligible health expenses as defined in section 36(1) (a) through (e) of this act.

(3) The governor or his or her designee shall monitor the request made under subsection (2) of this section and report to the appropriate committees of the legislature.

(4) If all federal statute or regulatory waivers necessary to fully implement sections 32 through 37 of this act have not been obtained by the effective date of this section, this act shall remain in effect. Individuals participating in a health care savings account must consider all employer-made contributions on their behalf into their health care savings account as taxable income unless otherwise granted tax exemption or deferral under applicable compensation and pension laws and regulations.

Sec. 39. RCW 43.72.130 and 1993 c 492 s 449 are each amended to read as follows:

STANDARD BENEFITS PACKAGE DESIGN. ((~~(1) The commission shall define the uniform benefits package, which shall include those health services that, consistent with the goals and intent of chapter 492, Laws of 1993, are effective and necessary on a societal basis for the maintenance of the health of citizens of the state, weighed against the need to control state health services expenditures.~~

~~(2) The schedule of covered health services shall emphasize proven preventive and primary health care and shall be composed of the following essential health services: (a) Primary and specialty health services; (b) inpatient and outpatient hospital services; (c) prescription drugs and medications; (d) reproductive services; (e) services necessary for maternity and well-child care, including preventive dental services for children; and (f) case-managed chemical dependency, mental health, short-term skilled nursing facility, home health, and hospice services, to the extent that such services reduce inappropriate utilization of more intensive or less efficacious medical~~

~~services. The commission shall determine the specific schedule of health services within the uniform benefits package, including limitations on scope and duration of services. The schedule shall be the benefit and actuarial equivalent of the schedule of benefits offered by the basic health plan on January 1, 1993, including any additions that may result from the inclusion of the services listed in (c) through (f) of this subsection. The commission shall consider the recommendations of health services effectiveness panels [committee] established pursuant to RCW 43.72.060 in defining the uniform benefits package.~~

~~(3) The uniform benefits package shall not limit coverage for preexisting or prior conditions, except that the commission shall establish exclusions for preexisting or prior conditions to the extent necessary to prevent residents from waiting until health services are needed before enrolling in a certified health plan.~~

~~(4) The commission shall establish enrollee point of service cost-sharing for nonpreventive health services, related to enrollee household income, such that financial considerations are not a barrier to access for low-income persons, but that, for those of means, the uniform benefits package provides for moderate point of service cost-sharing. All point of service cost-sharing and cost control requirements shall apply uniformly to all health care providers providing substantially similar uniform benefits package services. The schedule shall provide for an alternate and lower schedule of cost-sharing applicable to enrollees with household income below the federal poverty level.~~

~~(5) The commission shall adopt rules related to coordination of benefits and premium payments. The rules shall not have the effect of eliminating enrollee financial participation. The commission shall endeavor to assure an equitable distribution, among both employers and employees, of the costs of coverage for those households composed of more than one member in the work force.~~

~~(6) In determining the uniform benefits package, the commission shall endeavor to seek the opinions of and information from the public. The commission shall consider the results of official public health assessment and policy development activities including recommendations of the department of health in discharging its responsibilities under this section.~~

~~(7) The commission shall submit the following to the legislature by December 1, 1994, and by December 1 of the year preceding any year in which the commission proposes to significantly modify the uniform benefits package: (a) The uniform benefits package; and (b) an independent actuarial analysis of the cost of the proposed package, giving consideration to the factors considered under RCW 43.72.040(6). The commission shall not modify the services included in the uniform benefits package before January 1, 1999.~~)) (1) The standard benefits package shall be the same as the basic health plan, pursuant to chapter 70.47 RCW, and may be modified only by an act of law.

(2) Point-of-service cost-sharing shall include deductibles, copayments, or coinsurance. Deductibles shall be limited to four thousand dollars per person, per year. There shall be no point-of-service cost-sharing for preventive services provided in the standard benefits package. The administrator of the health care authority shall establish a model standard benefits package with uniform point-of-service cost-sharing requirements, which all carriers shall offer to provide consumers information to compare plans.

(3) Each health carrier except health maintenance organizations shall offer the standard benefits package with the following set of deductible options, using the appropriate copayment amounts as applied by the basic health plan as of July 1, 1994, and revised annually to account for inflation using the consumer price index and rounded to the nearest whole dollar:

(a) Zero deductible;

(b) Two hundred fifty dollars deductible for individuals, seven hundred fifty dollars deductible for families;

(c) Five hundred dollars deductible for individuals, one thousand dollars deductible for families;

(d) One thousand dollars deductible for individuals, two thousand dollars deductible for families;

(e) Two thousand dollars deductible for individuals, four thousand dollars deductible for families.

NEW SECTION. **Sec. 40.** A new section is added to chapter 48.43 RCW to read as follows:

(1) The insurance commissioner shall appoint representatives from health insurers, health service contractors, and health maintenance organizations and participate with them in their work to:

(a) Using the contract developed under RCW 70.47.060(1), prepare various versions of the benefits contract to reflect each of the various point-of-service cost-sharing options. The representatives may prepare separate contract forms for each of the different types of health carriers, such as health insurers, health service contractors, and health maintenance organizations as the representatives deem necessary. The benefits contract with its various point-of-service cost-sharing options are to be submitted to the commissioner not later than October 1, 1996;

(b) Prepare a brochure for the standard benefits plan which will be used by all health carriers to describe the coverage provided by the standard benefits plan to potential enrollees. The brochure shall describe the various point-of-service cost-sharing options. The representatives may prepare separate brochures for each of the different types of health carriers, such as health insurers, health service organizations, and health maintenance contractors as the representatives deem necessary. The brochure is to be submitted to the commissioner not later than November 1, 1996;

(c) Prepare a claim form for the standard benefits plan which will be used by all health carriers for enrollees to report claims. The representative shall consult with the department of health in the design of the claim form to maximize, to the greatest extent possible, the inclusion of data collection elements needed by the department in the data collection for the state's health data system. The representatives may prepare separate claim forms for each of the different types of health carriers, such as health insurers, health service contractors, and health maintenance organizations as the representatives deem necessary. The claim form is to be submitted to the commissioner not later than December 1, 1996.

(2) If the representatives appointed in subsection (1) of this section fail to submit the required documents within the time periods required by subsection (1) of this section, or if the commissioner finds the documents submitted by the representatives are inadequate to meet the requirements of chapter . . ., Laws of 1995 (this act), the commissioner shall either make revisions to the documents submitted by the representatives or redraft the documents required by subsection (1) of this section. If the commissioner either makes revisions or redrafts any of the documents, the commissioner shall, within ten days of initiating such action, notify the speaker of the house of

representatives, the majority leader of the senate, and each of the members of the joint committee on health systems oversight of his or her decision to exercise this option and the reasons for exercising this option.

Sec. 41. RCW 43.72.160 and 1993 c 492 s 452 are each amended to read as follows:

No ((~~uniform~~)) standard benefits package ((~~or supplemental benefits~~)) may be offered, delivered, or issued for delivery to any person in this state unless it otherwise complies with chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act), and complies with the following:

(1) ((~~All certified health plan forms for uniform and supplemental benefits issued by the plan to enrollees and such other marketing documents purporting to describe the plan's benefits shall comply with the minimum standards the commissioner deems reasonable and necessary to carry out the purposes and provisions of this chapter and consistent with health services commission standards. The plan's forms and documents shall fully inform enrollees of the health services to which they are entitled, and shall fully disclose any limitations, exclusions, rights, responsibilities, and duties required of either the enrollee or the certified health plan. No form or document may be issued, delivered, or issued for delivery unless it has been filed with and approved by the commissioner~~)) Each health carrier shall submit its contracts and brochures for the standard benefits plan to the commissioner for approval.

(a) Each carrier is encouraged to use the standard contract and brochure prepared pursuant to section 40 of this act and the use of such contract and brochure by a carrier shall be deemed approved in form when submitted.

(b) Any health carrier may develop its own contract and brochure for the standard benefits plan and submit it for approval to the commissioner. The commissioner shall adopt minimum standards that define the terms, conditions, limitations, and exclusions. These terms, conditions, limitations, and exclusions shall not add to or delete services from the standard benefits plan. No form or document may be issued, delivered, or issued for delivery unless it has been filed with and approved by the commissioner.

(2) ((~~Every form or document filing containing a certification, in a manner approved by the commissioner, by either the chief executive officer of the plan or by an actuary who is a member of the American academy of actuaries, attesting that the filing complies with Title 48 RCW, Title 284 WAC, and this chapter, may be used by such certified health plan immediately after filing with the commissioner. The commissioner may order a plan to cease using a certified form or document upon the grounds set forth in subsection (6) of this section.~~

~~(3)~~)) Every filing ((~~that does not contain a certification pursuant to subsection (2) of this section~~)) of forms or documents shall be made not less than thirty days in advance of any such issuance, delivery, or use. At the expiration of such thirty days the form or document filed shall be deemed approved unless affirmatively approved or disapproved by the commissioner within the thirty-day period. The commissioner may extend by not more than an additional fifteen days the period within which the commissioner may review such filing, by notifying the plan of the extension before expiration of the initial thirty-day period. At the expiration of any extension period and in the absence of prior affirmative approval or disapproval, any such form or document shall be deemed approved. The commissioner may withdraw approval at any time for cause. By approval of any filing for immediate use, the commissioner may waive any unexpired portion of the initial thirty-day waiting period.

((~~(4)~~)) (3) Whenever the commissioner disapproves a filing or withdraws a previous approval, the commissioner shall state the grounds for disapproval and cite the statute or rule used as grounds for disapproval.

((~~(5)~~)) (4) The commissioner may exempt from the requirements of this section any plan document or form that, in the commissioner's opinion, may not practicably be applied to, or the filing and approval of which are, in the commissioner's opinion, not desirable or necessary for the protection of the public.

((~~(6)~~)) (5) The commissioner shall disapprove any form or document or shall withdraw any previous approval, only:

(a) If it is in any respect in violation of or does not comply with Title 48 RCW, Title 284 WAC, and this chapter, or any applicable order of the commissioner;

(b) If it does not comply with any controlling filing previously made and approved;

(c) If it contains or incorporates by reference any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions that unreasonably or deceptively affect the health services purported to be offered or provided;

(d) If it has any title, heading, or other indication of its provisions that is misleading;

(e) If purchase of health services under the form or document is being solicited by deceptive advertising; or

(f) If the health service benefits provided in the form or document are unreasonable in relation to the premium charged.

Sec. 42. RCW 43.72.170 and 1993 c 492 s 453 are each amended to read as follows:

(1) Premium rates for ((~~uniform benefits package and supplemental benefits~~)) health plans shall not be excessive or inadequate, and shall not discriminate in a manner prohibited by RCW 43.72.100((~~(3)~~))(2) (as recodified by this act). ((~~Premium rates, enrollee point of service cost-sharing, or maximum enrollee financial participation amounts for a uniform benefits package may not exceed the limits established by the health services commission in accordance with RCW 43.72.040.~~)) Premium rates for ((~~uniform benefits package and supplemental benefits~~)) health plans shall be developed on a ((~~community-rated~~)) standardized rate basis as determined by the ((~~health services commission~~)) commissioner.

(2) Prior to using, every ((~~certified health plan~~)) health carrier shall file with the commissioner its enrollee point-of-service((~~,~~)) cost-sharing amounts, enrollee financial participation amounts, rates, its rating plan, and any other information used to determine the specific premium to be charged any enrollee and every modification of any of the foregoing.

(3) Every such filing shall indicate the type and extent of the health services contemplated and must be accompanied by sufficient information to permit the commissioner to determine whether it meets the requirements of this chapter. A ((~~plan~~)) carrier shall offer in support of any filing:

(a) Any historical data and actuarial projections used to establish the rate filed;

(b) An exhibit detailing the major elements of operating expense for the types of health services affected by the filing;

(c) An explanation of how investment income has been taken into account in the proposed rates;

(d) Any other information that the ((~~plan~~)) carrier deems relevant; and

(e) Any other information that the commissioner requires by rule.

(4) If a ((~~plan~~)) carrier has insufficient loss experience to support its proposed rates, it may submit loss experience for similar exposures of other ((~~plans~~)) carriers within the state.

(5) Every health carrier shall use standardized rating, set forth as follows:

(a) Adjustments to the rates for a health plan permitted for age shall not result in a rate per enrollee of more than four hundred percent of the lowest rate for any enrollee in the first year of the plan, three hundred percent in the second year of the plan, and two hundred percent thereafter. Such age adjustments shall not use age brackets smaller than five-year increments, and shall begin with age thirty and end with age sixty-five.

(b) Adjustments to the rates for a health plan permitted for wellness programs shall be limited to plus or minus twenty percent.

(c) The premium charged for a health plan may not be adjusted more frequently than annually except for rate decreases and, except that rates may be changed to reflect enrollment changes, changes in family composition of the enrollee, or benefit changes to the health plan requested by the employer or enrollee.

(d) A health plan that restricts an enrollee to use of a defined provider network may vary in rate from a plan that does not contain such a restriction, provided that the restriction of benefits of network providers results in appropriate reductions in claim costs.

(e) Adjustment to the rates are permitted for coverage of one child.

(6) Every filing shall state its proposed effective date.

((~~(6)~~)) (7) Actuarial formulas, statistics, and assumptions submitted in support of a rate or form filing by a ((~~plan~~)) carrier or submitted to the commissioner at the commissioner's request shall be withheld from public inspection in order to preserve trade secrets or prevent unfair competition.

((~~(7)~~)) (8) No ((~~plan~~)) carrier may make or issue a benefits package except in accordance with its filing then in effect.

((~~(8)~~)) (9) The commissioner shall review a filing as soon as reasonably possible after made, to determine whether it meets the requirements of this section. The commissioner shall ensure that differences in rates charged for health plans by health carriers are reasonable and reflect objective differences in plan design or coverage. The commissioner may establish rules that prescribe the manner in which geographic areas may be used by carriers to prevent unfair risk selection.

((~~(9)~~)) (10)(a) Except for (d) of this subsection, no filing may become effective within thirty days after the date of filing with the commissioner, which period may be extended by the commissioner for an additional period not to exceed fifteen days if the commissioner gives notice within such waiting period to the ((~~plan~~)) carrier that the commissioner needs additional time to consider the filing.

(b) A filing shall be deemed to meet the requirements of this section unless disapproved by the commissioner within the waiting period or any extension period.

(c) If within the waiting or any extension period, the commissioner finds that a filing does not meet the requirements of this section, the commissioner shall disapprove the filing, shall notify the ((~~plan~~)) carrier of the grounds for disapproval, and shall prohibit the use of the disapproved filing.

((~~(10)~~)) (d) A rate filing shall be deemed approved upon filing if the purpose of the filing is to increase rates by no more than the latest annual consumer price index increase for Washington state as determined by the office of financial management, provided the rate meets the other requirements of this section.

(11) If at any time after the applicable review period provided in this section, the commissioner finds that a filing does not meet the requirements of this section, the commissioner shall, after notice and hearing, issue an order specifying in what respect the commissioner finds that such filing fails to meet the requirements of this section, and stating when, within a reasonable period thereafter, the filings shall be deemed no longer effective.

The order shall not affect any benefits package made or issued prior to the expiration of the period set forth in the order.

Sec. 43. RCW 43.72.300 and 1993 c 492 s 447 are each amended to read as follows:

(1) The legislature recognizes that competition among health care providers, facilities, payers, and purchasers will yield the best allocation of health care resources, the lowest prices for health care, and the highest quality of health care when there exists a large number of buyers and sellers, easily comparable health care plans and services, minimal barriers to entry and exit into the health care market, and adequate information for buyers and sellers to base purchasing and production decisions. However, the legislature finds that purchasers of health care services and health care coverage do not have adequate information upon which to base purchasing decisions; that health care facilities and providers of health care services face legal and market disincentives to develop economies of scale or to provide the most cost-efficient and efficacious service; that health insurers, contractors, and health maintenance organizations face market disincentives in providing health care coverage to those Washington residents with the most need for health care coverage; and that potential competitors in the provision of health care coverage bear unequal burdens in entering the market for health care coverage.

(2) The legislature therefore intends to exempt from state anti-trust laws, and to provide immunity from federal anti-trust laws through the state action doctrine for activities approved under this chapter that might otherwise be constrained by such laws and intends to displace competition in the health care market: To contain the aggregate cost of health care services; to promote the development of comprehensive, integrated, and cost-effective health care delivery systems through cooperative activities among health care providers and facilities; to promote comparability of health care coverage; to improve the cost-effectiveness in providing health care coverage relative to health promotion, disease prevention, and the amelioration or cure of illness; to assure universal access to a publicly determined, ((~~uniform~~)) standardized package of health care benefits; and to create reasonable equity in the distribution of funds, treatment, and medical risk among purchasers of health care coverage, payers of health care services, providers of health care services, health care facilities, and Washington residents. To these ends, any lawful action taken pursuant to chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act) by any person or entity created or regulated by chapter 492, Laws of 1993 ((~~are~~)) as amended by chapter . . ., Laws of 1995 (this act) is declared to be taken pursuant to

state statute and in furtherance of the public purposes of the state of Washington.

(3) The legislature does not intend and, unless explicitly permitted in accordance with RCW 43.72.310 as recodified by this act or under rules adopted pursuant to chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act), does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state and federal anti-trust laws including but not limited to conspiracies or agreements:

(a) Among competing health care providers not to grant discounts, not to provide services, or to fix the price of their services;

(b) Among ((~~certified health plans~~)) health carriers as to the price or level of reimbursement for health care services;

(c) Among ((~~certified health plans~~)) health carriers to boycott a group or class of health care service providers;

(d) Among purchasers of ((~~certified health plan~~)) health carrier coverage to boycott a particular ((~~plan~~)) carrier or class of ((~~plans~~)) carriers;

(e) Among ((~~certified health plans~~)) health carriers to divide the market for health care coverage; or

(f) Among ((~~certified health plans~~)) health carriers and purchasers to attract or discourage enrollment of any Washington resident or groups of residents ((~~in~~)) with a ((~~certified health plan~~)) health carrier based upon the perceived or actual risk of loss in including such resident or group of residents in a ((~~certified~~)) health plan or subscriber purchasing group.

Sec. 44. RCW 43.72.310 and 1993 c 492 s 448 are each amended to read as follows:

(1) A ((~~certified health plan~~)) health carrier, health care facility, health care provider, or other person involved in the development, delivery, or marketing of health care or ((~~certified~~)) health plan((~~s~~)) may request, in writing, that the ((~~commission~~)) commissioner obtain an informal opinion from the attorney general as to whether particular conduct is authorized by chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act). The attorney general shall issue such opinion within thirty days of receipt of a written request for an opinion or within thirty days of receipt of any

additional information requested by the attorney general necessary for rendering an opinion unless extended by the attorney general for good cause shown. If the attorney general concludes that such conduct is not authorized by chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act), the person or organization making the request may petition the ((~~commission~~)) commissioner for review and approval of such conduct in accordance with subsection (3) of this section.

(2) After obtaining the written opinion of the attorney general and consistent with such opinion, the ((~~health services commission~~)) commissioner:

(a) May authorize conduct by a ((~~certified health plan~~)) health carrier, health care facility, health care provider, or any other person that could tend to lessen competition in the relevant market upon a strong showing that the conduct is likely to achieve the policy goals of chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act) and a more competitive alternative is impractical;

(b) Shall adopt rules governing conduct among providers, health care facilities, and ((~~certified health plans~~)) health carriers including rules governing provider and facility contracts with ((~~certified health plans~~)) health carriers, rules governing the use of "most favored nation" clauses and exclusive dealing clauses in such contracts, and rules providing that ((~~certified health plans~~)) health carriers in rural areas contract with a sufficient number and type of health care providers and facilities to ensure consumer access to local health care services;

(c) Shall adopt rules permitting health care providers within the service area of a plan to collectively negotiate the terms and conditions of contracts with a ((~~certified health plan~~)) health carrier including the ability of providers to meet and communicate for the purposes of these negotiations; and

(d) Shall adopt rules governing cooperative activities among health care facilities and providers.

(3) A ((~~certified health plan~~)) health carrier, health care facility, health care provider, or any other person involved in the development, delivery, and marketing of health services or ((~~certified~~)) health plan((~~s~~)) may file a written petition with the ((~~commission~~)) commissioner requesting approval of conduct that could tend to lessen competition in the relevant market. Such petition shall

be filed in a form and manner prescribed by rule of the ((~~commission~~)) commissioner.

The ((~~commission~~)) commissioner shall issue a written decision approving or denying a petition filed under this section within ninety days of receipt of a properly completed written petition unless extended by the ((~~commission~~)) commissioner for good cause shown. The decision shall set forth findings as to benefits and disadvantages and conclusions as to whether the benefits outweigh the disadvantages.

(4) In authorizing conduct and adopting rules of conduct under this section, the ((~~commission~~)) commissioner with the advice of the attorney general, shall consider the benefits of such conduct in furthering the goals of health care reform including but not limited to:

(a) Enhancement of the quality of health services to consumers;

(b) Gains in cost efficiency of health services;

(c) Improvements in utilization of health services and equipment;

(d) Avoidance of duplication of health services resources; or

(e) And as to (b) and (c) of this subsection: (i) Facilitates the exchange of information relating to performance expectations; (ii) simplifies the negotiation of delivery arrangements and relationships; and (iii) reduces the transactions costs on the part of ((~~certified health plans~~)) health carriers and providers in negotiating more cost-effective delivery arrangements.

These benefits must outweigh disadvantages including and not limited to:

(i) Reduced competition among ((~~certified health plans~~)) health carriers, health care providers, or health care facilities;

(ii) Adverse impact on quality, availability, or price of health care services to consumers; or

(iii) The availability of arrangements less restrictive to competition that achieve the same benefits.

(5) Conduct authorized by the ((~~commission~~)) commissioner shall be deemed taken pursuant to state statute and in the furtherance of the public purposes of the state of Washington.

(6) With the assistance of the attorney general's office, the ((~~commission~~)) commissioner shall actively supervise any conduct authorized under this section to determine whether such conduct or rules permitting certain conduct should be continued and whether a more competitive alternative is practical. The ((~~commission~~)) commissioner

shall periodically review petitioned conduct through, at least, annual progress reports from petitioners, annual or more frequent reviews by the ((~~commission~~)) commissioner that evaluate whether the conduct is consistent with the petition, and whether the benefits continue to outweigh any disadvantages. If the ((~~commission~~)) commissioner determines that the likely benefits of any conduct approved through rule, petition, or otherwise by the ((~~commission~~)) commissioner no longer outweigh the disadvantages attributable to potential reduction in competition, the ((~~commission~~)) commissioner shall order a modification or discontinuance of such conduct. Conduct ordered discontinued by the ((~~commission~~)) commissioner shall no longer be deemed to be taken pursuant to state statute and in the furtherance of the public purposes of the state of Washington.

(7) Nothing contained in chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act) is intended to in any way limit the ability of rural hospital districts to enter into cooperative agreements and contracts pursuant to RCW 70.44.450 and chapter 39.34 RCW.

Sec. 45. RCW 43.72.800 and 1993 c 492 s 457 are each amended to read as follows:

(1) To meet the health needs of the residents of Washington state, it is critical to finance and provide long-term care and support services through an integrated, comprehensive system that promotes human dignity and recognizes the individuality of all functionally disabled persons. This system shall be available, accessible, and responsive to all residents based upon an assessment of their functional disabilities. The governor and the legislature recognize that families, volunteers, and community organizations are essential for the delivery of effective and efficient long-term care and support services, and that this private and public service infrastructure should be supported and strengthened. Further, it is important to provide benefits without requiring family or program beneficiary impoverishment for service eligibility.

(2) To realize the need for a strong long-term care system and to carry out the November 30, 1992, final recommendations of the Washington health care cost control and access commission, established under House Concurrent Resolution No. 4443 adopted by the legislature

in 1990, related to long-term care, the ((~~commission~~)) joint committee on health systems oversight shall((~~:~~

~~(a) Engage in a planning process, in conjunction with an advisory committee appointed for this purpose, for the inclusion of long-term care services in the uniform benefits package established under RCW 43.72.130 by July 1999;~~

~~(b)~~)) include in its planning process consideration of the scope of services to be covered, the cost of and financing of such coverage, the means through which existing long-term care programs and delivery systems can be coordinated and integrated, and the means through which family members can be supported in their role as informal caregivers for their parents, spouses, or other relatives.

(3) The ((~~commission~~)) committee shall submit recommendations concerning any necessary statutory changes or modifications of public policy to the governor and the legislature by January 1, ((~~1995~~)) 1997.

(4) The departments of health, retirement systems, revenue, social and health services, and veterans' affairs, the offices of financial management, ((~~insurance commissioner,~~)) and state actuary, along with the health care authority, shall participate in the review of the long-term care needs enumerated in this section and provide necessary supporting documentation and staff expertise as requested by the ((~~commission~~)) committee.

(5) The ((~~commission~~)) committee shall include in its planning process, the development of two social health maintenance organization long-term care pilot projects. The two pilot projects shall be referred to as the Washington life care pilot projects. Each life care pilot program shall be a single-entry system administered by an individual organization that is responsible for bringing together a full range of medical and long-term care services. ((~~The commission, in coordination with the appropriate agencies and departments, shall establish a Washington life care benefits package that shall include the uniform benefits package established in chapter 492, Laws of 1993 and long-term care services.~~)) The Washington life care benefits package shall include, but not be limited to, the following long-term care services: Case management, intake and assessment, nursing home care, adult family home care, home health and home health aide care, hospice, chore services/homemaker/personal care, adult day care, respite care, and appropriate social services. The pilot project shall

develop assessment and case management protocol that emphasize home and community-based care long-term care options.

(a) In designing the pilot projects, the ((~~commission~~)) committee shall address the following issues: Costs for the long-term care benefits, a projected case-mix based upon disability, the required federal waiver package, reimbursement, capitation methodology, marketing and enrollment, management information systems, identification of the most appropriate case management models, and provider contracts((~~, and the preferred organizational design that will serve as a functioning model for efficiently and effectively transitioning long-term care services into the uniform benefits package established in chapter 492, Laws of 1993~~)). The ((~~commission~~)) committee shall also be responsible for establishing the size of the two membership pools.

(b) Each program shall enroll applicants based on their level of functional disability and personal care needs. The distribution of these functional level categories and ethnicity within the enrolled program population shall be representative of their distribution within the community, using the best available data to estimate the community distributions.

(c) The two sites selected for the Washington life care pilot ((~~program[s]~~)) programs shall be drawn from the largest urban areas and include one site in the eastern part of the state and one site in the western part of the state. The two organizations selected to manage and coordinate the life care services shall have the proven ability to provide ambulatory care, personal care/chore services, dental care, case management and referral services, must be accredited and licensed to provide long-term care for home health services, and may be licensed to provide nursing home care.

(d) The report on the development and establishment date of the two social health maintenance organizations shall be submitted to the governor and appropriate committees of the legislature by September 16, 1994. If the necessary federal waivers cannot be secured by January 1, ((~~1995~~)) 1997, the ((~~commission~~)) committee may elect to not establish the two pilot programs.

Sec. 46. RCW 43.72.810 and 1993 c 492 s 474 are each amended to read as follows:

(1) The ((~~commission~~)) commissioner shall determine the state and federal laws that would need to be repealed, amended, or waived to implement chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act), and report its recommendations, with proposed revisions to the Revised Code of Washington, to the governor, and appropriate committees of the legislature by July 1, 1994.

(2) The governor, in consultation with the ((~~commission~~)) commissioner, shall take the following steps in an effort to receive waivers or exemptions from federal statutes necessary to fully implement chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act) to include, but not be limited to:

(a) Negotiate with the United States congress and the federal department of health and human services, health care financing administration to obtain a statutory or regulatory waiver of the provisions of the medical assistance statute, Title XIX of the federal social security act that constitute barriers to allowing payments for long-term care services even if care or services are provided by family members or friends.

(b) Negotiate with the United States congress and the federal department of health and human services, health care financing administration to obtain a statutory or regulatory waiver of provisions of the medical assistance statute, Title XIX of the federal social security act that currently constitute barriers to full implementation of provisions of chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act) related to access to health services for low-income residents of Washington state. Such waivers shall include any waiver needed to require that: (i) Medical assistance recipients enroll in managed care systems, as defined in chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act); and (ii) enrollee point of service, cost-sharing levels adopted pursuant to RCW 43.72.130 as recodified by this act be applied to medical assistance recipients. ((~~In negotiating the waiver, consideration shall be given to the degree to which supplemental benefits should be offered to medicaid recipients, if at all.~~)) Waived provisions may include and are not limited to: Categorical eligibility restrictions related to age, disability, blindness, or family structure; income and resource limitations tied to financial eligibility requirements of the federal aid to families with dependent children and supplemental security income programs; administrative requirements regarding single state

agencies, choice of providers, and fee for service reimbursement; and other limitations on health services provider payment methods.

((~~(b) Negotiate with the United States congress and the federal department of health and human services, health care financing administration to obtain a statutory or regulatory waiver of provisions of the medicare statute, Title XVIII of the federal social security act that currently constitute barriers to full implementation of provisions of chapter 492, Laws of 1993 related to access to health services for elderly and disabled residents of Washington state. Such waivers shall include any waivers needed to implement managed care programs. Waived provisions include and are not limited to: Beneficiary cost-sharing requirements; restrictions on scope of services; and limitations on health services provider payment methods.~~

~~(c) Negotiate with the United States congress and the federal department of health and human services to obtain any statutory or regulatory waivers of provisions of the United States public health services act necessary to ensure integration of federally funded community and migrant health clinics and other health services funded through the public health services act into the health services system established pursuant to chapter 492, Laws of 1993. The commission shall request in the waiver that funds from these sources continue to be allocated to federally funded community and migrant health clinics to the extent that such clinics' patients are not yet enrolled in certified health plans.~~

~~(d) Negotiate with the United States congress to obtain a statutory exemption from provisions of the employee retirement income security act that limit the state's ability to ensure that all employees and their dependents in the state comply with the requirement to enroll in certified health plans, and have their employers participate in financing their enrollment in such plans.~~

~~(e)~~)) (c) Request that the United States congress amend the internal revenue code to treat employee ((~~premium~~)) contributions to ((~~plans~~)) employee insurance coverage, such as the basic health plan or the ((~~uniform~~)) standard benefits package offered through a ((~~certified health plan~~)) health carrier, as fully deductible from adjusted gross income.

(3) On or before December 1, 1995, the ((~~commission~~)) commissioner shall report the ((~~following to the appropriate committees of the legislature:~~

~~(a) The~~)) status of its efforts to obtain the waivers provided in subsection (2) of this section((~~;~~

~~(b) If all federal statutory or regulatory waivers necessary to fully implement chapter 492, Laws of 1993 have not been obtained:~~

~~(i) The extent to which chapter 492, Laws of 1993 can be implemented without receipt of all of such waivers; and~~

~~(ii) Changes in chapter 492, Laws of 1993 necessary to implement a residency-based health services system using one or a limited number of sponsors, or an alternative system that will ensure access to care and control health services costs~~)).

Sec. 47. RCW 43.72.830 and 1993 c 492 s 476 are each amended to read as follows:

(((~~(1) By July 1, 1997, the legislative budget committee either directly or by contract shall conduct the following study:~~

~~A study to determine the desirability and feasibility of consolidating the following programs, services, and funding sources into the delivery and financing of uniform benefits package services through certified health plans:~~

~~(a) State and federal veterans' health services;~~

~~(b) Civilian health and medical program of the uniformed services (CHAMPUS) of the federal department of defense and other federal agencies; and~~

~~(c) Federal employee health benefits.~~

~~(2)~~)) The legislative budget committee shall evaluate the implementation of the provisions of ((~~chapter 492, Laws of 1993~~)) chapter . . ., Laws of 1995 (this act). The study shall determine to what extent chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995, (this act) has been implemented consistent with the principles and elements set forth in ((~~chapter 492, Laws of 1993~~)) chapter . . ., Laws of 1995 (this act) and shall report its findings to the governor and appropriate committees of the legislature by July 1, 2003.

Sec. 48. RCW 43.72.860 and 1993 c 492 s 486 are each amended to read as follows:

(1) The department of labor and industries, in consultation with the workers' compensation advisory committee, may conduct pilot projects to purchase medical services for injured workers through ((~~managed care~~)) health care coverage arrangements. The projects shall

assess the effects of ((~~managed care~~)) health care coverage on the cost and quality of, and employer and employee satisfaction with, medical services provided to injured workers.

(2) The pilot projects may be limited to specific employers. The implementation of a pilot project shall be conditioned upon a participating employer and a majority of its employees, or, if the employees are represented for collective bargaining purposes, the exclusive bargaining representative, voluntarily agreeing to the terms of the pilot. Unless the project is terminated by the department, both the employer and employees are bound by the project agreements for the duration of the project.

(3) Solely for the purpose and duration of a pilot project, the specific requirements of Title 51 RCW that are identified by the department as otherwise prohibiting implementation of the pilot project shall not apply to the participating employers and employees to the extent necessary for conducting the project. ((~~Managed care~~)) Health care coverage arrangements for the pilot projects may include the designation of doctors responsible for the care delivered to injured workers participating in the projects.

(4) The projects shall conclude no later than ((~~January~~)) July 1, 1996. The department shall present an interim report on or before October 1, 1996, the results of the pilot projects, and any recommendations related to the projects to the governor and appropriate committees of the legislature on or before ((~~October 1, 1996~~)) April 1, 1997.

Sec. 49. RCW 43.72.910 and 1993 c 492 s 487 are each amended to read as follows:

This act may be known and cited as the Washington ((~~health services~~)) reform improvement act of ((~~1993~~)) 1995.

Sec. 50. RCW 47.64.270 and 1993 c 492 s 224 are each amended to read as follows:

Until December 31, 1996, absent a collective bargaining agreement to the contrary, the department of transportation shall provide contributions to insurance and health care plans for ferry system employees and dependents, as determined by the state health care authority, under chapter 41.05 RCW; and the ferry system management and employee organizations may collectively bargain for other insurance and

health care plans, and employer contributions may exceed that of other state agencies as provided in RCW 41.05.050, subject to RCW 47.64.180. On January 1, 1997, ferry employees shall enroll ((~~in certified health plans~~)) with health carriers under the provisions of chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act). To the extent that ferry employees by bargaining unit have absorbed the required offset of wage increases by the amount that the employer's contribution for employees' and dependents' insurance and health care plans exceeds that of other state general government employees in the 1985-87 fiscal biennium, employees shall not be required to absorb a further offset except to the extent the differential between employer contributions for those employees and all other state general government employees increases during any subsequent fiscal biennium. If such differential increases in the 1987-89 fiscal biennium or the 1985-87 offset by bargaining unit is insufficient to meet the required deduction, the amount available for compensation shall be reduced by bargaining unit by the amount of such increase or the 1985-87 shortage in the required offset. Compensation shall include all wages and employee benefits.

Sec. 51. RCW 48.43.150 and 1993 c 492 s 446 are each amended to read as follows:

Beginning January 1, 1997, the insurance commissioner shall report annually to the ((~~health services commission~~)) appropriate committees in the legislature on the ((~~compliance of certified health plans and health insurance purchasing cooperatives with the provisions~~)) implementation of chapter 492, Laws of 1993((~~. The report shall include information on (1) compliance with chapter 492, Laws of 1993 open enrollment and antidiscrimination provisions, (2) financial solvency requirements, (3) the mix of enrollee characteristics within and among plans and groups including age, sex, ethnicity, and any easily obtainable information related to medical risk, (4) the geographic distribution of plans and groups, and (5) other information that the commission may request consistent with the goals of chapter 492, Laws of 1993~~)) as amended by chapter . . ., Laws of 1995 (this act).

NEW SECTION. **Sec. 52.** A new section is added to chapter 48.20 RCW to read as follows:

All disability insurance policies that are health plans as defined in chapter 48.43 RCW, and insurers who provide such policies, shall comply with the requirements of chapter 48.43 RCW. If there is any conflict between this chapter and chapter 48.43 RCW, chapter 48.43 RCW shall govern. The insurance commissioner shall advise the appropriate committees of the legislature and may issue bulletins or make rules to clarify conflicts between this chapter and chapter 48.43 RCW.

NEW SECTION. **Sec. 53.** A new section is added to chapter 48.21 RCW to read as follows:

All group disability insurance policies that are health plans as defined in chapter 48.43 RCW, and insurers who provide such policies, shall comply with the requirements of chapter 48.43 RCW. If there is any conflict between this chapter and chapter 48.43 RCW, chapter 48.43 RCW shall govern. The insurance commissioner shall advise the appropriate committees of the legislature and may issue bulletins or make rules to clarify conflicts between this chapter and chapter 48.43 RCW.

NEW SECTION. **Sec. 54.** A new section is added to chapter 48.36A RCW to read as follows:

All contractual benefits that are health plans as defined in chapter 48.43 RCW, and the society that provides such benefits, shall comply with the requirements of chapter 48.43 RCW. If there is any conflict between this chapter and chapter 48.43 RCW, chapter 48.43 RCW shall govern. The insurance commissioner shall advise the appropriate committees of the legislature and may issue bulletins or make rules to clarify conflicts between this chapter and chapter 48.43 RCW.

NEW SECTION. **Sec. 55.** A new section is added to chapter 48.44 RCW to read as follows:

All health care services that are health plans as defined in chapter 48.43 RCW, and the health care service contractor that provides such benefits, shall comply with the requirements of chapter 48.43 RCW. If there is any conflict between this chapter and chapter 48.43 RCW, chapter 48.43 RCW shall govern. The insurance commissioner shall advise the appropriate committees of the legislature and may issue bulletins or make rules to clarify conflicts between this chapter and chapter 48.43 RCW.

NEW SECTION. **Sec. 56.** A new section is added to chapter 48.46 RCW to read as follows:

All health care services that are health plans as defined in chapter 48.43 RCW, and the health maintenance organization that provides such benefits, shall comply with the requirements of chapter 48.43 RCW. If there is any conflict between this chapter and chapter 48.43 RCW, chapter 48.43 RCW shall govern. The insurance commissioner shall advise the appropriate committees of the legislature and may issue bulletins or make rules to clarify conflicts between this chapter and chapter 48.43 RCW.

Sec. 57. RCW 48.41.110 and 1987 c 431 s 11 are each amended to read as follows:

(1) The administrator shall prepare a brochure outlining the benefits and exclusions of the pool policy in plain language. After approval by the board of directors, such brochure shall be made reasonably available to participants or potential participants. The health insurance policy issued by the pool shall pay only usual, customary, and reasonable charges for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of illnesses, injuries, and conditions which are not otherwise limited or excluded. Eligible expenses are the usual, customary, and reasonable charges for the health care services and items for which benefits are extended under the pool policy. Such benefits shall at minimum include((~~, but not be limited to, the following services or related items:~~

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

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

~~(c) The first twenty outpatient professional visits for the diagnosis or treatment of one or more mental or nervous conditions or alcohol, drug, or chemical dependency or abuse rendered during a calendar year by one or more physicians, psychologists, or community mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners;~~

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

~~(o) Hospice services;~~

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

~~(q) Other medical equipment, services, or supplies required by physician's orders and medically necessary and consistent with the diagnosis, treatment, and condition~~)) the standard benefits package as defined in chapter 48.43 RCW.

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

(3) The pool benefit policy may contain benefit limitations, exceptions, and reductions that are generally included in health insurance plans and are approved by the insurance commissioner; however, no limitation, exception, or reduction may be approved that would exclude coverage for any disease, illness, or injury.

(4) The insurance commissioner and the administrator for the health care authority shall develop procedures for transferring enrollees in the health insurance pool provided by this chapter, to other health care plans or to the basic health plan by January 1, 1997. The pool shall discontinue providing health care coverage on December 31, 1996. All enrollees in the pool on December 31, 1996, shall be transferred to the coverage provided by the health care authority on December 31, 1996.

Sec. 58. RCW 48.43.160 and 1993 c 492 s 426 are each amended to read as follows:

(1) No person may establish or operate a ((~~health insurance purchasing cooperative~~)) subscriber-purchasing group as defined in this chapter without having first obtained a certificate of authority from the insurance commissioner.

(2) Every proposed ((~~cooperative~~)) group shall furnish notice to the insurance commissioner that shall:

(a) Identify the principal name and address of the ((~~cooperative~~)) group;

(b) Furnish the names and addresses of the initial officers of the ((~~cooperative~~)) group;

(c) Include copies of letters of agreement for participation in the ((~~cooperative~~)) group including minimum term of participation;

(d) Furnish copies of its proposed articles and bylaws; and

(e) Provide other information as prescribed by the insurance commissioner ((~~in consultation with the health services commission~~)) to verify that the ((~~cooperative~~)) group is qualified and is managed by competent and trustworthy individuals.

(3)(((~~(a) The commissioner shall approve applications for certificates in accordance with the order received.~~

~~(b)~~)) The commissioner shall establish by rule a fee to be paid by ((~~cooperatives~~)) groups in an amount necessary to review and approve applications for a certificate of authority. Such fee shall accompany the application and no certificate may be issued until such fee is

paid. Fees collected for such purpose shall be deposited in the insurance commissioner's regulatory account in the state treasury.

(4) All funds representing premiums or return premiums received by a ((~~cooperative~~)) group in its fiduciary capacity shall be accounted for and maintained in a separate account from all other funds. Each willful violation of this section constitutes a misdemeanor.

(5) Every ((~~cooperative~~)) group shall keep at its principal address, a record of all transactions it has consummated on behalf of its members with ((~~certified health plans~~)) health carriers. All such records shall be kept available and open to the inspection of the insurance commissioner at any business time during a five-year period immediately after the date of completion of the transaction.

Sec. 59. RCW 48.43.170 and 1993 c 492 s 431 are each amended to read as follows:

(1) Balancing the need for health care reform and the need to protect health care providers, as a class and as individual providers, from improper exclusion presents a problem that can be satisfied with the creation of a process to ensure fair consideration of the inclusion of health care providers in ((~~managed~~)) health care systems operated by ((~~certified health plans~~)) health carriers. It is therefore the intent of the legislature that the ((~~health services commission~~)) commissioner in developing rules in accordance with this section and the attorney general in monitoring the level of competition in the various geographic markets, balance the need for cost-effective and quality delivery of health services with the need for inclusion of both individual health care providers and categories of health care providers in ((~~managed~~)) health care programs developed by ((~~certified health plans~~)) health carriers.

(2) All licensed health care providers licensed by the state, irrespective of the type or kind of practice, should be afforded the opportunity for inclusion ((~~in certified health plans~~)) by health carriers consistent with the goals of health care reform.

The ((~~health services commission~~)) commissioner shall adopt rules requiring ((~~certified health plans~~)) health carriers to publish general criteria for the plan's selection or termination of health care providers. Such rules shall not require the disclosure of criteria deemed by the plan to be of a proprietary or competitive nature that would hurt the plan's ability to compete or to manage health services.

Disclosure of criteria is proprietary or anticompetitive if revealing the criteria would have the tendency to cause health care providers to alter their practice pattern in a manner that would harm efforts to contain health care costs and is proprietary if revealing the criteria would cause the plan's competitors to obtain valuable business information.

If a ((~~certified health plan~~)) health carrier uses unpublished criteria to judge the quality and cost-effectiveness of a health care provider's practice under any specific program within the plan, the plan may not reject or terminate the provider participating in that program based upon such criteria until the provider has been informed of the criteria that his or her practice fails to meet and is given a reasonable opportunity to conform to such criteria.

(3)(a) Whenever a determination is made under (b) of this subsection that a plan's share of the market reaches a point where the plan's exclusion of health care providers from a program of the plan would result in the substantial inability of providers to continue their practice thereby unreasonably restricting consumer access to needed health services, the ((~~certified health plan~~)) health carrier must allow all providers within the affected market to participate in the programs of the ((~~certified health plan~~)) health carrier. All such providers must meet the published criteria and requirements of the programs.

(b) The attorney general with the assistance of the insurance commissioner shall periodically analyze the market power of ((~~certified health plans~~)) health carriers to determine when the market share of any program of a ((~~certified health plan~~)) health carrier reaches a point where the plan's exclusion of health service providers from a program of the plan would result in the substantial inability of providers to continue their practice thereby unreasonably restricting consumer access to needed health services. In analyzing the market power of a ((~~certified health plan~~)) health carrier, the attorney general shall consider:

(i) The ease with which providers may obtain contracts with other plans;

(ii) The amount of the private pay and government employer business that is controlled by the ((~~certified health plan~~)) health carrier taking into account the selling of its provider network to self-insured employer plans;

(iii) The difficulty in establishing new competing plans in the relevant geographic market; and

(iv) The sufficiency of the number or type of providers under contract with the plan available to meet the needs of plan enrollees.

Notwithstanding the provisions of this subsection, if the ((~~certified health plan~~)) health carrier demonstrates to the satisfaction of the attorney general and the ((~~health services commission~~)) commissioner that health service utilization data and similar information shows that the inclusion of additional health service providers would substantially lessen the plan's ability to control health care costs and that the plan's procedures for selection of providers are not improperly exclusive of providers, the plan need not include additional providers within the plan's program.

(4) The ((~~health services commission~~)) commissioner shall adopt rules for the resolution of disputes between providers and ((~~certified health plans~~)) health carriers including disputes regarding the decision of a plan not to include the services of a provider.

(5) Nothing contained in this section shall be construed to require a plan to allow or continue the participation of a provider if the plan is a federally qualified health maintenance organization and the participation of the provider or providers would prevent the health maintenance organization from operating as a health maintenance organization in accordance with 42 U.S.C. Sec. 300e.

NEW SECTION. **Sec. 60.** A new section is added to chapter 48.43 RCW to read as follows:

(1) After January 1, 1994, every health carrier shall waive any preexisting condition exclusion or limitation for persons who had similar coverage under a health plan, including a self-funded health plan, in the three-month period immediately preceding the effective date of coverage under the new agreement to the extent that such person has satisfied a waiting period under such health plan. However, if the person satisfied a twelve-month waiting period under such preceding health plan the health carrier shall waive any preexisting condition exclusion or limitation. The health carrier need not waive a preexisting condition exclusion or limitation under the new health plan for coverage not provided under such preceding health plan.

(2) No health carrier may deny, exclude, or limit coverage for preexisting conditions in health plans entered into or renewed after

the effective date of this section, except that a carrier may impose a six-month benefit waiting period for preexisting conditions for which medical advice was given within six months of the effective date of coverage, for which a health care provider recommended or provided treatment within the six months preceding the effective date of coverage within the six months preceding the effective date of coverage under the health plan.

(3) The commissioner may adopt rules to implement this section. The commissioner shall not include in the rules an open enrollment period that precludes a health carrier from establishing a benefit waiting period provided for under subsection (2) of this section.

NEW SECTION. **Sec. 61.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Utilization review processes employed or contracted for by health carriers shall, among other things, do the following:

(a) Be based on written policies and procedures on all review activities, both delegated and nondelegated, for covered services, especially regarding adverse review decisions, an appeals procedure, clinical review criteria, handling emergencies, data collection, confidentiality, and timeframes for making decisions;

(b) Use provider peers in making review decisions on the necessity and appropriateness of the health care services being reviewed;

(c) Provide an appeals process for adverse decisions, using provider peers;

(d) Issue utilization review decisions in a timely manner; and

(e) Document adverse review decisions, and make this documentation, including the specific clinical or other reason for the adverse decision, available to the covered person and affected provider or facility.

(2) As used in this section, the following definitions apply unless the context clearly requires otherwise:

(a) "Adverse review decision" or "adverse decision" means a determination that an admission, continued stay, or other health care service being reviewed does not meet the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness.

(b) "Appeals procedure" means a formal process whereby a covered person, attending physician, health care provider, or facility can appeal an adverse decision.

(c) "Clinical review criteria" means the screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health plan to determine necessity and appropriateness of health care services.

(d) "Provider peer" means a physician or other health care provider who is licensed under Title 18 RCW and is qualified to render a professional opinion on the medical condition, procedure, or treatment under review.

(e) "Utilization review process" means a system or set of formal techniques designed to monitor and evaluate the clinical necessity, appropriateness, and efficiency of health care services. Techniques may include ambulatory review, prospective review, second opinions, concurrent review, case management, discharge planning, and retrospective review.

(3) The commissioner may adopt necessary rules, standards, and guidelines regarding utilization review processes.

Sec. 62. RCW 48.70.040 and 1982 c 181 s 23 are each amended to read as follows:

(1) By July 1, 1983, the commissioner shall adopt all rules necessary to ensure that specified disease policies provide a reasonable level of benefits to policyholders, and that purchasers and potential purchasers of such policies are fully informed of the level of benefits provided.

(2) The commissioner shall adopt rules prohibiting the offering of specified disease policies to individuals who are not covered by a standard benefits package as defined in chapter 48.43 RCW.

Sec. 63. RCW 48.70.900 and 1982 c 181 s 24 are each amended to read as follows:

This chapter shall apply to all policies issued on or after July 1, 1983. ((~~This chapter shall not apply to services provided by health care service contractors as defined in RCW 48.44.010.~~))

Sec. 64. RCW 48.85.010 and 1993 c 492 s 458 are each amended to read as follows:

The department of social and health services shall ((~~from July 1, 1993, to July 1, 1998~~)), in conjunction with the office of the insurance commissioner, coordinate a ((~~pilot~~)) long-term care insurance

program entitled the Washington long-term care partnership, whereby private insurance and medicaid funds shall be used to finance long-term care. ((~~This program must allow for the exclusion of an individual's assets, as approved by the federal health care financing administration, in a determination of the individual's eligibility for medicaid; the amount of any medicaid payment; or any subsequent recovery by the state for a payment for medicaid services to the extent such assets are protected by a long-term care insurance policy or contract governed by chapter 48.84 RCW and meeting the criteria prescribed in this chapter.~~)) For individuals purchasing a long-term care insurance policy or contract governed by chapter 48.84 RCW and meeting the criteria prescribed in this chapter, and any other terms as specified by the office of the insurance commissioner and the department of social and health services, this program shall allow for the exclusion of some or all of the individual's assets in determination of medicaid eligibility as approved by the federal health care financing administration.

Sec. 65. RCW 48.85.020 and 1993 c 492 s 459 are each amended to read as follows:

The department of social and health services shall seek approval and a waiver of appropriate federal medicaid regulations to allow the protection of an individual's assets as provided in this chapter. The department shall adopt all rules necessary to implement the Washington long-term care partnership program, which rules shall permit the exclusion of all or some of an individual's assets in a manner specified by the office of the insurance commissioner and the department of social and health services in a determination of medicaid eligibility to the extent that private long-term care insurance provides payment or benefits for services ((~~that medicaid would approve or cover for medicaid recipients~~)).

Sec. 66. RCW 48.85.030 and 1993 c 492 s 460 are each amended to read as follows:

(1) The insurance commissioner shall adopt rules defining the criteria that long-term care insurance policies must meet to satisfy the requirements of this chapter. The rules shall provide that all long-term care insurance policies purchased for the purposes of this chapter:

(a) Be guaranteed renewable;

(b) Provide coverage for ((~~home and community-based services and~~)) nursing home care;

(c) Provide optional coverage for home and community-based services;

(d) Provide automatic compounded inflation protection or similar coverage to protect the policyholder from future increases in the cost of long-term care;

((~~(d)~~)) (e) Not require prior hospitalization or confinement in a nursing home as a prerequisite to receiving long-term care benefits; and

((~~(e)~~)) (f) Contain at least a six-month grace period that permits reinstatement of the policy or contract retroactive to the date of termination if the policy or contract holder's nonpayment of premiums arose as a result of a cognitive impairment suffered by the policy or contract holder as certified by a physician.

(2) Insurers offering long-term care policies for the purposes of this chapter shall demonstrate to the satisfaction of the insurance commissioner that they:

(a) Have procedures to provide notice to each purchaser of the long-term care consumer education program;

(b) Offer case management services;

(c) Have procedures that provide for the keeping of individual policy records and procedures for the explanation of coverage and benefits identifying those payments or services available under the policy that meet the purposes of this chapter;

(d) Agree to provide the insurance commissioner, on or before September 1 of each year, an annual report containing ((~~the following~~)) information((~~:~~

~~(i) The number of policies issued and of the policies issued, that number sorted by issue age;~~

~~(ii) To the extent possible, the financial circumstance of the individuals covered by such policies;~~

~~(iii) The total number of claims paid; and~~

~~(iv) Of the number of claims paid, the number paid for nursing home care, for home care services, and community-based services~~)) derived from the long-term care partnership long-term care insurance uniform data set as specified by the office of the insurance commissioner.

Sec. 67. RCW 48.85.040 and 1993 c 492 s 461 are each amended to read as follows:

The insurance commissioner, in conjunction with the department of social and health services and members of the long-term care insurance industry, shall develop a consumer education program designed to educate consumers as to the need for long-term care, methods for financing long-term care, the availability of long-term care insurance, and the availability and eligibility requirements of the asset protection program provided under this chapter.

Sec. 68. RCW 48.85.050 and 1993 c 492 s 462 are each amended to read as follows:

By January 1 of each year until 1998, the insurance commissioner, in conjunction with the department of social and health services, shall report to the legislature on the progress of the asset protection program. The report shall include:

(1) The success of the agencies in implementing the program;

(2) The number of insurers offering long-term care policies meeting the criteria for asset protection;

(3) The number, age, and financial circumstances of individuals purchasing long-term care policies meeting the criteria for asset protection;

(4) The number of individuals seeking consumer information services;

(5) The extent and type of benefits paid by insurers offering policies meeting the criteria for asset protection;

(6) Estimates of the impact of the program on present and future medicaid expenditures;

(7) The cost-effectiveness of the program; and

(8) A determination regarding the appropriateness of continuing the program.

Sec. 69. RCW 70.47.060 and 1994 c 309 s 5 are each amended to read as follows:

The administrator has the following powers and duties:

(1) ((~~To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be necessary for basic health care, which~~

~~subsidized and nonsubsidized enrollees~~)) (a) To administer a schedule of covered health services entitled the basic health plan, which shall be the physician services, inpatient and outpatient hospital services, and prescription drugs and medications that were covered by the basic health plan as of July 1, 1994, with the following additional services: Limited chemical dependency services and limited mental health services. After the administrator has made the modifications to the basic health plan that are necessary to include chemical dependency services and mental health services, the basic health plan may not be further modified except by an act of law.

(b) All subsidized and nonsubsidized enrollees in any participating ((~~managed~~)) health care system under the Washington basic health plan shall be entitled to receive services under the basic health plan in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care and shall include all services necessary for prenatal, postnatal, and well-child care. However, with respect to coverage for groups of subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the ((~~managed care~~)) provider. The schedule of services shall also include a separate schedule of basic health care services for children, eighteen years of age and younger, for those subsidized or nonsubsidized enrollees who choose to secure basic coverage through the plan only for their dependent children. ((~~In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.42.080, and such other factors as the administrator deems appropriate. On and after July 1, 1995, the uniform benefits package adopted and from time to time revised by the Washington health services commission pursuant to RCW 43.72.130 shall be implemented by the administrator as the schedule of covered basic health care services. However, with respect to coverage for subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that the services are necessary over not more than a one-month period in order~~

~~to maintain continuity of care after diagnosis of pregnancy by the managed care provider.~~))

(2)(a) To design and implement a structure of periodic premiums due the administrator from subsidized enrollees that is based upon gross family income, giving appropriate consideration to family size and the ages of all family members. The enrollment of children shall not require the enrollment of their parent or parents who are eligible for the plan. The structure of periodic premiums shall be applied to subsidized enrollees entering the plan as individuals pursuant to subsection (9) of this section and to the share of the cost of the plan due from subsidized enrollees entering the plan as employees pursuant to subsection (10) of this section.

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

(c) An employer or other financial sponsor may, with the prior approval of the administrator, pay the premium, rate, or any other amount on behalf of a subsidized or nonsubsidized enrollee, by arrangement with the enrollee and through a mechanism acceptable to the administrator, but in no case shall the payment made on behalf of the enrollee exceed the total premiums due from the enrollee.

(3) To design and implement a structure of copayments due a ((~~managed~~)) health care system from subsidized and nonsubsidized enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services. ((~~On and after July 1, 1995, the administrator shall endeavor to make the copayments structure of the plan consistent with enrollee point of service cost-sharing levels adopted by the Washington health services commission, giving consideration to funding available to the plan.~~))

(4) To limit enrollment of persons who qualify for subsidies so as to prevent an overexpenditure of appropriations for such purposes. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment until the administrator finds the danger no longer exists.

(5) To limit the payment of subsidies to subsidized enrollees, as defined in RCW 70.47.020.

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

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

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

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan as subsidized or nonsubsidized enrollees, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and at least semiannually thereafter, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient

of medical assistance or medical care services under chapter 74.09 RCW. If, as a result of an eligibility review, the administrator determines that a subsidized enrollee's income exceeds twice the federal poverty level and that the enrollee knowingly failed to inform the plan of such increase in income, the administrator may bill the enrollee for the subsidy paid on the enrollee's behalf during the period of time that the enrollee's income exceeded twice the federal poverty level. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to re-enroll in the plan. Enrollees whose income is less than one hundred twenty-five percent of the federal poverty level shall not pay any premium share.

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

(11) To determine the rate to be paid to each participating ((~~managed~~)) health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same for similar enrollees, the rates negotiated with participating ((~~managed~~)) health care systems may vary among the systems. In negotiating rates with participating systems, the administrator shall consider the characteristics of the populations served by the respective systems,

economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant.

(12) To monitor the provision of covered services to enrollees by participating ((~~managed~~)) health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating ((~~managed~~)) health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating ((~~managed~~)) health care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the ((~~managed~~)) health care systems and to the plan. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

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

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

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

(16) To develop and implement, no later than July 1, 1996, procedures where a hospital or clinic, upon admission of a patient, can expeditiously determine the patient's eligibility for the basic health plan and enroll the patient in the basic health plan.

Sec. 70. 1993 c 492 s 279 (uncodified) is amended to read as follows:

(1) The University of Washington shall prepare a primary care shortage plan that accomplishes the following:

(a) Identifies specific activities that the school of medicine shall pursue to increase the number of Washington residents serving as primary care physicians in rural and medically underserved areas of the

state, including establishing a goal ((~~that assures that no less than fifty percent~~)) of training an adequate number of medical school graduates who are Washington state residents at the time of matriculation and will enter into primary care residencies, to the extent possible, in Washington state ((~~by the year 2000~~));

(b) Assures that the school of medicine shall establish among its highest training priorities the distribution of its primary care physician graduates from the school and associated postgraduate residency programs into rural and medically underserved areas;

(c) Establishes the goal of assuring that the annual number of graduates from the family practice residency network entering rural or medically underserved practice shall be increased ((~~by forty percent over a baseline period from 1988 through 1990 by 1995~~)) appropriately;

(d) Establishes a further goal to make operational at least two additional family practice residency programs within Washington state in geographic areas identified by the plan as underserved in family practice by 1997. The geographic areas identified by the plan as being underserved by family practice physicians shall be consistent with any such similar designations as may be made in the health personnel research plan as authorized under chapter 28B.125 RCW;

(e) Establishes, with the cooperation of existing community and migrant health clinics in rural or medically underserved areas of the state, three family practice residency training tracks. Furthermore, the primary care shortage plan shall provide that one of these training tracks shall be a joint American osteopathic association and American medical association approved training site coordinated with an accredited college of osteopathic medicine with extensive experience in training primary care physicians for the western United States. Such a proposed joint accredited training track will have at least fifty percent of its residency positions in osteopathic medicine; and

(f) Implements the plan, with the exception of the expansion of the family practice residency network, within current biennial appropriations for the University of Washington school of medicine.

(2) The plan shall be submitted to the appropriate committees of the legislature no later than December 1, 1993.

Sec. 71. RCW 51.14.010 and 1971 ex.s. c 289 s 26 are each amended to read as follows:

(1) Except as otherwise provided in this section, every employer under this title shall secure the payment of compensation under this title by:

((~~(1)~~)) (a) Insuring and keeping insured the payment of such benefits with the state fund; or

((~~(2)~~)) (b) Qualifying as a self-insurer under this title.

(2) Beginning July 1, 1996, with respect to medical aid benefits required under this title, an employer may elect to provide the medical aid benefits through the employee health care benefit plan sponsored by the employer to provide general health care benefits to employees if the employer pays one hundred percent of the premium cost of the employee health care benefit plan. An employer electing this option:

(a) Must provide notice of the election to the department in a manner prescribed by department rules;

(b) May not require deductibles, coinsurance, copayment, or other point-of-service cost-sharing for services related to industrial injuries or diseases; and

(c) Is not relieved of any liability to his or her employees imposed by this title.

Sec. 72. RCW 51.16.060 and 1985 c 315 s 1 are each amended to read as follows:

(1) Every employer not qualifying as a self-insurer, shall insure with the state ((~~and~~)), except that employers electing the option authorized under RCW 51.14.010(2), as recodified by this act, shall not be required to insure medical aid benefits with the state.

(2) Employers insuring with the state shall, on or before the last day of January, April, July and October of each year thereafter, furnish the department with a true and accurate payroll for the period in which workers were employed by it during the preceding calendar quarter, the total amount paid to such workers during such preceding calendar quarter, and a segregation of employment in the different classes established pursuant to this title, and shall pay its premium thereon to the appropriate fund. Premiums for a calendar quarter, whether reported or not, shall become due and delinquent on the day immediately following the last day of the month following the calendar quarter. The sufficiency of such statement shall be subject to the approval of the director((~~: PROVIDED, That~~)). The director may in his or her discretion and for the effective administration of this title

require an employer in individual instances to furnish a supplementary report containing the name of each individual worker, his or her hours worked, his or her rate of pay and the class or classes in which such work was performed((~~: PROVIDED FURTHER, That in the event~~)).

(3) If an employer ((~~shall furnish~~)) furnishes the department with four consecutive quarterly reports wherein each such quarterly report indicates that no premium is due the department may close the account((~~: PROVIDED FURTHER, That~~)).

(4) The department may ((~~promulgate~~)) adopt rules ((~~and regulations~~)) in accordance with chapter 34.05 RCW to establish other reporting periods and payment due dates in lieu of reports and payments following each calendar quarter, and may also establish terms and conditions for payment of premiums and assessments based on estimated payrolls, with such payments being subject to approval as to sufficiency of the estimated payroll by the department, and also subject to appropriate periodic adjustments made by the department based on actual payroll((~~: AND PROVIDED FURTHER, That~~)).

(5) A temporary help company which provides workers on a temporary basis to its customers shall be considered the employer for purposes of reporting and paying premiums and assessments under this title according to the appropriate rate classifications as determined by the department((~~: PROVIDED, That~~)). However, the employer shall be liable for paying premiums and assessments, should the temporary help company fail to pay the premiums and assessments under this title.

Sec. 73. RCW 51.16.140 and 1989 c 385 s 3 are each amended to read as follows:

(1) Every employer who is not a self-insurer, or who has not elected the option authorized in RCW 51.14.010(2), as recodified by this act, shall deduct from the pay of each of his or her workers one-half of the amount he or she is required to pay, for medical benefits within each risk classification. Such amount shall be periodically determined by the director and reported by him or her to all employers under this title: PROVIDED, That the state governmental unit shall pay the entire amount into the medical aid fund for volunteers, as defined in RCW 51.12.035, and the state apprenticeship council shall pay the entire amount into the medical aid fund for registered apprentices or trainees, for the purposes of RCW 51.12.130. The deduction under this section is not authorized for premiums assessed under RCW 51.16.210.

(2) It shall be unlawful for the employer, unless specifically authorized by this title, to deduct or obtain any part of the premium or other costs required to be paid by him or her ((~~paid~~)) from the wages or earnings of any of his or her workers, and the making of or attempt to make any such deduction shall be a gross misdemeanor.

NEW SECTION. **Sec. 74.** The department of labor and industries shall prepare recommendations for legislation necessary to implement RCW 51.14.010(2), as recodified by this act, including requirements for maintaining financial responsibility sufficient to cover the entire liability of the employer for injuries and occupational diseases of his or her employees that occurred during the period of the election made under RCW 51.14.010(2), as recodified by this act, and requirements for claims reporting. The department shall report its recommendations to the appropriate committees of the legislature by December 1, 1995.

NEW SECTION. **Sec. 75.** RCW 51.14.010 is recodified in chapter 51.16 RCW.

Sec. 76. RCW 70.170.100 and 1993 c 492 s 259 are each amended to read as follows:

((~~(1)~~)) To promote the public interest consistent with the purposes of chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act), the department ((~~is responsible for the development, implementation, and custody of a state-wide~~)) in cooperation with the joint committee on health system oversight and the department's information services board shall develop a standardized health care data ((~~system, with policy direction and oversight to be provided by the Washington health services commission. As part of the design stage for development of the system, the department shall undertake a needs assessment of the types of, and format for, health care data needed~~)) set to be used by consumers, purchasers, health ((~~care payers~~)) carriers, providers, and state government as consistent with the intent of chapter 492, Laws of 1993 as amended by chapter . . ., Laws of 1995 (this act). ((~~The department shall identify a set of health care data elements and report specifications which satisfy these needs. The Washington health services commission, created by RCW 43.72.020, shall review the design of the data system and may establish a technical advisory committee on health data and may, if deemed cost-effective and~~

~~efficient, recommend that the department contract with a private vendor for assistance in the design of the data system or for any part of the work to be performed under this section. The data elements, specifications, and other distinguishing features of this data system shall be made available for public review and comment and shall be published, with comments, as the department's first data plan by July 1, 1994.~~

~~(2) Subsequent to the initial development of the data system as published as the department's first data plan, revisions to the data system shall be considered with the oversight and policy guidance of the Washington health services commission or its technical advisory committee and funded by the legislature through the biennial appropriations process with funds appropriated to the health services account.~~

~~In designing the state-wide health care data system and any data plans, the department shall identify health care data elements relating to health care costs, the quality of health care services, the outcomes of health care services, and use of health care by consumers. Data elements shall be reported as the Washington health services commission directs by reporters in conformance with a uniform reporting system established by the department, which shall be adopted by reporters. "Reporter" means an individual, hospital, or business entity, required to be registered with the department of revenue for payment of taxes imposed under chapter 82.04 RCW or Title 48 RCW, that is primarily engaged in furnishing or insuring for medical, surgical, and other health services to persons. In the case of hospitals this includes data elements identifying each hospital's revenues, expenses, contractual allowances, charity care, bad debt, other income, total units of inpatient and outpatient services, and other financial information reasonably necessary to fulfill the purposes of chapter 492, Laws of 1993, for hospital activities as a whole and, as feasible and appropriate, for specified classes of hospital purchasers and payers. Data elements relating to use of hospital services by patients shall, at least initially, be the same as those currently compiled by hospitals through inpatient discharge abstracts. The commission and the department shall encourage and permit reporting by electronic transmission or hard copy as is practical and economical to reporters.~~

~~(3) The state-wide health care data system shall be uniform in its identification of reporting requirements for reporters across the state~~

~~to the extent that such uniformity is useful to fulfill the purposes of chapter 492, Laws of 1993. Data reporting requirements may reflect differences that involve pertinent distinguishing features as determined by the Washington health services commission by rule. So far as is practical, the data system shall be coordinated with any requirements of the trauma care data registry as authorized in RCW 70.168.090, the federal department of health and human services in its administration of the medicare program, the state in its role of gathering public health statistics, or any other payer program of consequence so as to minimize any unduly burdensome reporting requirements imposed on reporters.~~

~~(4) In identifying financial reporting requirements under the state-wide health care data system, the department may require both annual reports and condensed quarterly reports from reporters, so as to achieve both accuracy and timeliness in reporting, but shall craft such requirements with due regard of the data reporting burdens of reporters.~~

~~(5) The health care data collected, maintained, and studied by the department or the Washington health services commission shall only be available for retrieval in original or processed form to public and private requestors and shall be available within a reasonable period of time after the date of request. The cost of retrieving data for state officials and agencies shall be funded through the state general appropriation. The cost of retrieving data for individuals and organizations engaged in research or private use of data or studies shall be funded by a fee schedule developed by the department which reflects the direct cost of retrieving the data or study in the requested form.~~

~~(6) All persons subject to chapter 492, Laws of 1993 shall comply with departmental or commission requirements established by rule in the acquisition of data.~~))

NEW SECTION. **Sec. 77.** A new section is added to chapter 82.04 RCW to read as follows:

Persons with fewer than twenty-five full-time equivalent employees are entitled to a credit against their tax liability under this chapter if:

(1) The person was not engaging in business activities in this state before July 1, 1994; and

(2) The person is providing health benefits to employees and paying at least fifty percent of the premium for each employee who has worked full time for at least sixty days. For the purposes of this section, "full time" means working one hundred twenty or more hours in a calendar month.

The amount of the credit shall equal a percentage of the amounts paid during the reporting period for health care benefits for employees according to the following table:

Amount of Credit	**Time Period**
100%	1st 12 months
75%	2nd 12 months
50%	3rd 12 months
25%	4th 12 months

Credits under this section may only be taken for the first forty-eight months the person provides health care benefits to employees. No credit may be taken in excess of the person's tax liability for the reporting period, and no credit may carry over to a subsequent reporting period.

The department of revenue shall adopt rules to administer this tax credit by May 1996, and shall utilize data collected by other agencies from employers to the greatest extent reasonably possible in the administration of this tax credit.

NEW SECTION. **Sec. 78.** The legislative budget committee shall conduct a feasibility study to determine the cost-effectiveness and logistics of contracting out the administration and delivery of all juvenile and adult inmate health care services and plan for the implementation of contracted services. The study shall be submitted to the appropriate committees of the legislature on or before December 12, 1995.

NEW SECTION. **Sec. 79.** MANDATED COVERAGE. The following acts or parts of acts are each repealed:

(1) RCW 41.05.170 and 1989 c 345 s 4;

(2) RCW 41.05.180 and 1994 sp.s. c 9 s 725 & 1989 c 338 s 5;

(3) RCW 48.20.390 and 1963 c 87 s 1;

(4) RCW 48.20.393 and 1994 sp.s. c 9 s 728 & 1989 c 338 s 1;

(5) RCW 48.20.395 and 1985 c 54 s 5 & 1983 c 113 s 1;

(6) RCW 48.20.397 and 1985 c 54 s 1;
(7) RCW 48.20.410 and 1965 c 149 s 2;
(8) RCW 48.20.411 and 1994 sp.s. c 9 s 729 & 1973 1st ex.s. c 188 s 3;
(9) RCW 48.20.412 and 1971 ex.s. c 13 s 1;
(10) RCW 48.20.414 and 1971 ex.s. c 197 s 1;
(11) RCW 48.20.416 and 1974 ex.s. c 42 s 1;
(12) RCW 48.20.520 and 1988 c 173 s 1;
(13) RCW 48.21.130 and 1963 c 87 s 2;
(14) RCW 48.21.140 and 1965 c 149 s 3;
(15) RCW 48.21.141 and 1994 sp.s. c 9 s 730 & 1973 1st ex.s. c 188 s 4;
(16) RCW 48.21.142 and 1971 ex.s. c 13 s 2;
(17) RCW 48.21.144 and 1971 ex.s. c 197 s 2;
(18) RCW 48.21.146 and 1974 ex.s. c 42 s 2;
(19) RCW 48.21.160 and 1987 c 458 s 13 & 1974 ex.s. c 119 s 1;
(20) RCW 48.21.180 and 1990 1st ex.s. c 3 s 7, 1987 c 458 s 14, & 1974 ex.s. c 119 s 3;
(21) RCW 48.21.190 and 1975 1st ex.s. c 266 s 10 & 1974 ex.s. c 119 s 5;
(22) RCW 48.21.195 and 1987 c 458 s 15;
(23) RCW 48.21.197 and 1987 c 458 s 21;
(24) RCW 48.21.220 and 1988 c 245 s 31, 1984 c 22 s 1, & 1983 c 249 s 1;
(25) RCW 48.21.225 and 1994 sp.s. c 9 s 731 & 1989 c 338 s 2;
(26) RCW 48.21.230 and 1985 c 54 s 6 & 1983 c 113 s 2;
(27) RCW 48.21.235 and 1985 c 54 s 2;
(28) RCW 48.21.240 and 1987 c 283 s 3, 1986 c 184 s 2, & 1983 c 35 s 1;
(29) RCW 48.21.300 and 1988 c 173 s 2;
(30) RCW 48.21.310 and 1989 c 345 s 2;
(31) RCW 48.21.320 and 1989 c 331 s 2;
(32) RCW 48.44.225 and 1983 c 154 s 5;
(33) RCW 48.44.240 and 1990 1st ex.s. c 3 s 12, 1987 c 458 s 16, 1975 1st ex.s. c 266 s 14, & 1974 ex.s. c 119 s 4;
(34) RCW 48.44.245 and 1987 c 458 s 17;
(35) RCW 48.44.290 and 1994 sp.s. c 9 s 733, 1986 c 223 s 6, & 1981 c 175 s 1;
(36) RCW 48.44.300 and 1986 c 223 s 7 & 1983 c 154 s 2;

(37) RCW 48.44.309 and 1983 c 286 s 1;
(38) RCW 48.44.310 and 1986 c 223 s 8 & 1983 c 286 s 2;
(39) RCW 48.44.320 and 1989 1st ex.s. c 9 s 222, 1988 c 245 s 33, 1984 c 22 s 3, & 1983 c 249 s 3;
(40) RCW 48.44.325 and 1994 sp.s. c 9 s 734 & 1989 c 338 s 3;
(41) RCW 48.44.330 and 1985 c 54 s 7 & 1983 c 113 s 3;
(42) RCW 48.44.335 and 1985 c 54 s 3;
(43) RCW 48.44.340 and 1987 c 283 s 4, 1986 c 184 s 3, & 1983 c 35 s 2;
(44) RCW 48.44.440 and 1988 c 173 s 3;
(45) RCW 48.44.450 and 1989 c 345 s 1;
(46) RCW 48.44.460 and 1989 c 331 s 3;
(47) RCW 48.46.275 and 1994 sp.s. c 9 s 735 & 1989 c 338 s 4;
(48) RCW 48.46.280 and 1985 c 54 s 8 & 1983 c 113 s 4;
(49) RCW 48.46.285 and 1985 c 54 s 4;
(50) RCW 48.46.290 and 1987 c 283 s 5, 1986 c 184 s 4, & 1983 c 35 s 3;
(51) RCW 48.46.350 and 1990 1st ex.s. c 3 s 14, 1987 c 458 s 18, & 1983 c 106 s 13;
(52) RCW 48.46.355 and 1987 c 458 s 19;
(53) RCW 48.46.510 and 1988 c 173 s 4;
(54) RCW 48.46.520 and 1989 c 345 s 3;
(55) RCW 48.46.530 and 1989 c 331 s 4; and
(56) RCW 49.64.040 and 1988 c 259 s 1.

NEW SECTION. **Sec. 80.** The following acts or parts of acts are each repealed:
(1) RCW 43.72.030 and 1993 c 492 s 405;
(2) RCW 43.72.040 and 1994 c 4 s 3, 1993 c 494 s 2, & 1993 c 492 s 406;
(3) RCW 43.72.050 and 1993 c 492 s 407;
(4) RCW 43.72.060 and 1994 c 4 s 2 & 1993 c 492 s 404;
(5) RCW 43.72.110 and 1993 c 492 s 429;
(6) RCW 43.72.120 and 1993 c 492 s 430;
(7) RCW 43.72.140 and 1993 c 492 s 450;
(8) RCW 43.72.150 and 1993 c 492 s 451;
(9) RCW 43.72.180 and 1993 c 492 s 454;
(10) RCW 43.72.190 and 1993 c 492 s 455;
(11) RCW 43.72.210 and 1993 c 492 s 463;

(12) RCW 43.72.220 and 1993 c 494 s 3 & 1993 c 492 s 464;
(13) RCW 43.72.230 and 1993 c 492 s 465;
(14) RCW 43.72.225 and 1994 c 4 s 4;
(15) RCW 43.72.240 and 1993 c 494 s 4 & 1993 c 492 s 466;
(16) RCW 43.72.820 and 1993 c 492 s 475;
(17) RCW 43.72.870 and 1993 c 494 s 5;
(18) RCW 48.43.010 and 1993 c 492 s 432;
(19) RCW 48.43.020 and 1993 c 492 s 433;
(20) RCW 48.43.030 and 1993 c 492 s 434;
(21) RCW 48.43.040 and 1993 c 492 s 435;
(22) RCW 48.43.050 and 1993 c 492 s 436;
(23) RCW 48.43.060 and 1993 c 492 s 437;
(24) RCW 48.43.070 and 1993 c 492 s 438;
(25) RCW 48.43.080 and 1993 c 492 s 439;
(26) RCW 48.43.090 and 1993 c 492 s 440;
(27) RCW 48.43.100 and 1993 c 492 s 441;
(28) RCW 48.43.110 and 1993 c 492 s 442;
(29) RCW 48.43.120 and 1993 c 492 s 443;
(30) RCW 48.43.130 and 1993 c 492 s 444;
(31) RCW 48.01.210 and 1993 c 462 s 51;
(32) RCW 48.20.540 and 1993 c 492 s 283;
(33) RCW 48.21.340 and 1993 c 492 s 284;
(34) RCW 48.44.480 and 1993 c 492 s 285;
(35) RCW 48.46.550 and 1993 c 492 s 286;
(36) RCW 48.42.060 and 1984 c 56 s 1;
(37) RCW 48.42.070 and 1989 1st ex.s. c 9 s 221, 1987 c 150 s 79, & 1984 c 56 s 2;
(38) RCW 48.42.080 and 1984 c 56 s 3;
(39) RCW 70.170.110 and 1993 c 492 s 260 & 1989 1st ex.s. c 9 s 511;
(40) RCW 70.170.120 and 1993 c 492 s 261;
(41) RCW 70.170.130 and 1993 c 492 s 262; and
(42) RCW 70.170.140 and 1993 c 492 s 263.

NEW SECTION. **Sec. 81.** RCW 43.72.005, 43.72.010, 43.72.070, 43.72.080, 43.72.090, 43.72.100, 43.72.130, 43.72.160, 43.72.170, 43.72.200, 43.72.300, 43.72.310, 43.72.800, 43.72.810, 43.72.830, 43.72.840, 43.72.850, 43.72.860, 43.72.900, 43.72.902, 43.72.904, 43.72.906, and 43.72.910 are recodified in chapter 48.43 RCW.

NEW SECTION. **Sec. 82.** Sections 32 through 37 of this act shall constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec. 83.** Captions as used in this act constitute no part of the law.

NEW SECTION. **Sec. 84.** Section 15 of this act shall expire June 30, 1998.

NEW SECTION. **Sec. 85.** This act shall take effect January 1, 1996, except for section 70 of this act which shall take effect July 1, 1996.

NEW SECTION. **Sec. 86.** This act shall not be construed as affecting any existing right acquired or liability or obligation incurred under the sections amended or repealed in this act or under any rule or order adopted under those sections, nor as affecting any proceeding instituted under those sections.

NEW SECTION. **Sec. 87.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 88.** This act shall be submitted to the people for their adoption and ratification, or rejection, at the next succeeding general election to be held in this state, in accordance with Article II, section 1 of the state Constitution, as amended, and the laws adopted to facilitate the operation thereof.

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