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**SENATE BILL 5957**

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**State of Washington 65th Legislature 2017 2nd Special Session**

**By** Senators Chase, Hasegawa, and Saldaña

AN ACT Relating to establishing the healthy Washington program to provide comprehensive universal single-payer health care coverage for all residents of the state; adding a new chapter to Title 43 RCW; and providing a contingent effective date.

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

NEW SECTION. **Sec.**  The legislature finds and declares all of the following:

(1) All residents of this state have the right to health care. While the federal patient protection and affordable care act brought many improvements in health care and health care coverage, it still leaves many residents without coverage or with inadequate coverage.

(2) Individuals, employers, and taxpayers have experienced a rise in the cost of health care and health care coverage in recent years, including rising premiums, deductibles, and copays, as well as restricted provider networks and high out-of-network charges.

(3) Businesses have also experienced increases in the costs of health care benefits for their employees, and many employers are shifting a larger share of the cost of coverage to their employees or dropping coverage entirely.

(4) Individuals often find that they are deprived of affordable care and choice because of decisions by health benefit plans guided by the plan's economic needs rather than consumers' health care needs.

(5) To address the fiscal crisis facing the health care system and the state, and to ensure all residents can exercise their right to health care, comprehensive health care coverage needs to be provided.

(6) It is the intent of the legislature to establish a comprehensive universal single-payer health care coverage program and a health care cost control system for the benefit of all residents of the state. It is further the intent of the legislature to establish the healthy Washington program to provide universal health coverage for every resident based on his or her ability to pay and funded by broad-based revenue.

(7) The state shall work to obtain waivers and other approvals relating to medicaid, the state's children's health insurance program, medicare, the exchange marketplace, and any other federal programs so that any federal funds and other subsidies that would otherwise be paid to the state, residents, and health care providers would be paid by the federal government to the state of Washington and deposited in the healthy Washington trust fund. Under those waivers and approvals, the funds would be used for health coverage that provides health benefits equal to or exceeded by those programs as well as other program modifications, including elimination of cost sharing and insurance premiums. Those programs would be replaced and merged into the healthy Washington program, which will operate as a true single-payer program.

(8) If any necessary waivers or approvals are not obtained, it is the intent of the legislature that the state use state plan amendments and seek waivers and approvals to maximize, and make as seamless as possible, the use of federally matched public health programs and federal health programs in the healthy Washington program. Thus, even if other programs such as medicaid or medicare may contribute to paying for care, it is the goal of this act that the coverage be delivered by the healthy Washington program, and, as much as possible, that the multiple sources of funding be pooled with other healthy Washington program funds and not be apparent to program members or participating providers.

(9) This act does not create any employment benefit or require, prohibit, or limit the provision of any employment benefit.

(10) It is the intent of the legislature not to change or impact in any way the role or authority of any licensing board or state agency that regulates the standards for or provision of health care and the standards for health care providers as established under current law. This act would in no way authorize the healthy Washington board, the healthy Washington program, or the department of health to establish or revise licensure standards for health care providers.

(11) It is the intent of the legislature that neither health information technology nor clinical practice guidelines limit the effective exercise of the professional judgment of physicians and registered nurses. Physicians and registered nurses will be free to override health information technology and clinical practice guidelines if, in their professional judgment, it is in the best interest of the patient and consistent with the patient's wishes.

(12) It is the intent of the legislature to prohibit the program, a state agency, a local agency, or a public employee acting under color of law from providing or disclosing to anyone including, but not limited to, the federal government, any personally identifiable information obtained including, but not limited to, a person's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status, for law enforcement or immigration purposes.

(13) It is the intent of the legislature to prohibit law enforcement agencies from using the program's funds, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the federal government or any federal agency based on religion, national origin, ethnicity, or immigration status.

(14) It is further the intent of the legislature to address the high cost of prescription drugs and ensure they are affordable for patients.

NEW SECTION. **Sec.**  This chapter may be known and cited as the healthy Washington act.

NEW SECTION. **Sec.**  The healthy Washington program is established to be governed by the healthy Washington board created in section 7 of this act.

NEW SECTION. **Sec.**  Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Affordable care act" means the federal patient protection and affordable care act (P.L. 111-148), as amended by the federal health care and education reconciliation act of 2010 (P.L. 111-152), and any amendments to or regulations or guidance issued under those acts, and any programs created by the affordable care act.

(2) "Allied health practitioner" means a group of health professionals that applies its expertise to prevent disease transmission, diagnose, treat, and rehabilitate people of all ages and in all specialties. Together with a range of technical and support staff, the group may deliver direct patient care, rehabilitation, treatment, diagnostics, and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive, and social functions. Examples of such groups include, but are not limited to, audiologists, occupational therapists, social workers, and radiographers.

(3) "Board" means the healthy Washington board created in section 7 of this act.

(4) "Care coordination" means services provided by a care coordinator as outlined in section 18 of this act.

(5) "Care coordinator" means an individual or entity approved by the board to provide care coordination under section 18 of this act.

(6) "Carrier" means a private health insurer licensed under Title 48 RCW.

(7) "Committee" means the public advisory committee established in section 8 of this act.

(8) "Essential community providers" means persons or entities acting as safety net clinics, safety net health care providers, or rural hospitals.

(9) "Federally matched public health program" means the state's medicaid program under Title XIX of the federal social security act (42 U.S.C. Sec. 1396 et seq.) and the state's children's health insurance program (CHIP) under Title XXI of the federal social security act (42 U.S.C. Sec. 1397aa et seq.).

(10) "Fund" means the healthy Washington trust fund established under section 23 of this act.

(11) "Health care organization" means an entity that is approved by the board to provide health care services to members under the program.

(12) "Health care service" means any health care service, including care coordination, that is included as a benefit under the program established under section 16 of this act.

(13) "Healthy Washington" or "program" means the healthy Washington program established in section 3 of this act.

(14) "Implementation period" means the period during which the program is subject to special eligibility and financing provisions until it is fully implemented.

(15) "Integrated health care delivery system" means a provider organization that meets both of the following criteria:

(a) Is fully integrated operationally and clinically to provide a broad range of health care services, including preventive care, prenatal and well-baby care, immunizations, screening diagnostics, emergency services, hospital and medical services, surgical services, and ancillary services; and

(b) Is compensated by healthy Washington using capitation payments or a similar payment methodology for the provision of health care services.

(16) "Long-term care" means long-term care, treatment, maintenance, or services not covered under the state's children's health insurance program, as appropriate, with the exception of short-term rehabilitation, and as defined by the board.

(17) "Medicaid" or "medical assistance" means the state's medicaid program under Title XIX of the federal social security act (42 U.S.C. Sec. 1396 et seq.), or the state's children's health insurance program under Title XXI of the federal social security act (42 U.S.C. Sec. 1397aa et seq.).

(18) "Medicare" means Title XVIII of the federal social security act (42 U.S.C. Sec. 1395 et seq.) and the programs under that act.

(19) "Member" means an individual who is enrolled in the program.

(20) "Out-of-state health care service" means a health care service provided in person to a member while the member is physically located out of the state under either of the following circumstances:

(a) It is medically necessary that the health care service be provided while the member is physically out of the state; or

(b) It is clinically appropriate and necessary, and cannot be provided in the state, because the health care service can only be provided by a particular health care provider physically located out of the state. However, any health care service provided to a member by a health care provider qualified by the board that is located outside the state is not considered an out-of-state service and is covered as otherwise provided in this chapter.

(21) "Participating provider" means any individual or entity that is a health care provider qualified by the board that provides health care services to members under the program, or a health care organization.

(22) "Resident" means an individual whose primary place of abode is in the state, without regard to the individual's immigration status.

NEW SECTION. **Sec.**  This chapter does not preempt any city, county, or city and county from adopting additional health care coverage for residents in that city, county, or city and county that provides more protections and benefits to Washington residents than this chapter.

NEW SECTION. **Sec.**  To the extent any provision of Washington law is inconsistent with this chapter or the legislative intent of the healthy Washington act, this chapter applies and prevails, except when explicitly provided otherwise under this chapter.

NEW SECTION. **Sec.**  (1) The healthy Washington board is established as an independent public entity to provide governance for the healthy Washington program. The board must consist of nine members who are residents of Washington. Of the members of the board, four must be appointed by the governor, two must be appointed by the senate, and two must be appointed by the house of representatives. The director of the health care authority or his or her designee shall serve as a voting, ex officio member of the board.

(2) Members of the board, other than an ex officio member, are appointed for a term of four years. Appointments by the governor are subject to confirmation by the senate. A member of the board may continue to serve until the appointment and qualification of his or her successor. Vacancies are filled by appointment for the unexpired term. The board shall elect a chairperson on an annual basis.

(3)(a) Each person appointed to the board shall have demonstrated and acknowledged expertise in health care. Appointing authorities shall also consider the expertise of the other members of the board and attempt to make appointments so that the board's composition reflects a diversity of expertise in the various aspects of health care.

(b) Appointments to the board by the governor, the senate, and the house of representatives must be composed of:

(i) At least one representative of a labor organization representing registered nurses;

(ii) At least one representative of the general public;

(iii) At least one representative of a labor organization; and

(iv) At least one representative of the medical provider community.

(4) Each member of the board has the responsibility and duty to meet the requirements of this chapter, the affordable care act, and all applicable state and federal laws and regulations, to serve the public interest of the individuals, employers, and taxpayers seeking health care coverage through the program, and to ensure the operational well-being and fiscal solvency of the program.

(5) In making appointments to the board, the appointing authorities shall take into consideration the cultural, ethnic, and geographical diversity of the state so that the board's composition reflects the communities of Washington.

(6) A member of the board or of the staff of the board must not be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of a health care provider, a health care facility, or a health clinic while serving on the board or on the staff of the board. A member of the board or of the staff of the board must not be a member, a board member, or an employee of a trade association of health facilities, health clinics, or health care providers while serving on the board or on the staff of the board. A member of the board or of the staff of the board must not be a health care provider unless he or she receives no compensation for rendering services as a health care provider and does not have an ownership interest in a health care practice.

(7) A board member must not receive compensation for his or her service on the board, but may receive a per diem and reimbursement for travel and other necessary expenses while engaged in the performance of official duties of the board.

(8) A member of the board must not make, participate in making, or in any way attempt to use his or her official position to influence the making of a decision that he or she knows, or has reason to know, will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or on either of the following:

(a) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status aggregating two hundred fifty dollars or more in value provided to, received by, or promised to the member within twelve months before the time when the decision is made; or

(b) Any business entity in which the member is a director, officer, partner, trustee, employee, or holds any position of management.

(9) There is no liability in a private capacity on the part of the board or a member of the board, or an officer or employee of the board, for or on account of an act performed or obligation entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this chapter or affairs related to this chapter.

(10) The board shall hire an executive director to organize, administer, and manage the operations of the board. The executive director is exempt from civil service and shall serve at the pleasure of the board.

(11) The board is subject to open public meetings, except that the board may hold closed sessions when considering matters related to litigation, personnel, contracting, and rates.

(12) The board may adopt rules as necessary to implement and administer this chapter.

(13) For purposes of this section, "health care provider" means a person licensed or certified in Washington under Title 18 RCW.

NEW SECTION. **Sec.**  (1) The executive director shall establish a public advisory committee to advise the board on all matters of policy for the program. The members of the committee must include all of the following:

(a) Four physicians, all of whom must be board certified in their fields, and at least one of whom must be a psychiatrist. The senate and the governor shall each appoint one member. The house of representatives shall appoint two of these members, both of whom must be primary care providers;

(b) Two registered nurses, to be appointed by the senate;

(c) One licensed allied health practitioner, to be appointed by the house of representatives;

(d) One mental health care provider, to be appointed by the senate;

(e) One dentist, to be appointed by the governor;

(f) One representative of private hospitals, to be appointed by the governor;

(g) One representative of public hospitals, to be appointed by the governor;

(h) One representative of an integrated health care delivery system, to be appointed by the governor;

(i) Four consumers of health care. The governor shall appoint two of these members, one of whom must be a person with disabilities. The senate shall appoint a member who is sixty-five years of age or older. The house of representatives shall appoint the fourth member;

(j) One representative of organized labor, to be appointed by the house of representatives;

(k) One representative of essential community providers, to be appointed by the senate;

(l) One member of organized labor, to be appointed by the senate;

(m) One representative of a small business, which is a business that employs less than twenty-five people, to be appointed by the governor;

(n) One representative of a large business, which is a business that employs more than two hundred fifty people, to be appointed by the house of representatives; and

(o) One pharmacist, to be appointed by the house of representatives.

(2) In making appointments under this section, the governor, the senate, and the house of representatives shall make good faith efforts to ensure that their appointments, as a whole, reflect, to the greatest extent feasible, the social and geographic diversity of the state.

(3) A committee member serves a four-year term. Committee members may be reappointed for succeeding four-year terms.

(4) Vacancies that occur must be filled within thirty days after the occurrence of the vacancy and in the same manner in which the vacating member was initially selected or appointed. The executive director shall notify the appropriate appointing authority of any expected vacancies on the public advisory committee.

(5) Members of the committee serve without compensation, but must be reimbursed for actual and necessary expenses incurred in the performance of their duties to the extent that reimbursement for those expenses is not otherwise provided or payable by another public agency or agencies, and receive one hundred dollars for each full day of attending a meeting of the committee. For purposes of this subsection, "full day of attending a meeting" means present at, and participation in, not less than seventy-five percent of the total meeting time of the committee during any particular twenty-four hour period.

(6) The public advisory committee shall meet at least six times per year in a place convenient to the public. All meetings of the committee are open, public meetings.

(7) The public advisory committee shall elect a chairperson who serves for two years and who may be reelected for an additional two years.

(8) Appointed committee members must have worked in the field they represent on the committee for a period of at least two years before being appointed to the committee.

(9) It is unlawful for the committee members or any of their assistants, clerks, or deputies to use for personal benefit any information that is filed with, or obtained by, the committee and that is not generally available to the public.

NEW SECTION. **Sec.**  (1) The board may establish and implement healthy Washington under this chapter. The program must provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state.

(2) The board shall, to the extent possible, organize, administer, and market the program and services as a single-payer program under the name "Healthy Washington," or any other name as the board determines, regardless of which law or source the definition of a benefit is found including, on a voluntary basis, retiree health benefits. In implementing this chapter, the board shall avoid jeopardizing federal financial participation in the programs that are incorporated into healthy Washington and shall promote public understanding and awareness of available benefits and programs.

(3) The board shall consider any matter to effectuate the provisions and purposes of this chapter. The board has no executive, administrative, or appointive duties except as otherwise provided under law.

(4) The board shall employ necessary staff and authorize reasonable expenditures, as necessary, from the healthy Washington trust fund to pay program expenses and to administer the program.

(5) The board may:

(a) Negotiate and enter into any necessary contracts including, but not limited to, contracts with health care providers, integrated health care delivery systems, and care coordinators;

(b) Sue and be sued;

(c) Receive and accept gifts, grants, or donations of moneys from any agency of the federal government, any agency of the state, and any municipality, county, or other political subdivision of the state;

(d) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict of interest provisions to be adopted by the board by rule; and

(e) Share information with relevant state departments, consistent with the confidentiality provisions in this chapter, necessary for the administration of the program.

(6) The board shall determine when individuals may begin enrolling in the program. There must be an implementation period that begins on the date that individuals may begin enrolling in the program and ends on a date determined by the board.

(7) A carrier may not offer benefits or cover any services for which coverage is offered to individuals under the program, but may, if otherwise authorized, offer benefits to cover health care services that are not offered to individuals under the program. However, this chapter does not prohibit a carrier from offering either of the following:

(a) Any benefits to or for individuals, including their families, who are employed or self-employed in the state but who are not residents of the state; or

(b) Any benefits during the implementation period to individuals who enrolled or may enroll as members of the program.

(8) After the end of the implementation period, a person is not a board member unless he or she is a member of the program, except the ex officio member.

(9) No later than two years after the effective date of this section, the board shall develop the following proposals:

(a) A proposal, consistent with this chapter, for provision by the program of long-term care coverage, including the development of a proposal, consistent with this chapter, for its funding. In developing the proposal, the board shall consult with an advisory committee, appointed by the chairperson of the board, including representatives of consumers and potential consumers of long-term care, providers of long-term care, members of organized labor, and other interested parties;

(b) Proposals for (i) accommodating employer retiree health benefits for people who have been members of healthy Washington but live as retirees out of the state, and (ii) accommodating employer retiree health benefits for people who earned or accrued those benefits while residing in the state before the implementation of healthy Washington and live as retirees out of the state; and

(c) A proposal for healthy Washington coverage of health care services currently covered under the workers' compensation system, including whether and how to continue funding for those services under that system and whether and how to incorporate an element of experience rating.

NEW SECTION. **Sec.**  The board may contract with not-for-profit organizations to provide both of the following:

(1) Assistance to consumers with respect to selecting a care coordinator or health care organization, enrolling, obtaining health care services, disenrolling, and other matters relating to the program; and

(2) Assistance to health care providers providing, seeking, or considering whether to provide health care services under the program, with respect to participating in a health care organization and interacting with a health care organization.

NEW SECTION. **Sec.**  The board shall provide grants from funds in the healthy Washington trust fund or from funds otherwise appropriated for this purpose to health planning agencies to support the operation of those health planning agencies.

NEW SECTION. **Sec.**  The board shall provide funds from the healthy Washington trust fund or funds otherwise appropriated for this purpose for a program for retraining and assisting job transition for individuals employed or previously employed in the fields of health insurance, health care service plans, and other third-party payments for health care or those individuals providing services to health care providers to deal with third-party payers for health care, whose jobs may be ending or have been ended as a result of the implementation of the program, consistent with otherwise applicable law.

NEW SECTION. **Sec.**  (1) The board shall provide for the collection and availability of all of the following data to promote transparency, assess adherence to patient care standards, compare patient outcomes, and review utilization of health care services paid for by the program:

(a) Inpatient discharge data, including acuity and risk of mortality;

(b) Emergency department and ambulatory surgery data, including charge data, length of stay, and patients' unit of observation; and

(c) Hospital annual financial data, including all of the following:

(i) Community benefits by hospital in dollar value;

(ii) Number of employees and classification by hospital unit;

(iii) Number of hours worked by hospital unit;

(iv) Employee wage information by job title and hospital unit;

(v) Number of registered nurses per staffed bed by hospital unit;

(vi) Type and value of healthy information technology; and

(vii) Annual spending on health information technology, including purchases, upgrades, and maintenance.

(2) The board shall make all disclosed data collected under subsection (1) of this section publicly available and searchable through an internet web site.

(3) The board shall, directly and through grants to not-for-profit entities, conduct programs using data collected through the healthy Washington program to promote and protect public, environmental, and occupational health, including cooperation with other data collection and research programs.

(4) Before full implementation of the program, the board shall provide for the collection and availability of data on the number of patients served by hospitals and the dollar value of the care provided, at cost, for all of the following categories:

(a) Patients receiving charity care;

(b) Contractual adjustments of county and indigent programs, including traditional and managed care; and

(c) Bad debts.

NEW SECTION. **Sec.**  (1) Healthy Washington, any state or local agency, or a public employee acting under color of law must not provide or disclose to anyone including, but not limited to, the federal government any personally identifiable information obtained including, but not limited to, a person's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status for law enforcement or immigration purposes.

(2) Law enforcement agencies must not use healthy Washington moneys, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the federal government or any federal agency based on religion, national origin, ethnicity, or immigration status.

NEW SECTION. **Sec.**  (1) Every resident of the state is eligible and entitled to enroll as a member under the healthy Washington program.

(2)(a) A member is not required to pay any fee, payment, or other charge for enrolling in or being a member under the program.

(b) A member is not required to pay any premium, copayment, coinsurance, deductible, or any other form of cost sharing for all covered benefits.

(3) A college, university, or other institution of higher education in the state may purchase coverage under the program for a student, or a student's dependent, who is not a resident of the state.

NEW SECTION. **Sec.**  Covered health care benefits under the program include all medical care determined to be medically appropriate by the member's health care provider. Covered health care benefits for members include, but are not limited to, all of the following:

(1) Licensed inpatient and licensed outpatient medical and health facility services;

(2) Inpatient and outpatient professional health care provider medical services;

(3) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services;

(4) Medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids and the repair, technical support, and customization needed for individual use;

(5) Inpatient and outpatient rehabilitative care;

(6) Emergency care services;

(7) Emergency transportation;

(8) Necessary transportation for health care services for persons with disabilities or who may qualify as low income;

(9) Child and adult immunizations and preventive care;

(10) Health and wellness education;

(11) Hospice care;

(12) Care in a skilled nursing facility;

(13) Home health care, including health care provided in an assisted living facility;

(14) Mental health services;

(15) Substance abuse treatment;

(16) Dental care;

(17) Vision care;

(18) Prescription drugs;

(19) Pediatric care;

(20) Prenatal and postnatal care;

(21) Podiatric care;

(22) Chiropractic care;

(23) Acupuncture;

(24) Therapies that are shown by the national institutes of health and national center for complementary and integrative health to be safe and effective;

(25) Blood and blood products;

(26) Dialysis;

(27) Adult day care;

(28) Rehabilitative and habilitative services;

(29) Ancillary health care or social services previously covered by a behavioral health organization;

(30) Ancillary health care or social services previously covered for persons with developmental disabilities;

(31) Case management and care coordination;

(32) Language interpretation and translation for health care services, including sign language and Braille or other services needed for individuals with communication barriers;

(33) Health care and long-term supportive services currently covered under medicaid or the state's children's health insurance program; and

(34) All health care services required to be covered under any of the following provisions, without regard to whether the member would otherwise be eligible for or covered by the program or source referred to:

(a) The state's children's health insurance program;

(b) Medicaid or medical assistance programs;

(c) The federal medicare program;

(d) Health insurers or carriers licensed under Title 48 RCW;

(e) Any additional health care services authorized to be added to the program's benefits by the program; and

(f) All essential health benefits mandated by the affordable care act as of January 1, 2017.

NEW SECTION. **Sec.**  (1) Any health care provider who is licensed to practice in this state and is otherwise in good standing is qualified to participate in the program as long as the health care provider's services are performed within the state of Washington.

(2) The board shall establish and maintain procedures and standards for recognizing health care providers located out of the state for purposes of providing coverage under the program for members who require out-of-state health care services while the member is temporarily located out of the state.

(3) Any health care provider qualified to participate under this section may provide covered health care services under the program, as long as the health care provider is legally authorized to perform the health care service for the individual and under the circumstances involved.

(4) A member may choose to receive health care services under the program from any participating provider, consistent with this chapter, the willingness or availability of the provider, subject to provisions of this chapter relating to discrimination, and the appropriate clinically relevant circumstances.

(5) A person who chooses to enroll with an integrated health care delivery system, group medical practice, or essential community provider that offers comprehensive services shall retain membership for at least one year after an initial three-month evaluation period during which time the person may withdraw for any reason.

(a) The three-month period commences on the date when a member first sees a primary care provider.

(b) A person who wants to withdraw after the initial three-month period shall request a withdrawal pursuant to the dispute resolution procedures established by the board and may request assistance from the patient advocate, which must be provided for in the dispute resolution procedures, in resolving the dispute. The dispute must be resolved in a timely fashion and not have an adverse effect on the care a patient receives.

NEW SECTION. **Sec.**  (1) Care coordination must be provided to the member by his or her care coordinator. A care coordinator may employ or utilize the services of other individuals or entities to assist in providing care coordination for the member, consistent with rules of the board and with the statutory requirements and rules of the care coordinator's licensure.

(2) Care coordination includes administrative tracking and medical recordkeeping services for members, except as otherwise specified for integrated health care delivery systems.

(3) Care coordination administrative tracking and medical recordkeeping services for members are not required to utilize a certified electronic health record, meet any other requirements of the federal health information technology for economic and clinical health act, enacted under the federal American recovery and reinvestment act of 2009 (P.L. 111-5), or meet certification requirements of the federal centers for medicare and medicaid services' electronic health records incentive programs, including meaningful use requirements.

(4) The care coordinator shall comply with all federal and state privacy laws including, but not limited to, the federal health insurance portability and accountability act (HIPAA; 42 U.S.C. Sec. 1320d et seq.) and its implementing regulations.

(5) Referrals from a care coordinator are not required for a member to see any eligible provider.

(6) A care coordinator may be an individual or entity that is approved by the program and is any of the following:

(a) A health care practitioner that is the member's primary care provider, the member's provider of primary gynecological care, or, at the option of a member who has a chronic condition that requires specialty care, a specialist health care practitioner who regularly and continually provides treatment to the member for that condition;

(b) An entity licensed by the state of Washington, such as the following: Health facility; health care service plan; long-term health care facility; residential care facility for persons with chronic, life-threatening illness; residential care facility for the elderly; home health agency; private duty nursing agency; hospice; pediatric day health and respite care facility; home care service; or mental health care provider;

(c) A health care organization;

(d) A Taft-Hartley health and welfare fund, with respect to its members and their family members. This provision does not preclude a Taft-Hartley health and welfare fund from becoming a care coordinator or a health care organization; or

(e) Any not-for-profit or governmental entity approved by the program.

(7)(a) A health care provider may only be reimbursed for services if the member is enrolled with a care coordinator at the time the health care service is provided.

(b) Every member is encouraged to enroll with a care coordinator that agrees to provide care coordination before receiving health care services to be paid for under the program. If a member receives health care services before choosing a care coordinator, the program must assist the member, when appropriate, with choosing a care coordinator.

(c) The member remains enrolled with that care coordinator until the member becomes enrolled with a different care coordinator or ceases to be a member. Members may change their care coordinators on terms at least as permissive as medicaid relating to an individual changing his or her primary care provider or managed care provider.

(8) A health care organization may establish rules relating to care coordination for members in the health care organization that are different from this section but otherwise consistent with this chapter and other applicable laws.

(9) An individual or entity may not be a care coordinator unless the services included in care coordination are within the individual's professional scope of practice or the entity's legal authority.

(10)(a) The board shall develop and implement procedures and standards, by rule, for an individual or entity to be approved as a care coordinator in the program including, but not limited to, procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the individual or entity is incompetent to be a care coordinator or has exhibited a course of conduct that is inconsistent with program standards and rules, that exhibits an unwillingness to meet those standards and rules, or is a potential threat to the public health or safety.

(b) The procedures and standards adopted by the board must be consistent with professional practice, licensure standards, and rules, as applicable.

(11) To maintain approval under the program, a care coordinator shall:

(a) Renew its status every three years pursuant to rules adopted by the board; and

(b) Provide to the program any data required that would enable the board to evaluate the impact of care coordinators on quality, outcomes, and cost of health care.

NEW SECTION. **Sec.**  (1) The board shall adopt rules regarding contracting for, and establishing payment methodologies for, covered health care services and care coordination provided to members under the program by participating providers, care coordinators, and health care organizations. There may be a variety of different payment methodologies, including those established on a demonstration basis. All payment rates under the program must be reasonable and reasonably related to the cost of efficiently providing the health care service and ensuring an adequate and accessible supply of health care services.

(2) Except as provided in subsection (3) of this section, health care services provided to members under the program, except for care coordination, must be paid for on a fee-for-service basis unless and until another payment methodology is established by the board.

(3) Integrated health care delivery systems, essential community providers, and group medical practices that provide comprehensive, coordinated services may choose to be reimbursed on a capitated basis or similar methodology that covers all costs of providing health care services.

(4) The program must engage in good faith negotiations with health care providers' representatives including, but not limited to, in relation to rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies. Those negotiations must be through a single entity on behalf of the entire program for prescription and nonprescription drugs.

(5)(a) Payment for health care services established under this chapter are considered payment in full.

(b) A participating provider must not charge any rate in excess of the payment established under this chapter for any health care service provided to a member under the program and not solicit or accept payment from any member or third party for any health care service, except as provided under a federal program.

(c) This section does not preclude the program from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program.

(6) The program may adopt, by rule, payment methodologies for the payment of capital-related expenses for specifically identified capital expenditures incurred by not-for-profit or governmental entities that are licensed health facilities. Any capital-related expense generated by a capital expenditure that requires prior approval must have received that approval to be paid by the program.

(7) Payment methodologies and payment rates must include a distinct component of reimbursement for direct and indirect graduate medical education.

(8) The board shall adopt, by rule, payment methodologies and procedures for paying for health care services provided to a member while the member is located out of the state.

NEW SECTION. **Sec.**  (1) A member may choose to enroll with and receive program care coordination and ancillary health care services from a health care organization.

(2) A health care organization must be a not-for-profit or governmental entity that is approved by the board.

(3)(a) The board shall develop and implement procedures and standards, by rule, for an entity to be approved as a health care organization in the program including, but not limited to, procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the entity is incompetent to be a health care organization or has exhibited a course of conduct that is inconsistent with program standards and rules, that exhibits an unwillingness to meet those standards and rules, or is a potential threat to the public health or safety.

(b) The procedures and standards adopted by the board must be consistent with professional practice and licensure standards as applicable.

(c) In developing and implementing standards of approval of health care organizations, the board shall consult with the department of health and department of social and health services.

(4) To maintain approval under the program, a health care organization shall:

(a) Renew its status at a frequency determined by the board; and

(b) Provide data to the department of social and health services, as required by the board, to enable the board to evaluate the health care organization in relation to the quality of health care services, health care outcomes, and cost.

(5) The board may adopt narrowly focused rules relating solely to health care organizations for the sole and specific purpose of ensuring consistent compliance with this chapter.

(6) This section may not be construed to alter the professional practice of health care providers or their licensure standards established in Title 18 RCW.

(7) Health care organizations must not use health information technology or clinical practice guidelines that limit the effective exercise of the professional judgment of physicians and registered nurses. Physicians and registered nurses may override health information technology and clinical practice guidelines if, in their professional judgment, it is in the best interest of the patient and consistent with the patient's wishes.

NEW SECTION. **Sec.**  Healthy Washington shall establish a single standard of safe, therapeutic care for all residents of the state by the following means:

(1) The board shall establish requirements and standards, by rule, for the program and for health care organizations, care coordinators, and health care providers, consistent with this chapter and consistent with the applicable professional practice and licensure standards as applicable:

(a) The scope, quality, and accessibility of health care services;

(b) Relations between health care organizations or health care providers and members; and

(c) Relations between health care organizations and health care providers, including credentialing and participation in the health care organization, and terms, methods, and rates of payment.

(2) The board shall establish requirements and standards, by rule, under the program that include, but are not limited to, provisions to promote all of the following:

(a) Simplification, transparency, uniformity, and fairness in health care provider credentialing and participation in health care organization networks, referrals, payment procedures and rates, claims processing, and approval of health care services, as applicable;

(b) In-person primary and preventive care, care coordination, efficient and effective health care services, quality assurance, and promotion of public, environmental, and occupational health;

(c) Elimination of health care disparities;

(d) Nondiscrimination with respect to members and health care providers on the basis of race, color, ancestry, national origin, religion, citizenship, immigration status, primary language, mental or physical disability, age, sex, gender, sexual orientation, gender identity or expression, medical condition, genetic information, marital status, familial status, military or veteran status, or source of income; however, health care services provided under the program must be appropriate to the patient's clinically relevant circumstances;

(e) Accessibility of care coordination, health care organization services, and health care services, including accessibility for persons with disabilities and persons with limited ability to speak or understand English; and

(f) Provision of care coordination, health care organization services, and health care services in a culturally competent manner.

(3) The board shall establish requirements and standards, to the extent authorized by federal law, by rule, for replacing and merging with the healthy Washington program health care services and ancillary services currently provided by other programs including, but not limited to, medicare, programs offered under the affordable care act, and federally matched public health programs.

(4) Any participating provider or care coordinator that is organized as a for-profit entity is required to meet the same requirements and standards as entities organized as not-for-profit entities, and payments under the program paid to those entities must not be calculated to accommodate the generation of profit, revenue for dividends, or other return on investment or the payment of taxes that would not be paid by a not-for-profit entity.

(5) Every participating provider shall furnish information as required by the board to permit examination of that information by the program as may be reasonably required for purposes of reviewing accessibility and utilization of health care services, quality assurance, cost containment, the making of payments, and statistical or other studies of the operation of the program or for protection and promotion of public, environmental, and occupational health.

(6) In developing requirements and standards and making other policy determinations under this chapter, the board shall consult with representatives of members, health care providers, care coordinators, health care organizations, labor organizations representing health care employees, and other interested parties.

NEW SECTION. **Sec.**  (1) The board shall seek all federal waivers and other federal approvals and arrangements and submit state plan amendments as necessary to operate the program consistent with this chapter.

(2)(a) The board shall apply to the United States secretary of health and human services or other appropriate federal official for all waivers of requirements, and make other arrangements, under medicare, any federally matched public health program, programs offered under the affordable care act, and any other federal programs that provide federal funds for payment for health care services that are necessary to enable all healthy Washington members to receive all benefits under the program through the program, to enable the state to implement this chapter, and to allow the state to receive and deposit all federal payments under those programs, including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits, in the state treasury to the credit of the healthy Washington trust fund and to use those funds for the program and other provisions under this chapter.

(b) To the fullest extent possible, the board shall negotiate arrangements with the federal government to ensure that federal payments are paid to healthy Washington in place of federal funding of, or tax benefits for, federally matched public health programs or federal health programs.

(c) The board may require members or applicants to provide information necessary for the program to comply with any waiver or arrangement under this chapter. Information provided by members to the board for the purposes of this subsection (2)(c) must not be used for any other purpose.

(d) The board may take any additional actions necessary to effectively implement healthy Washington to the maximum extent possible as a single-payer program consistent with this chapter.

(3) The board may take actions consistent with this chapter to enable the program to administer medicare in Washington, and the program must be a provider of supplemental insurance coverage (medicare part B) and provide premium assistance drug coverage under medicare part D for eligible members of the program.

(4) The board may waive or modify the applicability of any provisions of this section relating to any federally matched public health program or medicare, as necessary, to implement any waiver or arrangement under this section or to maximize the federal benefits to the program under this section, provided that the board, in consultation with the office of financial management, determines that the waiver or modification is in the best interest of the state and members affected by the action.

(5) The board may apply for coverage for, and enroll, any eligible member under any federally matched public health program or medicare. Enrollment in a federally matched public health program or medicare must not cause any member to lose any health care service provided by the program or diminish any right the member would otherwise have.

(6)(a) The board, by rule, shall increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally matched public health program and for any program to reduce or eliminate an individual's coinsurance, cost sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to medicare or any program created under the affordable care act.

(b) The board may act under this subsection (6) upon a finding approved by the office of financial management and the board that the action does all of the following:

(i) Will help to increase the number of members who are eligible for and enrolled in federally matched public health programs, or for any program to reduce or eliminate an individual's coinsurance, cost sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to medicare or any program created under the affordable care act;

(ii) Will not diminish any individual's access to any health care service or right the individual would otherwise have;

(iii) Is in the interest of the program;

(iv) Does not require or has received any necessary federal waivers or approvals to ensure federal financial participation;

(c) Actions under this subsection (6) do not apply to eligibility for payment for long-term care;

(7) To enable the board to apply for coverage for, and enroll, any eligible member under any federally matched public health program or medicare, the board may require that every member or applicant provide the information necessary to enable the board to determine whether the applicant is eligible for a federally matched public health program or for medicare, or any program or benefit under medicare.

(8) As a condition of continued eligibility for health care services under the program, a member who is eligible for benefits under medicare shall enroll in medicare, including parts A, B, and D.

(9) The program must provide premium assistance for all members enrolling in a medicare part D drug coverage plan under section 1860D of Title XVIII of the federal social security act (42 U.S.C. Sec. 1395w-101 et seq.), limited to the low-income benchmark premium amount established by the federal centers for medicare and medicaid services and any other amount the federal agency establishes under its de minimis premium policy, except that those payments made on behalf of members enrolled in a medicare advantage plan may exceed the low-income benchmark premium amount if determined to be cost-effective to the program.

(10) If the board has reasonable grounds to believe that a member may be eligible for an income-related subsidy under section 1860D-14 of Title XVIII of the federal social security act (42 U.S.C. Sec. 1395w-114), the member shall provide, and authorize the program to obtain, any information or documentation required to establish the member's eligibility for that subsidy; however, the board shall attempt to obtain as much of the information and documentation as possible from records that are available to it.

(11) The program must make a reasonable effort to notify members of their obligations under this section. After a reasonable effort has been made to contact the member, the member must be notified in writing that he or she has sixty days to provide the required information. If the required information is not provided within the sixty-day period, the member's coverage under the program may be terminated. Information provided by members to the board for the purposes of this section must not be used for any other purpose. The board shall assume responsibility for all benefits and services paid for by the federal government with those funds.

NEW SECTION. **Sec.**  (1) The healthy Washington trust fund is created in the state treasury. All moneys in the fund must be continuously appropriated without regard to fiscal year for the purposes of this chapter. Any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year.

(2) Moneys deposited in the fund must not be loaned to, or borrowed by, any other special fund or the general fund, a county general fund, or any other county fund.

(3) The board shall establish and maintain a prudent reserve in the fund.

(4) The board or staff of the board shall not utilize any funds intended for the administrative and operational expenses of the board for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

(5) All interest earned on the moneys that have been deposited into the fund must be retained in the fund and used for purposes consistent with the fund.

(6) The fund consists of all of the following:

(a) All moneys obtained pursuant to legislation enacted as proposed under section 24 of this act;

(b) Federal payments received as a result of any waiver of requirements granted or other arrangements agreed to by the United States secretary of health and human services or other appropriate federal officials for health care programs established under medicare, any federally matched public health program, or programs established under the affordable care act;

(c) The amounts paid by the state that are equivalent to those amounts that are paid on behalf of residents of this state under medicare, any federally matched public health program, or programs established under the affordable care act for health benefits that are equivalent to health benefits covered under healthy Washington;

(d) Federal and state funds for purposes of the provision of services authorized under Title XX of the federal social security act (42 U.S.C. Sec. 1397 et seq.) that would otherwise be covered under healthy Washington; and

(e) State moneys that would otherwise be appropriated to any governmental agency, office, program, instrumentality, or institution that provides health care services for services and benefits covered under healthy Washington. Payments to the fund under this section must be in an amount equal to the money appropriated for those purposes in the fiscal year beginning immediately preceding the effective date of this section.

(7) All federal moneys must be placed into the healthy Washington federal funds account, which is hereby created within the healthy Washington trust fund.

(8) Moneys in the fund may only be used for the purposes established in this chapter.

NEW SECTION. **Sec.**  (1) It is the intent of the legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for the program. In developing the revenue plan, it is the intent of the legislature to consult with appropriate officials and stakeholders.

(2) It is the intent of the legislature to enact legislation that would require all state revenues from the program to be deposited in an account within the healthy Washington trust fund to be established and known as the healthy Washington trust fund account.

NEW SECTION. **Sec.**  For purposes of this section and sections 26 through 28 of this act, the following definitions apply:

(1)(a) "Health care provider" means a person who is licensed, certified, registered, or authorized to practice a health care profession pursuant to Title 18 RCW and who is any of the following:

(i) An individual who practices that profession as a health care provider or as an independent contractor;

(ii) An owner, officer, shareholder, or proprietor of a health care provider; or

(iii) An entity that employs or utilizes health care providers to provide health care services including, but not limited to, a health facility licensed in Washington state.

(b) A health care provider who practices as an employee of a health care provider is not a health care provider for purposes of this subchapter.

(2) "Health care providers' representative" means a third party that is authorized by health care providers to negotiate on their behalf with healthy Washington over terms and conditions affecting those health care providers.

NEW SECTION. **Sec.**  (1) Health care providers may meet and communicate for the purpose of collectively negotiating with healthy Washington on any matter relating to healthy Washington including, but not limited to, rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies.

(2) This subchapter must not be construed to:

(a) Allow or authorize an alteration of the terms of the internal and external review procedures set forth in law;

(b) Allow a strike of healthy Washington by health care providers related to the collective negotiations; or

(c) Allow or authorize terms or conditions that would impede the ability of healthy Washington to obtain or retain accreditation by the national committee for quality assurance or a similar body, or to comply with applicable state or federal law.

NEW SECTION. **Sec.**  (1) Collective negotiation rights granted under this subchapter must meet all of the following requirements:

(a) Health care providers may communicate with other health care providers regarding the terms and conditions to be negotiated with healthy Washington.

(b) Health care providers may communicate with health care providers' representatives.

(c) A health care providers' representative is the only party authorized to negotiate with healthy Washington on behalf of the health care providers as a group.

(d) A health care provider can be bound by the terms and conditions negotiated by the health care providers' representatives.

(e) In communicating or negotiating with the health care providers' representative, healthy Washington is entitled to offer and provide different terms and conditions to individual competing health care providers.

(2) This subchapter does not affect or limit:

(a) The right of a health care provider or group of health care providers to collectively petition a governmental entity for a change in a law, rule, or regulation; or

(b) Collective action or collective bargaining on the part of a health care provider with his or her employer or any other lawful collective action or collective bargaining.

(3) Before engaging in collective negotiations with healthy Washington on behalf of health care providers, a health care providers' representative shall file with the board, in the manner prescribed by the board, information identifying the representative, the representative's plan of operation, and the representative's procedures to ensure compliance with this subchapter.

(4) Each person who acts as the representative of negotiating parties under this subchapter shall pay a fee to the board to act as a representative. The board, by rule, shall set fees in amounts deemed reasonable and necessary to cover the costs incurred by the board in administering this subchapter.

NEW SECTION. **Sec.**  (1) This subchapter does not authorize competing health care providers to act in concert in response to a health care providers' representative's discussions or negotiations with healthy Washington, except as authorized by other law.

(2) A health care providers' representative must not negotiate any agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care provider or group of health care providers with respect to the performance of services that are within the health care provider's scope of practice, license, registration, or certificate.

NEW SECTION. **Sec.**  The legislature finds and declares that this chapter imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies. The legislature declares it is necessary for that information to remain confidential to protect private, confidential, and proprietary information.

NEW SECTION. **Sec.**  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.**  Sections 1 through 29 of this act constitute a new chapter in Title 43 RCW.

NEW SECTION. **Sec.**  (1) This act takes effect when the executive director of the healthy Washington board notifies the secretary of the senate and the chief clerk of the house of representatives in writing that he or she has determined that the healthy Washington trust fund has the revenues to fund the costs of implementing this act.

(2) The board shall publish a copy of the notice on its internet web site.

**--- END ---**