2590-S AMH H4754.3

SHB 2590 - H AMD **0077 FAILED 2/12/92**
By Representatives Moyer, Schmidt, Bowman and Tate

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** The legislature finds that the well-being of Washington citizens is directly related to the availability of quality health care. It also finds that Washington citizens must be able to purchase and keep health care coverage to ensure that they will have health care when it is needed. The legislature further finds that its role is to be a catalyst in working with all health care providers to achieve universal access to health care. It is the intent of the legislature to take the lead by increasing citizen access, securing health care cost containment, and restricting medical malpractice liability. Access will be increased by the health care commission's development of alternative uniform benefit plans, through expanding the basic health plan, ensuring small business employers affordable health care coverage, assisting issuers with stoploss protection, and seeking a medicare supplement for its retired state employees. Immediate cost containment measures include recording costs on patients' charts and standardizing claim forms. Long-range cost containment measures include health cost data collecting, finding alternatives to cost shifting by providers, and researching purchase of medicaid medical care through private contractors. Liability will be restricted by statutorily establishing attorney contingent fee rates, requiring a certificate of merit before a cause is filed, purchasing malpractice insurance for retired physicians volunteering their time in public,

free clinics, and developing an affirmative defense based on practice parameters. It is not the intent of this chapter to provide health care services for those persons who are presently covered through private employer-based health plans, nor to replace employer-based health plans. Further, it is the intent of the legislature to expand, wherever possible, the availability of private health care coverage and to discourage the decline of employer-based coverage."

"PART I - HEALTH CARE ACCESS"

"NEW SECTION. **Sec. 2.** DUTIES AND RESPONSIBILITIES. In addition to the duties and responsibilities specified in House Concurrent Resolution No. 4443 adopted by the legislature in 1990, the health care cost and access commission authorized therein shall in its report to the legislature and the governor on November 1, 1992, make recommendations on the following:

(1) Recommend proposed alternative uniform benefit plans that the legislature should consider, including estimates of the cost of each alternative plan and recommendations on copayments, deductibles, and premium sharing that should be included; and

(2) Analyze the effects and implications of the Employee's Retirement Income Security Act (ERISA) self-funding provisions and the need for changes in federal law."

"**Sec. 3.** RCW 70.47.020 and 1987 1st ex.s. c 5 s 4 are each amended to read as follows:

As used in this chapter:

(1) "Washington basic health plan" or "plan" means the system of enrollment and payment on a prepaid capitated basis for basic health

care services, administered by the plan administrator through participating managed health care systems, created by this chapter.

(2) "Administrator" means the Washington basic health plan administrator.

(3) "Managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the administrator and rendered by duly licensed providers, on a prepaid capitated basis to a defined patient population enrolled in the plan and in the managed health care system.

(4) "Enrollee" means both system and nonsubsidized enrollees.

(5) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children, or both, all under the age of sixty-five and not otherwise eligible for medicare, who is a resident of the state of Washington, whose gross family income at the time of enrollment is between two hundred percent and three hundred percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services, and who chooses to obtain basic health coverage as determined under this chapter from a particular managed health care system in return for periodic payments to the plan that reflect the full cost of the plan plus costs of administration.

(6) "System enrollee" means an individual, or an individual plus the individual's spouse ((~~and/~~))or dependent children, or both, all under the age of sixty-five and not otherwise eligible for medicare, who resides in an area of the state served by a managed health care system participating in the plan, whose gross family income at the time of enrollment does not exceed ((~~twice~~)) two hundred percent of the federal poverty level as adjusted for family size and determined

annually by the federal department of health and human services, who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan.

((~~(5)~~)) (7) "Subsidy" means the difference between the amount of periodic payment the administrator makes, from funds appropriated from the basic health plan trust account, to a managed health care system on behalf of an enrollee and the amount determined to be the enrollee's responsibility under RCW 70.47.060(2).

((~~(6)~~)) (8) "Premium" means a periodic payment((~~,~~)). A premium based upon gross family income and determined under RCW 70.47.060(2)((~~, which an~~)) is one a system enrollee makes to the plan as consideration for enrollment in the plan. A premium equal to the rate charged by the plan as provided in RCW 70.47.060(2) is one paid by a nonsubsidized enrollee plus the cost of administration.

((~~(7)~~)) (9) "Rate" means the per capita amount, negotiated by the administrator with and paid to a participating managed health care system, that is based upon the enrollment of enrollees in the plan and in that system."

"**Sec. 4.** RCW 70.47.030 and 1991 sp.s. c 13 s 68 and 1991 sp.s. c 4 s 1 are each reenacted and amended to read as follows:

The basic health plan trust account is hereby established in the state treasury. All nongeneral fund-state funds collected for this program shall be deposited in the basic health plan trust account and may be expended without further appropriation. Moneys in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of enrollees in the plan and payment of costs of administering the plan. After July 1, 1991, the administrator shall not expend or encumber for an ensuing fiscal period amounts exceeding ninety-five percent of the

amount anticipated to be spent for purchased services during the fiscal year. Funds from the trust account or from enrollee premiums or other types of enrollee financial participation may not be expended to underwrite nonsubsidized enrollees' coverage in any amount."

"**Sec. 5.** RCW 70.47.060 and 1991 sp.s. c 4 s 2 and 1991 c 3 s 339 are each reenacted and 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, and other services that may be necessary for basic health care, which enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care, shall include all services necessary for prenatal, postnatal, and well-child care, and shall include a separate schedule of basic health care services for children, eighteen years of age and younger, for those 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.

(2)(a) To design and implement a structure of periodic premiums due the administrator from system enrollees that is based upon gross family income, giving appropriate consideration to family size as well as the ages of all family members.

(b) The premiums due the administrator from nonsubsidized enrollees must equal the unsubsidized rate required for the managed health care

system in which those enrollees are enrolled. The nonsubsidized enrollee is primarily responsible for staying current with his or her premium schedule. However, a responsible third party who files a statement of obligation with the administrator may assume responsibility for the nonsubsidized enrollee's premiums. The statement of obligation must identify the third party's relationship to the nonsubsidized enrollee, state the third party's address, and contain other information, statements, or disclaimers required by the administrator by rule.

(c) The enrollment of children shall not require the enrollment of their parent or parents who are eligible for the plan.

(3) To design and implement a structure of nominal copayments due a managed health care system from system 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.

(4) To design and implement, in concert with a sufficient number of potential providers in a discrete area, ((~~an~~)) a system enrollee financial participation structure, separate from that otherwise established under this chapter, that has the following characteristics:

(a) Nominal premiums that are based upon ability to pay, but not set at a level that would discourage enrollment;

(b) A modified fee-for-services payment schedule for providers;

(c) Coinsurance rates that are established based on specific service and procedure costs and the system enrollee's ability to pay for the care. However, coinsurance rates for families with incomes below one hundred twenty percent of the federal poverty level shall be nominal. No coinsurance shall be required for specific proven prevention programs, such as prenatal care. The coinsurance rate

levels shall not have a measurable negative effect upon the system enrollee's health status; and

(d) A case management system that fosters a provider-enrollee relationship whereby, in an effort to control cost, maintain or improve the health status of the system enrollee, and maximize patient involvement in her or his health care decision-making process, every effort is made by the provider to inform the system enrollee of the cost of the specific services and procedures and related health benefits.

The potential financial liability of the plan to any such providers shall not exceed in the aggregate an amount greater than that which might otherwise have been incurred by the plan on the basis of the number of system enrollees multiplied by the average of the prepaid capitated rates negotiated with participating managed health care systems under RCW 70.47.100 and reduced by any sums charged system enrollees on the basis of the coinsurance rates that are established under this subsection.

(5) 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.

(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.

In the selection of any area of the state for the initial operation of the plan, the administrator shall take into account the levels and rates of unemployment in different areas of the state, the need to provide basic health care coverage to a population reasonably representative of the portion of the state's population that lacks such

coverage, and the need for geographic, demographic, and economic diversity. When the number of applicants for nonsubsidized enrollment from a community not covered by a managed health care system becomes economically feasible to establish a managed health care system for that area, the administrator shall: (a) Publish in the state register a determination of economic feasibility; and (b) institute a managed health care system in that area within one year from the date of publication.

Before July 1, 1988, the administrator shall endeavor to secure participation contracts with managed health care systems in discrete geographic areas within at least five congressional districts.

(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.

(8) To receive periodic premiums from enrollees or third parties as provided in subsection (2) of this section, 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)(a) 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, to establish appropriate minimum-enrollment periods for enrollees as may be necessary((~~, and~~)).

(b) To determine, upon application and at least annually thereafter, or at the request of any system enrollee, or at the request of a nonsubsidized enrollee who states that the enrollee or his or her family, or both, now qualify as system enrollees, eligibility due to current gross family income for sliding scale premiums. An enrollee who remains current in payment of the sliding-scale premium, as determined under subsection (2) of this section, and whose gross family income has risen above ((~~twice~~)) two hundred percent of the federal poverty level, may continue enrollment unless and until the enrollee's gross family income has remained above ((~~twice~~)) two hundred percent of the poverty level for six consecutive months, by making payment at the unsubsidized rate required for the managed health care system in which he or she may be enrolled. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds ((~~twice~~)) two hundred percent of 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 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.

(c) To determine, upon request by a nonsubsidized enrollee, eligibility based on the gross family income over the preceding six months for subsidized programs offered system enrollees. The administrator shall cancel, upon notice, the enrollment of a nonsubsidized enrollee who remains current in his or her premiums due the Washington basic health plan and whose gross family income exceeds three hundred percent of the poverty level for six consecutive months.

The administrator may adopt rules governing the reenrollment of nonsubsidized enrollees whose enrollment is canceled or who drop their enrollment for no apparent good cause.

(10) 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.

(11) 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 administrator. 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.

(12) To monitor the access that state residents have to adequate and necessary health care services, determine the extent of any unmet

needs for such services or lack of access that may exist from time to time, identify the number of state residents who may be eligible enrollees yet who are not within an area covered by a managed health care system, and make such reports and recommendations to the legislature as the administrator deems appropriate.

(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 resources, technical assistance for rural health activities that endeavor to develop needed health care services in rural parts of the state."

"**Sec. 6.** RCW 70.47.080 and 1987 1st ex.s. c 5 s 10 are each amended to read as follows:

On and after July 1, 1988, the administrator shall accept for enrollment applicants eligible to receive covered basic health care services from the respective managed health care systems which are then participating in the plan. The administrator shall not allow the total enrollment of those eligible for subsidies to exceed thirty thousand.

Thereafter, total enrollment shall not exceed the number established by the legislature in any act appropriating funds to the plan.

Before July 1, ((~~1988~~)) 1993, the administrator shall endeavor to secure participation contracts from managed health care systems in discrete geographic areas ((~~within at least five congressional districts of the state and~~)) in such manner as to allow residents of

both urban and rural areas access to enrollment in the plan. The administrator shall make a special effort to secure agreements with health care providers in one such area that meets the requirements set forth in RCW 70.47.060(4) and (6).

The administrator shall at all times closely monitor growth patterns of enrollment so as not to exceed that consistent with the orderly development of the plan as a whole, in any area of the state or in any participating managed health care system."

"NEW SECTION. **Sec. 7.** A new section is added to chapter 70.47 RCW to read as follows:

BASIC HEALTH PLAN ENROLLMENT EXPANSION. The state basic health plan is authorized to expand the number of state-subsidized enrollments from up to twenty-four thousand, as is specified in 1991-93 biennial operating budget, section 230, chapter 16, Laws of 1991 sp. sess., to an enrollment limit of up to sixty-four thousand. If specific funding for the purposes of this section, referencing this act by bill number, is not provided by June 30, 1992, in the omnibus appropriations act, this section shall become null and void."

"**Sec. 8.** RCW 43.131.355 and 1987 1st ex.s. c 5 s 24 are each amended to read as follows:

The Washington basic health plan administrator and its powers and duties shall be terminated on June 30, ((~~1992~~)) 1994, as provided in RCW 43.131.356."

"**Sec. 9.** RCW 43.131.356 and 1987 1st ex.s. c 5 s 25 are each amended to read as follows:

The following acts or parts of acts, as now existing or hereafter amended, are each repealed, effective June 30, ((~~1993~~)) 1995:

(1) Section 1, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.900;

(2) Section 2, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.140;

(3) Section 3, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.010;

(4) Section 4, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.020;

(5) Section 5, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.030;

(6) Section 6, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.040;

(7) Section 7, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.050;

(8) Section 8, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.060;

(9) Section 9, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.070;

(10) Section 10, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.080;

(11) Section 11, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.090;

(12) Section 12, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.100;

(13) Section 13, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.110;

(14) Section 14, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.120;

(15) Section 15, chapter 5, Laws of 1987 1st ex.s. and RCW 70.47.130;

(16) Section 16, chapter 5, Laws of 1987 1st ex.s. and RCW 50.20.210;

(17) Section 17, chapter 5, Laws of 1987 1st ex.s. and RCW 51.28.090; and

(18) Section 18, chapter 5, Laws of 1987 1st ex.s. and RCW 74.04.033."

"NEW SECTION. **Sec. 10.** For the purposes of sections 11 through 19 of this act:

The legislature finds that small business employers are unable to buy affordable health care coverage for their employees that is comparable in cost and benefits or service to that available to larger businesses. It further finds that this inability directly affects Washington citizens' access to health care. It is, therefore, the intent of the legislature to make certain that all citizens have equal access to health care coverage through their employers. Thus, it is the further intent of the legislature to insure this access regardless of the size of the employer's business enterprise."

"NEW SECTION. **Sec. 11.** Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Issuer" means group disability insurers as defined in chapter 48.21 RCW, health service contractors as defined in chapter 48.44 RCW, and health maintenance organizations as defined in chapter 48.46 RCW.

(2) "Small employer" and "employer" mean a business which, during the most recent calendar year, employed at least three and not more than fifty employees who are eligible for coverage under a health care benefit plan on at least fifty percent of that business' working days.

(3) "Health care benefit plan" and "plan" mean any group policy, contract, or agreement, which provides medical, surgical, or hospital care or benefits to employees of a small employer and their dependents.

(4) "Premium" means consideration for issuance and administration of a policy, contract, or agreement."

"NEW SECTION. **Sec. 12.** (1)(a) An issuer providing a health care benefit plan to a small employer may refuse to renew the plan, without penalties, for any of the following reasons:

(i) Nonpayment of required premium;

(ii) Fraud or misrepresentation on the part of the employer; or

(iii) Noncompliance with provisions of the plan regarding minimum numbers of or percentages of insured employees;

(b) The refusal to renew a group health care benefit plan requires ninety days written notice to the group.

(2) If an issuer refuses to renew a health care benefit plan for any reason not under subsection (1)(a) of this section the issuer may not accept any new small employer business for a period of two years after it provides notice of such refusal.

(3) Nothing in this section is intended to prevent any issuer from rescinding or refusing to renew the coverage of any individual employee or dependent of that employee for fraud or material misrepresentation."

"NEW SECTION. **Sec. 13.** (1) An issuer shall establish the premium rate in accordance with the issuer's table, contractor's table, or organization's table of premium rates applicable to the age and class of risk of each person to be covered under the policy. However, no issuer shall charge any single group a rate greater than two times that of the lowest rate the issuer charges to any small business employer in the state.

(2) No issuer may increase the annual premium, subject to the limitations under subsection (1) of this section, by more than:

(a) The percentage change in the new business premium rate for employers with similar characteristics as measured between the first day of the calendar year in which the new rates take effect and the first day of the prior calendar year for groups with similar characteristics; plus

(b) Fifteen percent annually based on group experience; plus

(c) An adjustment because of changes in the coverage provided or changes in the work force characteristics of the employer."

"NEW SECTION. **Sec. 14.** No issuer may refuse to offer coverage under a health care benefit plan to employees of a small employer based solely on the nature of the employer's business. An issuer may charge additional premiums based on the nature of the employer's business that do not exceed one hundred fifty percent of the total premium that would be charged to that employer under section 12 of this act regardless of the nature of the employer's business."

"**Sec. 15.** RCW 48.21.260 and 1984 c 190 s 3 are each amended to read as follows:

(1) Except as otherwise provided by this section, any group disability insurance policy issued, renewed, or amended on or after January 1, 1985, that provides benefits for hospital or medical expenses shall contain a provision granting a person covered by the group policy the right to obtain a conversion policy from the insurer upon termination of the person's eligibility for coverage under the group policy.

(2) An insurer need not offer a conversion policy to:

(a) A person whose coverage under the group policy ended when the person's employment or membership was terminated for misconduct: PROVIDED, That when a person's employment or membership is terminated for misconduct, a conversion policy shall be offered to the spouse and/or dependents of the terminated employee or member. The policy shall include in the conversion provisions the same conversion rights and conditions which are available to employees or members and their spouses and/or dependents who are terminated for reasons other than misconduct; or

(b) A person who is ((~~eligible for federal Medicare coverage; or~~

~~(c) A person who is~~)) covered under another group plan, policy, contract, or agreement providing benefits for hospital or medical care.

(3) To obtain the conversion policy, a person must submit a written application and the first premium payment for the conversion policy not later than thirty-one days after the date the person's group coverage terminates. The conversion policy shall become effective, without lapse of coverage, immediately following termination of coverage under the group policy.

(4) If an insurer or group policyholder does not renew, cancels, or otherwise terminates the group policy, the insurer shall offer a conversion policy to any person who was covered under the terminated policy unless the person is eligible to obtain group hospital or medical expense coverage within thirty-one days after such nonrenewal, cancellation, or termination of the group policy.

(5) The insurer shall determine the premium for the conversion policy in accordance with the insurer's table of premium rates applicable to the age and class of risk of each person to be covered under the policy and the type and amount of benefits provided. The benefits offered shall not be less than those in the group policy and the individual premium shall not exceed one hundred thirty-five percent of the rate that would have been offered under the same plan in the same time period. The insurer may apply any benefits already paid under the plan against the benefit limits of the conversion policy providing that it shall also credit the insured with any waiting period, deductible, or coinsurance previously credited under the plan.

(6) If the insured is eligible for medicare the insurer shall offer a medigap policy providing supplemental benefits to medicare. The total benefits when combined with medicare shall not be less than those in the group policy. The individual premium shall not exceed seventy-five percent of the rate that is offered under the group plan. The insurer may apply any benefits already paid under the plan against the benefit limits of the conversion policy providing that it shall also

credit the insured with any waiting period, deductible, or coinsurance previously credited under the plan."

"**Sec. 16.** RCW 48.44.370 and 1984 c 190 s 6 are each amended to read as follows:

(1) Except as otherwise provided by this section, any group health care service contract entered into or renewed on or after January 1, 1985, that provides benefits for hospital or medical expenses shall contain a provision granting a person covered by the group contract the right to obtain a conversion contract from the contractor upon termination of the person's eligibility for coverage under the group contract.

(2) A contractor need not offer a conversion contract to:

(a) A person whose coverage under the group contract ended when the person's employment or membership was terminated for misconduct: PROVIDED, That when a person's employment or membership is terminated for misconduct, a conversion policy shall be offered to the spouse and/or dependents of the terminated employee or member. The policy shall include in the conversion provisions the same conversion rights and conditions which are available to employees or members and their spouses and/or dependents who are terminated for reasons other than misconduct; or

(b) A person who is ((~~eligible for federal Medicare coverage; or~~

~~(c) A person who is~~)) covered under another group plan, policy, contract, or agreement providing benefits for hospital or medical care.

(3) To obtain the conversion contract, a person must submit a written application and the first premium payment for the conversion contract not later than thirty-one days after the date the person's eligibility for group coverage terminates. The conversion contract

shall become effective, without lapse of coverage, immediately following termination of coverage under the group contract.

(4) If a health care service contractor or group contract holder does not renew, cancels, or otherwise terminates the group contract, the health care service contractor shall offer a conversion contract to any person who was covered under the terminated contract unless the person is eligible to obtain group hospital or medical expense coverage within thirty-one days after such nonrenewal, cancellation, or termination of the group contract.

(5) The health care service contractor shall determine the premium for the conversion contract in accordance with the contractor's table of premium rates applicable to the age and class of risk of each person to be covered under the contract and the type and amount of benefits provided. The benefits offered shall not be less than those in the group contract and the individual premium shall not exceed one hundred thirty-five percent of the rate that would have been offered under the same plan in the same time period. The insurer may apply any benefits already paid under the plan against the benefit limits of the conversion policy providing that it shall also credit the insured with any waiting period, deductible, or coinsurance previously credited under the plan.

(6) If the person covered under the group contract is eligible for medicare the contractor shall offer medigap coverage providing supplemental benefits to medicare. The total benefits when combined with medicare shall not be less than those in the group plan. The individual premium shall not exceed seventy-five percent of the rate that is offered under the group plan. The insurer may apply any benefits already paid under the plan against the benefit limits of the conversion policy providing that it shall also credit the insured with

any waiting period, deductible, or coinsurance previously credited under the plan."

"**Sec. 17.** RCW 48.46.450 and 1984 c 190 s 9 are each amended to read as follows:

(1) Except as otherwise provided by this section, any group health maintenance agreement entered into or renewed on or after January 1, 1985, that provides benefits for hospital or medical care shall contain a provision granting a person covered by the group agreement the right to obtain a conversion agreement from the health maintenance organization upon termination of the person's eligibility for coverage under the group agreement.

(2) A health maintenance organization need not offer a conversion agreement to:

(a) A person whose coverage under the group agreement ended when the person's employment or membership was terminated for misconduct: PROVIDED, That when a person's employment or membership is terminated for misconduct, a conversion policy shall be offered to the spouse and/or dependents of the terminated employee or member. The policy shall include in the conversion provisions the same conversion rights and conditions which are available to employees or members and their spouses and/or dependents who are terminated for reasons other than misconduct; or

(b) A person who is ((~~eligible for federal Medicare coverage; or~~

~~(c) A person who is~~)) covered under another group plan, policy, contract, or agreement providing benefits for hospital or medical care.

(3) To obtain the conversion agreement, a person must submit a written application and the first premium payment for the conversion agreement not later than thirty-one days after the date the person's eligibility for group coverage terminates. The conversion agreement

shall become effective without lapse of coverage, immediately following termination of coverage under the group agreement.

(4) If a health maintenance organization or group agreement holder does not renew, cancels, or otherwise terminates the group agreement, the health maintenance organization shall offer a conversion agreement to any person who was covered under the terminated agreement unless the person is eligible to obtain group benefits for hospital or medical care within thirty-one days after such nonrenewal, cancellation, or termination of the group agreement.

(5) The health maintenance organization shall determine the premium for the conversion agreement in accordance with the organization's table of premium rates applicable to the age and class of risk of each person to be covered under the agreement and the type and amount of benefits provided. The benefits offered shall not be less than those in the group agreement and the individual premium shall not exceed one hundred thirty-five percent of the rate that would have been offered under the same plan in the same time period. The insurer may apply any benefits already paid under the plan against the benefit limits of the conversion policy providing that it shall also credit the insured with any waiting period, deductible, or coinsurance previously credited under the plan.

(6) If the person covered under the group agreement is eligible for medicare the contractor shall offer medigap coverage providing supplemental benefits to medicare. The total benefits when combined with medicare shall not be less than those in the group plan. The individual premium shall not exceed seventy-five percent of the rate that is offered under the group plan. The insurer may apply any benefits already paid under the plan against the benefit limits of the conversion policy providing that it shall also credit the insured with

any waiting period, deductible, or coinsurance previously credited under the plan."

"NEW SECTION. **Sec. 18.** No issuer offering a health care benefit plan may refuse to accept for coverage under the plan, any person employed after the effective date of the policy, who on the date of application for the coverage is eligible, if that person has, as of that date, been continuously covered under a health care benefit plan or other employer provided health care coverage for a period of one year. However, the issuer may refuse to insure the employee for health underwriting considerations, sufficient to qualify the person as a high risk eligible for the Washington health insurance pool, or because the employee was previously insured by a policy issued by any state high risk pool. If a new employee is refused coverage, the employer shall facilitate coverage through the Washington state health insurance pool, under chapter 48.41 RCW, and pay the same premium amount to the pool as he or she is paying for the group coverage for the other employees. If the pool premium is a greater amount, the employee and employer shall negotiate the difference as part of the employment contract. An issuer does not need to provide benefits greater than those provided to a person insured as a standard risk under the health care benefit plan or greater than those that would have been provided under prior coverage had it remained in force if they were greater than the standard risk. For purposes of this section, a person is deemed to be continuously covered for a period of one year if the person is insured at the beginning and end of that period and has not had any breaks in coverage during that period totaling more than thirty-one days."

"**Sec. 19.** RCW 48.21.030 and 1947 c 79 s .21.03 are each amended to read as follows:

(1) A policy of group disability insurance may be issued to a corporation, as policyholder, existing primarily for the purpose of assisting individuals who are its subscribers in securing medical, hospital, dental, and other health care services for themselves and their dependents, covering all and not less than five hundred such subscribers and dependents, with respect only to medical, hospital, dental, and other health care services.

(2) This section does not apply to sections 10 through 13 and 17 of this act."

"NEW SECTION. **Sec. 20.** For the purposes of sections 21 through 23 of this act:

The legislature finds that it is difficult for group disability insurers, contractors, or health maintenance organizations to provide coverage to small employer groups because the experience rating base is small. It finds that when such coverage is provided the issuer may need to make enormous rate increases from one year to the next in order to cover losses. The legislature further finds that with huge rate increases, provisions such as guaranteed renewability and conversion rights lose their meaning, which creates a problem of accessibility.

It is the intent of the legislature to make it economically feasible for issuers to provide small employer group coverage by creating a stop-loss mechanism within the office of the insurance commissioner. The purpose of which will be to protect both employers and issuers from unusual claims."

"NEW SECTION. **Sec. 21.** (1) There is hereby created a nonprofit entity to be known as the Washington residents health care reinsurance pool. This pool will serve as a stop loss for claims that exceed

twenty-five thousand dollars in any one issuing year on any one individual within the small employer groups.

(2) All issuers providing small business coverage within the state of Washington shall participate in the Washington residents health care reinsurance pool.

(3)(a) The pool shall operate subject to the supervision and control of the board which is hereby created. Subject to the provisions of (b) of this subsection, the board shall consist of eight members appointed by the commissioner plus the commissioner or his or her designated representative, who shall serve as an ex officio member of the board.

(b) In selecting the members of the board, the commissioner shall include representatives of small employers and small employer issuers and other individuals determined to be qualified by the commissioner. At least five of the members of the board shall be representatives of reinsuring issuers and shall be selected from individuals nominated by small employer issuers in this state pursuant to procedures and guidelines developed by the commissioner.

(c) The initial board members shall be appointed as follows: (i) One-third of the members to serve a term of two years; (ii) one-third of the members to serve a term of four years; (iii) and one-third of the members to serve a term of six years. Subsequent board members shall serve for a term of three years. A board member’s term shall continue until his or her successor is appointed.

(d) A vacancy in the board shall be filled by the commissioner. A board member may be removed by the commissioner for cause.

(4) Premium rates charged for reinsurance by the pool to a health maintenance organization that is federally qualified under 42 U.S.C. Sec. 300c(c)(2)(A), and as such is subject to requirements that limit the amount of risk that may be ceded to the pool, shall be reduced to

reflect that portion of the risk above the amount that may not be ceded to the pool, if any.

(5) Small group employer issuers' participation in excess of loss claim payments will be set by the board in an equitable manner related to experience.

(6)(a) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the pool for reinsuring small employers and individuals. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer issuers in the state.

(b) The board periodically shall review the methodology established under (a) of this subsection, including the system of classification and rating factors, to assure that it reasonably reflects the claims experience of the pool. The board may propose changes to the methodology which shall be subject to the approval of the commissioner.

(c) The board may, with approval of the commissioner, change the assessment formula from time to time as appropriate. The board may provide for the shares of the assessment base attributable to premiums from all health benefit plans and to premiums from newly issued health benefit plans to vary during a transition period.

(d) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for reinsuring issuers that are approved health maintenance organizations that are federally qualified under 42 U.S.C. Sec. 300, et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer issuers."

"NEW SECTION. **Sec. 22.** The board, in consultation with members of the committee, shall study and report at least every three years to

the commissioner on the effectiveness of sections 20, 21, and 23 of this act. The report shall analyze the effectiveness of sections 20, 21, and 23 of this act in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance marketplace. The report shall address whether issuers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of sections 20, 21, and 23 of this act. The report may contain recommendations for market conduct or other regulatory standards or action."

"NEW SECTION. **Sec. 23.** The commissioner may adopt rules under sections 20 through 22 of this act."

"NEW SECTION. **Sec. 24.** MEDIGAP COVERAGE. For the purposes of section 25 of this act:

The legislature finds that when state employees purchase retired employees' medical care coverage through the health care authority the coordination of benefits clause may deprive them of benefits when their primary insurer is medicare. The legislature further finds that a nonduplication of benefits provision may mean that no benefits will be paid by the secondary insurer. It is the legislature's intent that retired employees covered under medicare are able to continue in the state insurance plan through individual purchase and receive a true medicare supplement that will pay the difference between the medicare benefits and the allowed charge, but not exceed one hundred percent of the allowed charge."

"**Sec. 25.** RCW 41.05.065 and 1988 c 107 s 8 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: PROVIDED, That liability insurance shall not be made available to dependents.

(2) The state 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, exercise, and automobile and motorcycle safety;

(d) Utilization review procedures including, but not limited to 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; and

(e) Effective coordination of benefits <u>considering the differing needs of employees and retirees insured under medicare and providing for a medicare supplemental plan</u>.

(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 may authorize premium contributions for an employee and the employee's dependents. Such authorization shall require a vote of five members of the board for approval.

(5) Employees may choose participation in only 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."

"PART II - COST CONTAINMENT"

"NEW SECTION. **Sec. 26.** A new section is added to chapter 70.41 RCW to read as follows:

(1) The legislature finds that the spiraling costs of health care are increasing at approximately twice the inflationary rate. By making physicians and other health care providers with hospital admitting privileges more aware of the cost consequences of health care services for consumers, these providers may exercise more restraint in providing only the most relevant and cost-beneficial hospital services. This could reduce the utilization of the most costly services. The legislature intends that informing physicians and other health care providers of the charges will have a positive effect on containing

health costs. Further, the choice to inform the patient of these charges can strengthen the necessary dialogue in the provider-patient relationship that is diminished by intervening third-party payors.

(2) The chief executive officer of a hospital licensed under this chapter and the superintendent of a state hospital shall establish and maintain a procedure for disclosing to physicians and other health care providers with admitting privileges the charges of all in-house health care services to be ordered for their patients. These charges shall be posted on the patient's chart and shall include total charges to date and an itemization of charges for the previous day. The physician or other health care provider may inform the patient of these charges."

"NEW SECTION. **Sec. 27.** The Washington state hospital association, in cooperation with the Washington state medical association, Washington state nurses association, and other appropriate interested parties, and in consultation with the department of health, is requested to develop a protocol that establishes a standardized system of disclosure of charges of hospital-based services for the purposes of this act; that promotes dialogue between hospitals, physicians, nurses, and other health care providers for encouraging a better cost consciousness regarding the services, procedures, medications and supplies which are ordered for hospital in-patients; that invites more cost-benefit comparisons of appropriate alternatives; and that minimizes the costs of instituting this standardized information system by the hospitals in this state."

"NEW SECTION. **Sec. 28.** The department of health shall report to the legislature by December 31, 1992, on the status of the development of the protocol developed pursuant to section 27 of this act and its implementation by hospitals, with recommendations on any necessary

revisions to this act (chapter ..., Laws of 1992), including its continued necessity and the appropriateness of its repeal."

"NEW SECTION. **Sec. 29.** A new section is added to chapter 48.20 RCW to read as follows:

APPLICATION TO DISABILITY INSURANCE POLICIES. (1) After January 1, 1994, all disability insurance policies that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 38 of this act shall be used by providers of health care and carriers under this chapter."

"NEW SECTION. **Sec. 30.** A new section is added to chapter 48.21 RCW to read as follows:

APPLICATION TO DISABILITY INSURANCE POLICIES. (1) After January 1, 1994, all group disability insurance policies that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 38 of this act shall be used by providers of health care and carriers under this chapter."

"NEW SECTION. **Sec. 31.** A new section is added to chapter 48.44 RCW to read as follows:

APPLICATION TO HEALTH CARE INSURANCE CONTRACTS. (1) After January 1, 1994, all health care insurance contracts that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 38 of this act shall be used by providers of health care and carriers under this chapter."

"NEW SECTION. **Sec. 32.** A new section is added to chapter 48.46 RCW to read as follows:

APPLICATION TO HEALTH MAINTENANCE AGREEMENTS. (1) After January 1, 1994, all health maintenance agreements that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 38 of this act shall be used by providers of health care and carriers under this chapter."

"NEW SECTION. **Sec. 33.** A new section is added to chapter 48.84 RCW to read as follows:

APPLICATION TO LONG-TERM CARE PROVIDERS. (1) After January 1, 1994, all providers of long-term care that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform bill (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 38 of this act shall be used by providers of health care and carriers under this chapter."

"NEW SECTION. **Sec. 34.** A new section is added to chapter 41.05 RCW to read as follows:

APPLICATION TO STATE HEALTH CARE AUTHORITY. After July 1, 1994, the health care financing administration (HCFA) 1500 form, or its successor, and the uniform billing (UB) 82 form, or its successor, shall be used in either paper or electronic format for state-paid health care services provided through the health care authority. The forms developed under section 38 of this act shall be used for billing purposes for pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services."

"NEW SECTION. **Sec. 35.** A new section is added to chapter 43.20A RCW to read as follows:

APPLICATION TO MEDICAID PROGRAM. After July 1, 1994, the health care financing administration (HCFA) 1500 form, or its successor, and the uniform billing (UB) 82 form, or its successor, shall be used in either paper or electronic format for state-paid health care services provided by the department. The forms developed under section 38 of

this act shall be used for billing purposes for pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services."

"NEW SECTION. **Sec. 36.** A new section is added to Title 51 RCW to read as follows:

APPLICATION TO LABOR AND INDUSTRIES. After July 1, 1994, the health care financing administration (HCFA) 1500 form, or its successor, and the uniform billing (UB) 82 form, or its successor, shall be used in either paper or electronic format for state-paid health care services provided under this title. The forms developed under section 38 of this act shall be used for billing purposes for pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services."

"NEW SECTION. **Sec. 37.** A new section is added to chapter 70.47 RCW to read as follows:

APPLICATION TO BASIC HEALTH PLAN. After July 1, 1994, the health care financing administration (HCFA) 1500 form, or its successor, and the uniform billing (UB) 82 form, or its successor, shall be used in either paper or electronic format for state-paid health care services provided under the basic health plan. The forms developed under section 38 of this act shall be used for billing purposes for pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services."

"NEW SECTION. **Sec. 38.** A new section is added to chapter 41.05 RCW to read as follows:

JOINT AGENCY RULES. By January 1, 1993, the basic health plan administrator, the health care authority administrator, the secretary

of social and health services, the director of the department of labor and industries, and the insurance commissioner shall jointly develop and adopt by rule in paper and electronic format billing forms to be used by pharmacists, dentists, home health/nursing services, eyeglasses, transportation, and vocational services. These forms shall be made available to providers of health care coverage licensed under chapters 48.20, 48.21, 48.44, 48.46, and 48.84 RCW."

"**Sec. 39.** RCW 70.170.010 and 1989 1st ex.s. c 9 s 501 are each amended to read as follows:

(1) The legislature finds and declares that there is a need for health care information that helps the general public understand health care issues and how they can be better consumers and that is useful to purchasers, payers, and providers in making health care choices, determining and monitoring the quality of health care services and ((~~negotiating payments~~)) making health care purchasing decisions. It is the purpose and intent of this chapter to establish a ((~~hospital~~)) personal health services data collection, storage, and retrieval system which supports these data needs and which also provides public officials and others engaged in the development of state health policy, the purchasing of health care services, and the monitoring of the health care system for quality the information necessary for the analysis of health care issues.

(2) The legislature finds that rising health care costs and access to health care services are of vital concern to the people of this state. It is, therefore, essential that strategies be explored that moderate health care costs and promote access to health care services.

(3) The legislature further finds that access to health care is among the state's goals and the provision of such care should be among the purposes of health care providers and facilities. Therefore, the

legislature intends that charity care requirements, cost shifting, and related enforcement provisions for hospitals be explicitly established.

(4) The lack of reliable statistical information about the delivery of charity care is a particular concern that should be addressed. ((~~It is the~~)) A purpose ((~~and intent~~)) of this chapter is to require hospitals, clinics, nursing homes, and physicians to provide, and report to the state, charity care to persons with acute care needs, and to have a state agency both monitor and report on the relative commitment of hospitals, clinics, nursing homes, and physicians to the delivery of charity care services, as well as the relative commitment of public and private purchasers or payers to charity care funding.

(5) It is further the intent of this chapter to designate the department of health as depository agency for personal health data collected pursuant to goals established in this section."

"**Sec. 40.** RCW 70.170.030 and 1989 1st ex.s. c 9 s 503 are each amended to read as follows:

(1) There is created the health care access and cost control council within the department of health consisting of the following: The director of the department of labor and industries; the administrator of the health care authority; the secretary of social and health services; the administrator of the basic health plan; a person representing the governor on matters of health policy; the secretary of health; and ((~~one member from the public-at-large to be selected by the governor who shall represent individual consumers of health care~~)) five public members, to be selected by the governor, comprised of two health care providers, two payers of health care services, and one member from the public-at-large who shall represent individual consumers of health care. The public member-at-large shall not have any fiduciary obligation to any health care facility or any financial interest in the

provision of health care services. Members employed by the state shall serve without pay and participation in the council's work shall be deemed performance of their employment. The public members shall be compensated in accordance with RCW 43.03.240 and shall be reimbursed for related travel expenses in accordance with RCW 43.03.050 and 43.03.060.

(2) A member of the council designated by the governor shall serve as chairman. The council shall elect a vice-chairman from its members biennially. Meetings of the council shall be held as frequently as its duties require. The council shall keep minutes of its meetings and adopt procedures for the governing of its meetings, minutes, and transactions.

(3) ((~~Four~~)) Seven members shall constitute a quorum, but a vacancy on the council shall not impair its power to act. No action of the council shall be effective unless ((~~four~~)) seven members concur therein."

"**Sec. 41.** RCW 70.170.040 and 1989 1st ex.s. c 9 s 504 are each amended to read as follows:

(1) In order to advise the department and the board of health in preparing executive request legislation and the state health report according to RCW 43.20.050, and, in order to ((~~represent the public interest~~)) assist the department to establish a depository of personal health services data, the council shall monitor and evaluate ((~~hospital and related~~)) health care services consistent with RCW 70.170.010. In fulfilling its responsibilities, the council shall have complete access to all the department's data and information systems.

(2) The council shall advise the department on the hospital and health care services data collection system required by this chapter.

(3) The council, in addition to participation in the development of the state health report, shall, from time to time, report to the governor and the appropriate committees of the legislature with proposed changes in ((~~hospital and related~~)) health care services, consistent with the findings in RCW 70.170.010.

(4) The department ((~~may~~)) shall undertake, with advice from the council and within available funds, the following studies and activities:

(a) Recommendations regarding health care cost containment, and the assurance of access and maintenance of adequate standards of care;

(b) Analysis of the effects of various payment methods on health care access and costs;

(c) The utility of the certificate of need program and related health planning process;

(d) Methods of permitting the inclusion of advance medical technology on the health care system, while controlling inappropriate use;

(e) The appropriateness of allocation of health care services;

(f) Professional liabilities on health care access and costs, to include:

(i) Quantification of the financial effects of professional liability on health care reimbursement;

(ii) Determination of the effects, if any, of nonmonetary factors upon the availability of, and access to, appropriate and necessary basic health services such as, but not limited to, prenatal and obstetrical care; and

(iii) Recommendation of proposals that would mitigate cost and access impacts associated with professional liability.

((~~The department shall report its findings and recommendations to the governor and the appropriate committees of the legislature not~~

~~later than July 1, 1991.~~)) (g) Strategies to engage in data collection activities necessary to pursue the objectives established under RCW 70.170.010;

(h) Strategies to standardize and coordinate existing state agency health care data systems necessary to pursue objectives established under RCW 70.170.010; and

(i) Strategies, to the extent possible, to develop data sharing activities between the public and private sectors on personal health data and to incorporate such data into the data repository consistent with objectives established under RCW 70.170.010."

"NEW SECTION. **Sec. 42.** The legislature finds that medicaid payments for medical services are frequently less than providers charge to other patients which causes providers to balance patient services so income covers expenses. It finds that this balancing may result in turning away some patients or setting limits on numbers of medicaid patients. Consequently, medicaid recipients may feel discouraged from obtaining early medical care. This can cause treatment delays and visits to the emergency room for more expensive services. The legislature further finds that recipient patients may see medicaid coupons as carrying a stigma, which may create the danger of de facto rationing. The legislature intends that all patients should receive the same quantity, quality, and promptness of care and, therefore, requests the secretary of social and health services to investigate the possibilities of contracting for medicaid services with managed health care systems, contractors, or insurers and report its findings to the chair and members of the house of representatives committee on health care by December 1, 1992."

"PART III - MEDICAL MALPRACTICE LIABILITY"

"**Sec. 43.** RCW 7.70.070 and 1975-’76 2nd ex.s. c 56 s 12 are each amended to read as follows:

The court shall, in any action under this chapter, determine the reasonableness of each party’s fixed attorneys fees. The court shall take into consideration the following:

(1) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

(2) The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;

(3) The fee customarily charged in the locality for similar legal services;

(4) The amount involved and the results obtained;

(5) The time limitations imposed by the client or by the circumstances;

(6) The nature and length of the professional relationship with the client;

(7) The experience, reputation, and ability of the lawyer or lawyers performing the services((~~;~~

~~(8) Whether the fee is fixed or contingent~~))."

"NEW SECTION. **Sec. 44.** CONTINGENT ATTORNEYS’ FEES LIMITED. (1) As used in this section:

(a) "Contingency fee agreement" means an agreement that an attorney’s fee is dependent or contingent, in whole or in part, upon successful prosecution or settlement of a claim or action, or upon the amount of recovery.

(b) "Properly chargeable disbursements" means reasonable expenses incurred and paid by an attorney on a client’s behalf in prosecuting or settling a claim or action.

(c) "Recovery" means the amount to be paid to an attorney’s client as a result of a settlement or money judgment.

(2) In a claim or action filed under this chapter for personal injury or wrongful death based upon the alleged conduct of another, if an attorney enters into a contingency fee agreement with his or her client and if a money judgment is awarded to the attorney’s client or the claim or action is settled, the attorney’s fee shall not exceed the amounts set forth in (a) and (b) of this subsection:

(a) Not more than forty percent of the first five thousand dollars recovered, then not more than thirty-five percent of the amount more than five thousand dollars but less than twenty-five thousand dollars, then not more than twenty-five percent of the amount of twenty-five thousand dollars or more but less than two hundred fifty thousand dollars, then not more than twenty percent of the amount of two hundred fifty thousand dollars or more but less than five hundred thousand dollars, and not more than ten percent of the amount of five hundred thousand dollars or more.

(b) As an alternative to (a) of this subsection, not more than one-third of the first two hundred fifty thousand dollars recovered, not more than twenty percent of an amount more than two hundred fifty thousand dollars but less than five hundred thousand dollars, and not more than ten percent of an amount more than five hundred thousand dollars.

(3) The fees allowed in subsection (2) of this section are computed on the net sum of the recovery after deducting from the recovery the properly chargeable disbursements. In computing the fee, the costs as taxed by the court are part of the amount of the money judgment. In

the case of a recovery payable in installments, the fee is computed using the present value of the future payments.

(4) A contingency fee agreement made by an attorney with a client must be in writing and must be executed at the time the client retains the attorney for the claim or action that is the basis for the contingency fee agreement. An attorney who fails to comply with this subsection is barred from recovering a fee in excess of the lowest fee available under subsection (2) of this section, but the other provisions of the contingency fee agreement remain enforceable.

(5) An attorney shall provide a copy of a contingency fee agreement to the client at the time the contingency fee agreement is executed. An attorney shall include his or her usual and customary hourly rate of compensation in a contingency fee agreement.

(6) An attorney who enters into a contingency fee agreement that violates subsection (2) of this section is barred from recovering a fee in excess of the attorney's reasonable actual attorney fees based on his or her usual and customary hourly rate of compensation, up to the lowest amount allowed under subsection (2) of this section, but the other provisions of the contingency fee agreement remain enforceable."

"NEW SECTION. **Sec. 45.** CERTIFICATE OF MERIT REQUIRED. (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, for any action for damages arising out of injuries resulting from health care by a person regulated by a disciplinary authority in the state of Washington to practice a health care profession under RCW 18.130.040 or by the state board of pharmacy under chapter 18.64 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. 46.** EFFECTIVE DATE. Section 45 of this act applies to all actions for damages arising out of injuries resulting from health care filed on or after July 1, 1992."

"NEW SECTION. **Sec. 47.** The legislature finds and declares that practice guidelines or parameters and risk management protocols can be effective means for assuring appropriate and efficacious treatments. Public policy should be established to encourage their development and use."

"NEW SECTION. **Sec. 48.** The chair of the house of representatives committee on judiciary shall initiate an interim study to recommend to the 1993 legislature how practice parameters can best be established to be available as an affirmative defense in medical malpractice causes and whether risk management protocols should be included. The study shall have the advice and consent of a task force appointed by the speaker of the house of representatives consisting of representatives from the house of representatives committees on judiciary and financial institutions and insurance, the Washington state medical association, group disability insurers, contractors, and health maintenance organizations, the Washington state bar association, and the Washington trial lawyers association from names submitted by each association or organization. The secretary of health or his or her designee shall also sit on the task force. The interim study shall report on the following issues:

(1) The health care services where practice parameters and risk management protocols can reasonably be developed given the current state of knowledge;

(2) The use of practice parameters and risk management protocols in quality assurance and as standards in malpractice litigation;

(3) Practical issues involved in developing practice parameters and risk management protocols, including needed data bases and monitoring capabilities;

(4) Appropriate roles for the public and private interests in the development and implementation of practice parameters and risk management protocols, including the role of health professional credentialing and disciplinary authorities, purchasers, consumers, health care research institutions, and others; and

(5) A strategy for the development of practice parameters and risk management protocols."

"NEW SECTION. **Sec. 49.** The legislature intends that retired physicians who wish to provide health care services to low-income patients without compensation shall be able to do so without the burden of malpractice insurance. The legislature declares that the purpose is to increase the availability of primary care to low-income persons and is in the interest of the public health and safety."

"NEW SECTION. **Sec. 50.** A new section is added to chapter 43.70 RCW to read as follows:

(1) The department shall purchase and maintain liability insurance by contracting with an insurer authorized to do business in this state to provide liability insurance, under this section and section 51 of this act, to retired physicians who provide primary care at community clinics that are public or private nonprofit tax-exempt corporations that utilize retired physicians for providing primary care without compensation to low-income individuals at a charge based upon ability to pay. Nothing shall prevent the contracting insurer from refusing to provide coverage for a participating physician in a clinic for claims experience reasons or other appropriate reasons.

(2) The state and its officers and employees, or individuals acting on their behalf, are immune from suit in any action, civil or criminal,

with regard to any claims against clinics or physicians or based upon the performance of official acts under this chapter.

(3) The department shall monitor the claims experience of retired physicians covered by liability insurers contracting with the department."

"NEW SECTION. **Sec. 51.** A new section is added to chapter 43.70 RCW to read as follows:

The department shall establish by rule the conditions of participation in the liability insurance program by retired physicians at clinics utilizing retired physicians for the purposes of this section and section 50 of this act. These conditions shall include, but not be limited to, the following:

(1) The participating physician associated with the clinic shall hold a valid license to practice medicine and surgery in this state and otherwise be in conformity with current requirements for licensure as a retired physician, including continuing education requirements;

(2) The participating physician shall limit the scope of practice in the clinic to primary care. Primary care shall be limited to noninvasive procedures and shall not include obstetrical care, or any specialized care and treatment. Noninvasive procedures include injections, suturing of minor lacerations, and incisions of boils or superficial abscesses;

(3) The provision of liability insurance coverage shall not extend to acts outside the scope of rendering medical services pursuant to this section and section 50 of this act;

(4) The participating physician shall limit the provision of health care services to low-income persons provided that clinics may, but are not required to, provide means tests for eligibility as a condition for obtaining health care services;

(5) The participating physician shall not accept compensation for providing health care services from patients served pursuant to this section and section 50 of this act, nor from clinics serving these patients. "Compensation" shall mean any remuneration of value to the participating physician for services provided by the physician, but shall not be construed to include any nominal copayments charged by the clinic, nor reimbursement of related expenses of a participating physician authorized by the clinic in advance of being incurred; and

(6) The use of mediation or arbitration for resolving questions of potential liability may be used, however any mediation or arbitration agreement format shall be expressed in terms clear enough for a person with a sixth grade level of education to understand, and on a form no longer than one page in length."

"NEW SECTION. **Sec. 52.** The sum of fifty thousand dollars, or as much thereof as may be necessary, is appropriated for the biennium ending June 30, 1993, from the general fund to the department of health for the purposes of this act."

"NEW SECTION. **Sec. 53.** Sections 10 through 14, 18, and 20 through 23 of this act shall constitute a new chapter in Title 48 RCW."

"NEW SECTION. **Sec. 54.** Sections 44 through 46 of this act are each added to chapter 7.70 RCW."

"NEW SECTION. **Sec. 55.** 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. 56.** Sections 10 through 14, 18, 20 through 23, and 26 through 28 of this act shall take effect July 1, 1993."

SHB 2590 - H AMD
By Representative

On page 1, line 1 of the title, after "care;" strike the remainder of the title and insert "amending RCW 70.47.020, 70.47.080, 43.131.355, 43.131.356, 48.21.260, 48.44.370, 48.46.450, 48.21.030, 41.05.065, 70.170.010, 70.170.030, 70.170.040, and 7.70.070; reenacting and amending RCW 70.47.030 and 70.47.060; adding new sections to chapter 70.47 RCW; adding a new section to chapter 70.41 RCW; adding a new section to chapter 48.20 RCW; adding a new section to chapter 48.21 RCW; adding a new section to chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; adding a new section to chapter 48.84 RCW; adding new sections to chapter 41.05 RCW; adding a new section to chapter 43.20A RCW; adding a new section to Title 51 RCW; adding new sections to chapter 7.70 RCW; adding new sections to chapter 43.70 RCW; adding a new chapter to Title 48 RCW; creating new sections; making an appropriation; and providing an effective date."