1 **5304-S2.E AMH DYER H2495.2**

2 E2SSB 5304 - H AMD **000344 LOST 4-8-93**
3 By Representative Dyer

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5 Strike everything after the enacting clause and insert the
6 following:

7 **"PART I. FINDINGS, GOALS, AND INTENT**

8 NEW SECTION. **Sec. 101.** FINDINGS. The legislature finds that our
9 health and financial security are jeopardized by our ever increasing
10 demand for medical care and by current medical insurance and medical
11 system practices. Current medical system practices encourage public
12 demand for unneeded, ineffective, and sometimes dangerous medical
13 treatments. These practices often result in unaffordable cost
14 increases that far exceed ordinary inflation for essential care.
15 Current total medical and health care expenditure rates should be
16 sufficient to provide access to essential health and medical care
17 interventions to all within a reformed, efficient system.
18 The legislature finds that too many of our state's residents are
19 without medical insurance, that each year many individuals and families
20 are forced into poverty because of serious illness, and that many must
21 leave gainful employment to be eligible for publicly funded medical
22 services. Additionally, thousands of citizens are at risk of losing
23 adequate medical insurance, have had insurance canceled recently, or
24 cannot afford to renew existing coverage.
25 The legislature finds that businesses find it difficult to pay for
26 medical insurance and remain competitive in a global economy, and that
27 individuals, the poor, and small businesses bear an inequitable medical
28 insurance burden.
29 The legislature finds that persons of color have significantly
30 higher rates of mortality, poor health outcomes, and substantially
31 lower numbers and percentages of persons covered by health insurance
32 than general population. It is intended that chapter ..., Laws of 1993
33 (this act) make provisions to address the special health care needs of
34 these racial and ethnic populations in order to improve their health
35 status.

1 The legislature finds that uncontrolled demand and expenditures for
2 medical care are eroding the ability of families, businesses,
3 communities, and governments to invest in other enterprises that
4 promote health, maintain independence, and ensure continued economic
5 welfare. Housing, nutrition, education, and the environment are all
6 diminished as we invest ever increasing shares of wealth in medical
7 treatments.
8 The legislature finds that while immediate steps must be taken, a
9 long-term plan of reform is also needed.

10 NEW SECTION. **Sec. 102.** LEGISLATIVE INTENT AND GOALS. (1) The
11 legislature intends that state government policy stabilize health
12 services costs, assure access to essential services for all residents,
13 actively address the health care needs of persons of color, improve the
14 public's health, and reduce unwarranted health services costs to
15 preserve the viability of nonmedical care businesses.
16 (2) The legislature intends that:
17 (a) Total health services costs be stabilized and controlled within
18 a managed, competitive marketplace;
19 (b) State residents be enrolled in the certified health plan of
20 their choice that meets state standards regarding affordability,
21 accessibility, cost-effectiveness, and comprehensiveness;
22 (c) State residents be able to choose health services in a manner
23 consistent with good health service management, quality assurance, and
24 cost effectiveness;
25 (d) Individuals and businesses have the option to purchase any
26 health or medical services they may choose in addition to those
27 contained in the uniform benefits package;
28 (e) These goals be accomplished within a reformed system using
29 private service providers and facilities in a way that allows consumers
30 to choose among competing plans; and
31 (f) That a policy of facilitating communication and networking in
32 the delivery, purchase, and provision of health services among the
33 federal, state, local, and tribal governments be encouraged and
34 accomplished by chapter . . ., Laws of 1993 (this act).
35 (3) Accordingly, the legislature intends that chapter . . ., Laws
36 of 1993 (this act) provide both early implementation measures and a
37 process for overall reform of the health services system.

PART II. EARLY IMPLEMENTATION

A. BASIC HEALTH PLAN EXPANSION

Sec. 201. RCW 70.47.010 and 1987 1st ex.s. c 5 s 3 are each amended to read as follows:

BASIC HEALTH PLAN--FINDINGS. (1) The legislature finds that:

(a) A significant percentage of the population of this state does not have reasonably available insurance or other coverage of the costs of necessary basic health care services;

(b) This lack of basic health care coverage is detrimental to the health of the individuals lacking coverage and to the public welfare, and results in substantial expenditures for emergency and remedial health care, often at the expense of health care providers, health care facilities, and all purchasers of health care, including the state; and

(c) The use of managed health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state generally, and by low-income pregnant women ((~~who are an especially vulnerable population, along with their children~~)), and at-risk children and adolescents who need greater access to managed health care.

(2) The purpose of this chapter is to provide or make more readily available necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization of necessary health care services. To that end, this chapter establishes a program to be made available to those residents ((~~under sixty-five years of age~~)) not ((~~otherwise~~)) eligible for medicare ((~~with gross family income at or below two hundred percent of the federal poverty guidelines~~)) or medical assistance who share in a portion of the cost or who pay the full cost of receiving basic health care services from a managed health care system.

(3) 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.

(4) ((~~The program authorized under this chapter is strictly limited in respect to the total number of individuals who may be allowed to~~

~~participate and the specific areas within the state where it may be established. All such restrictions or limitations shall remain in full force and effect until quantifiable evidence based upon the actual operation of the program, including detailed cost benefit analysis, has been presented to the legislature and the legislature, by specific act at that time, may then modify such limitations.~~))

(a) It is the purpose of this chapter to acknowledge the initial success of this program that has (i) assisted thousands of families in their search for affordable health care; (ii) demonstrated that low-income, uninsured families are willing to pay for their own health care coverage to the extent of their ability to pay; and (iii) proved that local health care providers are willing to enter into a public-private partnership as a managed care system.

(b) As a consequence, the legislature intends to extend an option to enroll to certain citizens below three hundred percent of the federal poverty guidelines within the state who reside in communities where the plan is operational and who collectively or individually wish to exercise the opportunity to purchase health care coverage through the basic health plan if the purchase is done at no cost to the state. It is also the intent of the legislature to allow employers and other financial sponsors to financially assist such individuals to purchase health care through the program. It is also the intent of the legislature to condition access to this plan for nonsubsidized enrollees upon the prior placement of subsidized enrollees, to the extent funding is available.

(c) The legislature directs that the basic health plan administrator identify enrollees who are likely to be eligible for medical assistance and assist these individuals in applying for and receiving medical assistance. The administrator and the department of social and health services shall implement a seamless system to coordinate eligibility determinations and benefit coverage for enrollees of the basic health plan and medical assistance recipients.

Sec. 202. RCW 70.47.020 and 1987 1st ex.s. c 5 s 4 are each amended to read as follows:

BASIC HEALTH PLAN--DEFINITIONS. 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) "Subsidized enrollee" means an individual, or an individual plus the individual's spouse ((~~and/or~~)) or dependent children, ((~~all under the age of sixty-five and~~)) not ((~~otherwise~~)) eligible for medicare or medical assistance, 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 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) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children, not eligible for medicare, who resides in an area of the state served by a managed health care system participating in the plan, who chooses to obtain basic health care coverage from a particular managed health care system and who pays or on whose behalf is paid the full costs for participation in the plan, without any subsidy from the plan.

(6) "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~~)) a subsidized enrollee plus the administrative cost to the plan of providing the plan to that subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

((~~(6)~~)) (7) "Premium" means a periodic payment, based upon gross family income ((~~and determined under RCW 70.47.060(2),~~)) which an ((~~enrollee~~)) individual, their employer or another financial sponsor

makes to the plan as consideration for enrollment in the plan as a subsidized enrollee or a nonsubsidized enrollee.

(((7))) (8) "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 subsidized and nonsubsidized enrollees in the plan and in that system.

Sec. 203. RCW 70.47.030 and 1992 c 232 s 907 are each amended to read as follows:

ACCOUNTS. (1) The basic health plan trust account is hereby established in the state treasury. ((All)) Any 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, 1993, 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.))

(2) The basic health plan subscription account is created in the custody of the state treasurer. All receipts from amounts due from or on behalf of nonsubsidized enrollees shall be deposited into the account. Funds in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of nonsubsidized enrollees in the plan and payment of costs of administering the plan. The account is subject to allotment procedures under chapter 43.88 RCW, but no appropriation is required for expenditures.

(3) The administrator shall take every precaution to see that none of the funds in the separate accounts created in this section or that any premiums paid either by subsidized or nonsubsidized enrollees are commingled in any way, except that the administrator may combine funds designated for administration of the plan into a single administrative account.

Sec. 204. RCW 70.47.040 and 1987 1st ex.s. c 5 s 6 are each amended to read as follows:

BASIC HEALTH PLAN--PROGRAM WITHIN STATE HEALTH CARE AUTHORITY. (1) The Washington basic health plan is created as an independent agency of the state. The administrative head and appointing authority of the plan shall be the administrator who shall be appointed by the governor, with the consent of the senate, and shall serve at the pleasure of the governor. The salary for this office shall be set by the governor pursuant to RCW 43.03.040. The administrator shall appoint a medical director. The ((~~administrator,~~)) medical director((~~,~~)) and up to five other employees of the plan shall be exempt from the civil service law, chapter 41.06 RCW.

(2) The administrator shall employ such other staff as are necessary to fulfill the responsibilities and duties of the administrator, such staff to be subject to the civil service law, chapter 41.06 RCW. In addition, the administrator may contract with third parties for services necessary to carry out its activities where this will promote economy, avoid duplication of effort, and make best use of available expertise. Any such contractor or consultant shall be prohibited from releasing, publishing, or otherwise using any information made available to it under its contractual responsibility without specific permission of the plan. The administrator may call upon other agencies of the state to provide available information as necessary to assist the administrator in meeting its responsibilities under this chapter, which information shall be supplied as promptly as circumstances permit.

(3) The administrator may appoint such technical or advisory committees as he or she deems necessary. The administrator shall appoint a standing technical advisory committee that is representative of health care professionals, health care providers, and those directly involved in the purchase, provision, or delivery of health care services, as well as consumers and those knowledgeable of the ethical issues involved with health care public policy. Individuals appointed to any technical or other advisory committee shall serve without compensation for their services as members, but may be reimbursed for their travel expenses pursuant to RCW 43.03.050 and 43.03.060.

(4) The administrator may apply for, receive, and accept grants, gifts, and other payments, including property and service, from any governmental or other public or private entity or person, and may make arrangements as to the use of these receipts, including the undertaking

of special studies and other projects relating to health care costs and access to health care.

(5) ((~~In the design, organization, and administration of the plan under this chapter, the administrator shall consider the report of the Washington health care project commission established under chapter 303, Laws of 1986. Nothing in this chapter requires the administrator to follow any specific recommendation contained in that report except as it may also be included in this chapter or other law~~)) Whenever feasible, the administrator shall reduce the administrative cost of operating the program by adopting joint policies or procedures applicable to both the basic health plan and employee health plans.

Sec. 205. RCW 70.47.060 and 1992 c 232 s 908 are each amended to read as follows:

ADMINISTRATOR'S POWERS AND DUTIES. The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be necessary for basic health care, which subsidized and nonsubsidized enrollees 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 and shall include all services necessary for prenatal, postnatal, and well-child care. However, ((~~for the period ending June 30, 1993,~~)) with respect to coverage for groups of subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for ((~~prenatal or postnatal~~)) such services ((~~that are provided under the medical assistance program under chapter 74.09 RCW~~)) except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider((~~, or except to provide any such services associated with pregnancies diagnosed by the managed care provider before July 1, 1992~~)). The schedule of services shall also include a separate schedule of basic health care services for children, eighteen years of age and younger, for those subsidized or nonsubsidized enrollees who choose to secure basic

coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.42.080, and such other factors as the administrator deems appropriate.

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

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

(3) To design and implement a structure of ((~~nominal~~)) copayments due a managed health care system from subsidized and nonsubsidized enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(4) ((~~To design and implement, in concert with a sufficient number of potential providers in a discrete area, an 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 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 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 enrollee, and maximize patient involvement in her or his health care decision-making process, every effort is made by the provider to inform the 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 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 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.

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

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

((~~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.~~

~~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. Contracts with participating managed health care systems shall ensure that basic health plan enrollees who become eligible for medicaid, may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

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

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan as subsidized or nonsubsidized enrollees, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and at least ((~~annually~~)) semiannually thereafter, or at the request of any enrollee, 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 the federal poverty level, may continue enrollment unless and until the enrollee's gross family income has remained above twice 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 the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If, as a result of an eligibility review, the

administrator determines that a subsidized enrollee's income exceeds twice the federal poverty level and that the enrollee knowingly failed to inform the plan of such increase in income, the administrator may bill the enrollee for the subsidy paid on the enrollee's behalf during the period of time that the enrollee's income exceeded twice the federal poverty level. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to re-enroll in the plan.

(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~~)) plan. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

(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, 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))) (13) 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)) (14) To endeavor to expand enrollment as much as possible to correspond to the proportion of persons of color in the community served using the best available data that estimates representation of persons of color and describe these efforts in its annual report.

Sec. 206. RCW 70.47.080 and 1987 1st ex.s. c 5 s 10 are each amended to read as follows:

ENROLLMENT. 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, 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))) subsidized enrollment shall not result in expenditures that exceed the total amount that has been made available by the legislature in any act appropriating funds to the plan. To the extent that new funding is appropriated for expansion, the administrator shall endeavor to secure participation contracts from managed health care systems in geographic

areas of the state that are unserved by the plan at the time at which the new funding is appropriated.

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. The annual or biennial enrollment limitations derived from operation of the plan under this section do not apply to nonsubsidized enrollees as defined in RCW 70.47.020(5).

B. EXPANDED MANAGED CARE FOR STATE EMPLOYEES

Sec. 207. RCW 41.05.011 and 1990 c 222 s 2 are each amended to read as follows:

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

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

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

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

(4) "Insuring entity" means an ((~~insurance carrier as defined in chapter 48.21 or 48.22~~)) insurer as defined in chapter 48.01 RCW, a health care service contractor as defined in chapter 48.44 RCW, or a health maintenance organization as defined in chapter 48.46 RCW.

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

(6) "Employee" includes all full-time and career seasonal employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; and includes any or all part-time and temporary employees under the terms and conditions established under this chapter by the authority; justices of

the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature or of the legislative authority of any county, city, or town who are elected to office after February 20, 1970. "Employee" also includes employees of a county, municipality, or other political subdivision of the state if the legislative authority of the county, municipality, or other political subdivision of the state seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205((~~, and employees of a school district if the board of directors of the school district seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority as provided in RCW 28A.400.350~~)).

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

C. HEALTH CARE PROVIDER CONFLICT OF INTEREST STANDARDS

Sec. 208. RCW 19.68.010 and 1973 1st ex.s. c 26 s 1 are each amended to read as follows:

It shall be unlawful for any person, firm, corporation or association, whether organized as a cooperative, or for profit or nonprofit, to pay, or offer to pay or allow, directly or indirectly, to any person licensed by the state of Washington to engage in the practice of medicine and surgery, drugless treatment in any form, dentistry, or pharmacy and it shall be unlawful for such person to request, receive or allow, directly or indirectly, a rebate, refund, commission, unearned discount or profit by means of a credit or other valuable consideration in connection with the referral of patients to any person, firm, corporation or association, or in connection with the furnishings of medical, surgical or dental care, diagnosis, treatment or service, on the sale, rental, furnishing or supplying of clinical laboratory supplies or services of any kind, drugs, medication, or medical supplies, or any other goods, services or supplies prescribed for medical diagnosis, care or treatment: PROVIDED, That ownership of a financial interest in any firm, corporation or association which furnishes any kind of clinical laboratory or other services prescribed for medical, surgical, or dental diagnosis shall not be prohibited under this section where (1) the referring practitioner affirmatively

discloses to the patient in writing, the fact that such practitioner has a financial interest in such firm, corporation, or association; and (2) the referring practitioner provides the patient with a list of effective alternative facilities, informs the patient that he or she has the option to use one of the alternative facilities, and assures the patient that he or she will not be treated differently by the referring practitioner if the patient chooses one of the alternative facilities.

Any person violating the provisions of this section is guilty of a misdemeanor.

D. DATA COLLECTION

Sec. 209. RCW 70.170.100 and 1990 c 269 s 12 are each amended to read as follows:

(1) To promote the public interest consistent with the purposes of chapter . . ., Laws of 1993 (this act), the department is responsible for the development, implementation, and custody of a state-wide ((~~hospital~~)) health care data system, with policy direction and oversight to be provided by the Washington health services commission. As part of the design stage for development of the system, the department shall undertake a needs assessment of the types of, and format for, ((~~hospital~~)) health care data needed by consumers, purchasers, health care payers, ((~~hospitals~~)) providers, and state government as consistent with the intent of chapter . . ., Laws of 1993 (this act) ((~~chapter~~)). The department shall identify a set of ((~~hospital~~)) health care data elements and report specifications which satisfy these needs. The ((~~council~~)) Washington health services commission, created by section 301 of this act, shall review the design of the data system and ((~~may direct the department to~~)) establish a technical advisory committee on health data. The department shall contract with a private vendor for assistance in the design of the data system or for any part of the work to be performed under this section. The data elements, specifications, and other ((~~design~~)) distinguishing features of this data system shall be made available for public review and comment and shall be published, with comments, as the department's first data plan by ((~~January 1, 1990~~)) July 1, 1994.

(2) Subsequent to the initial development of the data system as published as the department's first data plan, revisions to the data

system shall be considered ((~~through the department's development of a biennial data plan, as proposed to,~~)) with the oversight and policy guidance of the Washington health services commission or its technical advisory committee and funded by((~~,~~)) the legislature through the biennial appropriations process. ((~~Costs of data activities outside of these data plans except for special studies shall be funded through legislative appropriations.~~

~~(3)~~)) In designing the state-wide ((~~hospital~~)) health care data system and any data plans, the department shall identify ((~~hospital~~)) health care data elements relating to ((~~both hospital finances~~)) health care costs, the quality of health care services, the outcomes of health care services, and ((~~the~~)) use of ((~~services by patients~~)) health care by consumers. Data elements ((~~relating to hospital finances~~)) shall be reported ((~~by hospitals~~)) as the Washington health services commission directs by reporters in conformance with a uniform ((~~system of~~)) reporting ((~~as specified by the department and shall~~)) system established by the department, which shall be adopted by reporters. "Reporter" means an individual or business entity, other than a hospital, required to be registered with the department of revenue for payment of taxes imposed under chapter 82.04 RCW or Title 48 RCW, that is primarily engaged in furnishing or insuring for medical, surgical, and other health services to persons. In the case of hospitals this includes data elements identifying each hospital's revenues, expenses, contractual allowances, charity care, bad debt, other income, total units of inpatient and outpatient services, and other financial information reasonably necessary to fulfill the purposes of chapter . . ., Laws of 1993 (this ((~~chapter~~)) act), for hospital activities as a whole and, as feasible and appropriate, for specified classes of hospital purchasers and payers. Data elements relating to use of hospital services by patients shall, at least initially, be the same as those currently compiled by hospitals through inpatient discharge abstracts ((~~and reported to the Washington state hospital commission~~)). The commission and the department shall encourage and permit reporting by electronic transmission or hard copy as is practical and economical to reporters.

((~~(4)~~)) (3) The state-wide ((~~hospital~~)) health care data system shall be uniform in its identification of reporting requirements for ((~~hospitals~~)) reporters across the state to the extent that such uniformity is ((~~necessary~~)) useful to fulfill the purposes of chapter

. . ., Laws of 1993 (this ((chapter)) act). Data reporting requirements may reflect differences ((in hospital size; urban or rural location; scope, type, and method of providing service; financial structure; or other pertinent distinguishing factors)) that involve pertinent distinguishing features as determined by the Washington health services commission by rule. So far as ((possible)) is practical, the data system shall be coordinated with any requirements of the trauma care data registry as authorized in RCW 70.168.090, the federal department of health and human services in its administration of the medicare program, ((and)) the state in its role of gathering public health statistics, or any other payer program of consequence so as to minimize any unduly burdensome reporting requirements imposed on ((hospitals)) reporters.

((~~(5)~~)) (4) In identifying financial reporting requirements under the state-wide ((hospital)) health care data system, the department may require both annual reports and condensed quarterly reports from reporters, so as to achieve both accuracy and timeliness in reporting, but shall craft such requirements with due regard of the data reporting burdens of reporters.

((~~(6) In designing the initial state-wide hospital data system as published in the department's first data plan, the department shall review all existing systems of hospital financial and utilization reporting used in this state to determine their usefulness for the purposes of this chapter, including their potential usefulness as revised or simplified.~~

~~(7) Until such time as the state-wide hospital data system and first data plan are developed and implemented and hospitals are able to comply with reporting requirements, the department shall require hospitals to continue to submit the hospital financial and patient discharge information previously required to be submitted to the Washington state hospital commission. Upon publication of the first data plan, hospitals shall have a reasonable period of time to comply with any new reporting requirements and, even in the event that new reporting requirements differ greatly from past requirements, shall comply within two years of July 1, 1989.~~

~~(8)~~)) (5) The ((hospital)) health care data collected ((and)), maintained, and studied by the department or the Washington health services commission shall only be available for retrieval in original or processed form to public and private requestors and shall be

available within a reasonable period of time after the date of request. The cost of retrieving data for state officials and agencies shall be funded through the state general appropriation. The cost of retrieving data for individuals and organizations engaged in research or private use of data or studies shall be funded by a fee schedule developed by the department which reflects the direct cost of retrieving the data or study in the requested form.

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

Sec. 210. RCW 70.170.110 and 1989 1st ex.s. c 9 s 511 are each amended to read as follows:

The department shall provide, or may contract with a private entity to provide, ((~~hospital~~)) analyses and reports or any studies it chooses to conduct consistent with the purposes of chapter . . ., Laws of 1993 (this ((~~chapter~~)) act). Subject to the availability of funds and any policy direction that may be given by the Washington health services commission. ((~~Prior to release, the department shall provide affected hospitals with an opportunity to review and comment on reports which identify individual hospital data with respect to accuracy and completeness, and otherwise shall focus on aggregate reports of hospital performance.~~)) These studies, analyses, or reports shall include:

(1) Consumer guides on purchasing ((~~hospital care services and~~)) or consuming health care and publications providing verifiable and useful aggregate comparative information to ((~~consumers on hospitals and hospital services~~)) the public on health care services, their cost, and the quality of health care providers who participate in certified health plans;

(2) Reports for use by classes of purchasers, who purchase from certified health plans, health care payers, and providers as specified for content and format in the state-wide data system and data plan; ((~~and~~))

(3) Reports on relevant ((~~hospital~~)) health care policy ((~~issues~~)) including the distribution of hospital charity care obligations among hospitals; absolute and relative rankings of Washington and other states, regions, and the nation with respect to expenses, net revenues, and other key indicators; ((~~hospital~~)) provider efficiencies; and the

effect of medicare, medicaid, and other public health care programs on rates paid by other purchasers of ((~~hospital~~)) health care; and

(4) Any other reports the commission or department deems useful to assist the public or purchasers of certified health plans in understanding the prudent and cost-effective use of all health services.

NEW SECTION. **Sec. 211.** A new section is added to chapter 70.170 RCW to read as follows:

Notwithstanding the provisions of chapter 42.17 RCW, any material contained within the state-wide health care data system or in the files of either the department or the Washington health services commission shall be subject to the following limitations: (1) Records obtained, reviewed by, or on file that contain information concerning medical treatment of individuals shall be exempt from public inspection and copying; and (2) any actuarial formulas, statistics, and assumptions submitted by a certified health plan to the commission or department upon request shall be exempt from public inspection and copying in order to preserve trade secrets or prevent unfair competition.

All persons and any public or private agencies or entities whatsoever subject to this chapter shall comply with any requirements established by rule relating to the acquisition or use of health services data and maintain the confidentiality of any information which may, in any manner, identify individual persons.

NEW SECTION. **Sec. 212.** A new section is added to chapter 70.170 RCW to read as follows:

The Washington health services commission shall have access to all health data presently available to the secretary of health. To the extent possible, the commission shall use existing data systems and coordinate among existing agencies. The department of health shall be the designated depository agency for all health data collected pursuant to chapter . . ., Laws of 1993 (this act). The following data sources shall be developed or made available:

(1) The commission shall coordinate with the secretary of health to utilize data collected by the state center for health statistics, including hospital charity care and related data, rural health data, epidemiological data, ethnicity data, social and economic status data, and other data relevant to the commission's responsibilities.

1 (2) The commission, in coordination with the department of health
2 and the health science programs of the state universities shall develop
3 procedures to analyze clinical and other health services outcome data,
4 and conduct other research necessary for the specific purpose of
5 assisting in the design of the uniform benefit package under chapter
6 . . ., Laws of 1993 (this act).
7 (3) The commission shall establish cost data sources and shall
8 require each certified health plan to provide the commission and the
9 department of health with enrollee care and cost information, to
10 include, but not be limited to: (a) Enrollee demographic data,
11 including age, sex, and ethnicity; (b) provider identifier; (c)
12 diagnosis; (d) health care services or procedures provided; (e)
13 provider charges, if any; and (f) aggregated paid data. For the
14 purposes of this subsection (3)(f), the commission shall assure that
15 all data relating to amounts paid for health care services must be
16 collected, compiled, and evaluated in a state-wide aggregated form. To
17 protect a managed competitive health care market, the commission may
18 not identify purchaser-specific or payer-specific information relating
19 to amounts paid for health care services. The department shall
20 establish by rule confidentiality standards to safeguard the
21 information from inappropriate use or release.

22 <u>NEW SECTION.</u> **Sec. 213.** A new section is added to chapter 70.170
23 RCW to read as follows:
24 (1) The department is responsible for the implementation and
25 custody of a state-wide personal health services data and information
26 system. The data elements, specifications, and other design features
27 of this data system shall be consistent with criteria adopted by the
28 Washington health services commission. The department shall provide
29 the commission with reasonable assistance in the development of these
30 criteria, and shall provide the commission with periodic progress
31 reports related to the implementation of the system or systems related
32 to those criteria.
33 (2) The department shall coordinate the development and
34 implementation of the personal health services data and information
35 system with related private activities and with the implementation
36 activities of the data sources identified by the commission. Data
37 shall include, but not be limited to: (a) Enrollee demographic data,
38 including age, sex, and ethnicity; (b) provider identifier; (c)

diagnosis; (d) health services or procedures provided; (e) provider charges, if any; and (f) aggregated paid data. For the purposes of this subsection (2)(f), the commission shall assure that all data relating to amounts paid for health care services must be collected, compiled, and evaluated in a state-wide aggregated form. To protect a managed competitive health care market, the commission may not identify purchaser-specific or payer-specific information relating to amounts paid for health care services. The commission shall establish by rule, confidentiality standards to safeguard the information from inappropriate use or release. The department shall assist the commission in establishing reasonable time frames for the completion of the system development and system implementation.

E. DISCLOSURE OF HOSPITAL, NURSING HOME, AND PHARMACY CHARGES

NEW SECTION. **Sec. 214.** 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 continue to surmount efforts to contain them, increasing at approximately twice the inflationary rate. The causes of this phenomenon are complex. 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 be inclined to exercise more restraint in providing only the most relevant and cost-beneficial hospital services, with a potential for reducing the utilization of those services. The requirement of the hospital to inform physicians and other health care providers of the charges of the health care services that they order may have a positive effect on containing health costs. Further, the option of the physician or other health care provider to inform the patient of these charges may strengthen the necessary dialogue in the provider-patient relationship that tends to be diminished by intervening third-party payers.

(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 health care services ordered for their patients. Copies of hospital charges shall be made available to any physician and/or other health care provider

ordering care in hospital inpatient/outpatient services. The physician and/or other health care provider may inform the patient of these charges and may specifically review them. Hospitals are also directed to study methods for making daily charges available to prescribing physicians through the use of interactive software and/or computerized information thereby allowing physicians and other health care providers to review not only the costs of present and past services but also future contemplated costs for additional diagnostic studies and therapeutic medications.

NEW SECTION. **Sec. 215.** A new section is added to chapter 71.12 RCW to read as follows:

(1) The legislature finds that the spiraling costs of health care continue to surmount efforts to contain them, increasing at approximately twice the inflationary rate. The causes of this phenomenon are complex. 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 be inclined to exercise more restraint in providing only the most relevant and cost-beneficial hospital services, with a potential for reducing the utilization of those services. The requirement of the hospital to inform physicians and other health care providers of the charges of the health care services that they order may have a positive effect on containing health costs. Further, the option of the physician or other health care provider to inform the patient of these charges may strengthen the necessary dialogue in the provider-patient relationship that tends to be 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 health care services ordered for their patients. Copies of hospital charges shall be made available to any physician and/or other health care provider ordering care in hospital inpatient/outpatient services. The physician and/or other health care provider may inform the patient of these charges and may specifically review them. Hospitals are also directed to study methods for making daily charges available to prescribing physicians through the use of interactive software and/or computerized

1 information thereby allowing physicians and other health care providers
2 to review not only the costs of present and past services but also
3 future contemplated costs for additional diagnostic studies and
4 therapeutic medications.

5 NEW SECTION. **Sec. 216.** A new section is added to chapter 18.68
6 RCW to read as follows:
7 The legislature finds that the spiraling costs of health care
8 continue to surmount efforts to contain them, increasing at
9 approximately twice the inflationary rate. One of the fastest growing
10 segments of the health care expenditure involves prescription
11 medications. By making physicians and other health care providers with
12 prescriptive authority more aware of the cost consequences of health
13 care treatments for consumers, these providers may be inclined to
14 exercise more restraint in providing only the most relevant and cost-
15 beneficial drug and medication treatments. The requirement of the
16 pharmacy to inform physicians and other health care providers of the
17 charges of prescription drugs and medications that they order may have
18 a positive effect on containing health costs. Further, the option of
19 the physician or other health care provider to inform the patient of
20 these charges may strengthen the necessary dialogue in the provider-
21 patient relationship that tends to be diminished by intervening third-
22 party payers.

23 NEW SECTION. **Sec. 217.** A new section is added to chapter 18.68
24 RCW to read as follows:
25 The registered or licensed pharmacist of this chapter shall
26 establish and maintain a procedure for disclosing to physicians and
27 other health care providers with prescriptive authority information
28 detailed by prescriber, of the cost and dispensation of all
29 prescriptive medications prescribed by him or her for his or her
30 patients on request. These charges should be made available on at
31 least a quarterly basis for all requested patients and should include
32 medication, dosage, number dispensed, and the cost of the prescription.
33 Pharmacies may provide this information in a summary form for each
34 prescribing physician for all patients rather than as individually
35 itemized reports. All efforts should be made to utilize the existing
36 computerized records and software to provide this information in the
37 least costly format.

NEW SECTION. **Sec. 218.** A new section is added to chapter 18.51 RCW to read as follows:

(1) The legislature finds that the spiraling costs of nursing home care continue to surmount efforts to contain them, increasing at approximately twice the inflationary rate. The causes of this phenomenon are complex. By making nursing home facilities and care providers more aware of the cost consequences of care services for consumers, these providers may be inclined to exercise more restraint in providing only the most relevant and cost-beneficial services and care, with a potential for reducing the utilization of those services. The requirement of the nursing home to inform physicians, consumers, and other care providers of the charges of the services that they order may have a positive effect on containing health costs.

(2) The chief executive officer of a nursing home licensed under this chapter shall establish and maintain a procedure for disclosing to physicians, consumers, and other care providers the charges of all services to be ordered for residents. These charges shall be posted on the resident's bill and shall include total charges to date and an itemization of charges for each month.

NEW SECTION. **Sec. 219.** The department of health shall report to the legislature by December 31, 1994, with recommendations on any necessary revisions to sections 214 through 218 of this act, including their continued necessity and the appropriateness of their repeal.

F. HEALTH PROFESSIONAL SHORTAGES

Sec. 220. RCW 43.70.460 and 1992 c 113 s 2 are each amended to read as follows:

RETIRED PRIMARY CARE PROVIDERS--MALPRACTICE INSURANCE. (1) The department may establish a program to purchase and maintain liability malpractice insurance for retired ((~~physicians~~)) primary care providers who provide primary health care services at community clinics. The following conditions apply to the program:

(a) Primary health care services shall be provided at community clinics that are public or private tax-exempt corporations;

(b) Primary health care services provided at the clinics shall be offered to low-income patients based on their ability to pay;

(c) Retired ((~~physicians~~)) primary care providers providing health care services shall not receive compensation for their services; and

(d) The department shall contract only with a liability insurer authorized to offer liability malpractice insurance in the state.

(2) This section and RCW 43.70.470 shall not be interpreted to require a liability insurer to provide coverage to a ((~~physician~~)) primary care provider should the insurer determine that coverage should not be offered to a physician because of past claims experience or for other appropriate reasons.

(3) The state and its employees who operate the program shall be immune from any civil or criminal action involving claims against clinics or physicians that provided health care services under this section and RCW 43.70.470. This protection of immunity shall not extend to any clinic or ((~~physician~~)) primary care provider participating in the program.

(4) The department may monitor the claims experience of retired physicians covered by liability insurers contracting with the department.

(5) The department may provide liability insurance under chapter 113, Laws of 1992 only to the extent funds are provided for this purpose by the legislature.

Sec. 221. RCW 43.70.470 and 1992 c 113 s 3 are each amended to read as follows:

RETIRED PRIMARY CARE PROVIDERS--CONDITIONS. The department may 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 RCW 43.70.460. 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 as a physician under chapter 18.71 or 18.57 RCW, a physician assistant under chapter 18.36A, 18.71A, or 18.57A RCW, or an advanced registered nurse practitioner under chapter 18.88 RCW 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 RCW 43.70.460;

(4) The participating physician shall limit the provision of health care services to primarily 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 RCW 43.70.460, 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.

G. SHORT-TERM HEALTH INSURANCE REFORM

NEW SECTION. **Sec. 222.** The legislature intends that, during the transition to a fully reformed health services system, certain health insurance practices be modified to increase access to health insurance coverage for some individuals and groups. The legislature recognizes that health insurance reform will not remedy the significant lack of access to coverage in Washington state without the implementation of strong cost control measures. The authority granted to the commissioner in chapter . . ., Laws of 1993 (this act) is in addition to any authority the commissioner currently has under Title 48 RCW to regulate insurers, health care service contractors, and health maintenance organizations.

NEW SECTION. **Sec. 223.** A new section is added to chapter 48.18 RCW to read as follows:

Every insurer upon canceling, denying, or refusing to renew any disability policy, shall, upon written request, directly notify in writing the applicant or insured, as the case may be, of the reasons for the action by the insurer and to any person covered under a group contract. Any benefits, terms, rates, or conditions of such a contract that are restricted, excluded, modified, increased, or reduced shall, upon written request, be set forth in writing and supplied to the insured and to any person covered under a group contract. The written communications required by this section shall be phrased in simple language that is readily understandable to a person of average intelligence, education, and reading ability.

Sec. 224. RCW 48.21.200 and 1983 c 202 s 16 and 1983 c 106 s 24 are each reenacted and amended to read as follows:

(1) No individual or group disability insurance policy, health care service contract, or health maintenance agreement which provides benefits for hospital, medical, or surgical expenses shall be delivered or issued for delivery in this state ((~~after September 8, 1975~~)) which contains any provision whereby the insurer, contractor, or health maintenance organization may reduce or refuse to pay such benefits otherwise payable thereunder solely on account of the existence of similar benefits provided under any ((~~individual~~)) disability insurance policy, ((~~or under any individual~~)) health care service contract, or health maintenance agreement.

(2) No individual or group disability insurance policy, health care service contract, or health maintenance agreement providing hospital, medical or surgical expense benefits and which contains a provision for the reduction of benefits otherwise payable or available thereunder on the basis of other existing coverages, shall provide that such reduction will operate to reduce total benefits payable below an amount equal to one hundred percent of total allowable expenses exclusive of copayments, deductibles, and other similar cost-sharing arrangements.

(3) The commissioner shall by rule establish guidelines for the application of this section, including:

(a) The procedures by which persons ((~~insured~~)) covered under such policies, contracts, and agreements are to be made aware of the existence of such a provision;

(b) The benefits which may be subject to such a provision;

(c) The effect of such a provision on the benefits provided;

(d) Establishment of the order of benefit determination; ((~~and~~))

(e) Exceptions necessary to maintain the integrity of policies, contracts, and agreements that may require the use of particular health care facilities or providers; and

(f) Reasonable claim administration procedures to expedite claim payments and prevent duplication of payments or benefits under such a provision((~~: PROVIDED, HOWEVER, That any group disability insurance policy which is issued as part of an employee insurance benefit program authorized by RCW 41.05.025(3) may exclude all or part of any deductible amounts from the definition of total allowable expenses for purposes of coordination of benefits within the plan and between such plan and other applicable group coverages: AND PROVIDED FURTHER, That any group disability insurance policy providing coverage for persons in this state may exclude all or part of any deductible amounts required by a group disability insurance policy from the definition of total allowable expenses for purposes of coordination of benefits between such policy and a group disability insurance policy issued as part of an employee insurance benefit program authorized by RCW 41.05.025(3).~~

~~(3) The provisions of this section shall apply to health care service contractor contracts and health maintenance organization agreements~~)).

NEW SECTION. **Sec. 225.** A new section is added to chapter 48.20 RCW to read as follows:

(1) After January 1, 1994, every disability insurer issuing coverage against loss arising from medical, surgical, hospital, or emergency care coverage shall waive any preexisting condition exclusion or limitation for persons who had similar coverage under a different policy, health care service contract, or health maintenance agreement in the three-month period immediately preceding the effective date of coverage under the new policy to the extent that such person has satisfied a waiting period under such preceding policy, contract, or agreement; however, if the person satisfied a twelve-month waiting period under such preceding policy, contract, or agreement, the insurer shall waive any preexisting condition exclusion or limitation. The insurer need not waive a preexisting condition exclusion or limitation

under the new policy for coverage not provided under such preceding policy, contract, or agreement.

(2) The commissioner in consultation with insurers, health care service contractors, and health maintenance organizations shall study the effect of preexisting condition exclusions and limitations on the cost and availability of health care coverage and shall provide recommendations to the legislature on findings no later than January 1, 1994. No insurer, health care service contractor, or health maintenance organization may deny, exclude, or limit coverage for preexisting conditions for a period longer than that provided for in such rules after July 1, 1994.

(3) No disability insurer may waive or exclude any preexisting condition from coverage for more than a twelve-month period.

NEW SECTION. **Sec. 226.** A new section is added to chapter 48.21 RCW to read as follows:

(1) After January 1, 1994, every disability insurer issuing coverage against loss arising from medical, surgical, hospital, or emergency care coverage shall waive any preexisting condition exclusion or limitation for persons who had similar coverage under a different policy, health care service contract, or health maintenance agreement in the three-month period immediately preceding the effective date of coverage under the new policy to the extent that such person has satisfied a waiting period under such preceding policy, contract, or agreement; however, if the person satisfied a twelve-month waiting period under such preceding policy, contract, or agreement, the insurer shall waive any preexisting condition exclusion or limitation. The insurer need not waive a preexisting condition exclusion or limitation under the new policy for coverage not provided under such preceding policy, contract, or agreement.

(2) The commissioner in consultation with insurers, health care service contractors, and health maintenance organizations shall study the effect of preexisting condition exclusions and limitations on the cost and availability of health care coverage and shall provide recommendations to the legislature on findings no later than January 1, 1994. No insurer, health care service contractor, or health maintenance organization may deny, exclude, or limit coverage for preexisting conditions for a period longer than that provided for in such rules after July 1, 1994.

1 (3) No disability insurer may waive or exclude any preexisting
2 condition from coverage for more than a twelve-month period.

3 NEW SECTION. **Sec. 227.** A new section is added to chapter 48.44
4 RCW to read as follows:
5 (1) After January 1, 1994, every health care service contractor,
6 except limited health care service contractors as defined under RCW
7 48.44.035, shall waive any preexisting condition exclusion or
8 limitation for persons who had similar coverage under a different
9 policy, health care service contract, or health maintenance agreement
10 in the three-month period immediately preceding the effective date of
11 coverage under the new contract to the extent that such person has
12 satisfied a waiting period under such preceding policy, contract, or
13 agreement; however, if the person satisfied a twelve-month waiting
14 period under such preceding policy, contract, or agreement, the insurer
15 shall waive any preexisting condition exclusion or limitation. The
16 insurer need not waive a preexisting condition exclusion or limitation
17 under the new policy for coverage not provided under such preceding
18 policy, contract, or agreement.
19 (2) The commissioner in consultation with insurers, health care
20 service contractors, and health maintenance organizations shall study
21 the effect of preexisting condition exclusions and limitations on the
22 cost and availability of health care coverage and shall provide
23 recommendations to the legislature on findings no later than January 1,
24 1994. No insurer, health care service contractor, or health
25 maintenance organization may deny, exclude, or limit coverage for
26 preexisting conditions for a period longer than that provided for in
27 such rules after July 1, 1994.
28 (3) No health care service contractor may waive or exclude any
29 preexisting condition from coverage for more than a twelve-month
30 period.

31 NEW SECTION. **Sec. 228.** A new section is added to chapter 48.46
32 RCW to read as follows:
33 (1) After January 1, 1994, every health maintenance organization
34 shall waive any preexisting condition exclusion or limitation for
35 persons who had similar coverage under a different policy, health care
36 service contract, or health maintenance agreement in the one-month
37 period immediately preceding the effective date of coverage under the

1 new agreement to the extent that such person has satisfied a waiting
2 period under such preceding policy, contract, or agreement; however, if
3 the person satisfied a twelve-month waiting period under such preceding
4 policy, contract, or agreement, the insurer shall waive any preexisting
5 condition exclusion or limitation. The insurer need not waive a
6 preexisting condition exclusion or limitation under the new policy for
7 coverage not provided under such preceding policy, contract, or
8 agreement.

9 (2) The commissioner in consultation with insurers, health care
10 service contractors, and health maintenance organizations shall study
11 the effect of preexisting condition exclusions and limitations on the
12 cost and availability of health care coverage and shall provide
13 recommendations to the legislature on findings no later than January 1,
14 1994. No insurer, health care service contractor, or health
15 maintenance organization may deny, exclude, or limit coverage for
16 preexisting conditions for a period longer than that provided for in
17 such rules after July 1, 1994.

18 (3) No health maintenance organization may waive or exclude any
19 preexisting condition from coverage for more than a twelve-month
20 period.

21 **Sec. 229.** RCW 48.30.300 and 1975-'76 2nd ex.s. c 119 s 7 are each
22 amended to read as follows:

23 <u>Notwithstanding any provision contained in Title 48 RCW to the</u>
24 <u>contrary:</u>

25 <u>(1)</u> No person or entity engaged in the business of insurance in
26 this state shall refuse to issue any contract of insurance or cancel or
27 decline to renew such contract because of the sex or marital status, or
28 the presence of any sensory, mental, or physical handicap of the
29 insured or prospective insured. The amount of benefits payable, or any
30 term, rate, condition, or type of coverage shall not be restricted,
31 modified, excluded, increased or reduced on the basis of the sex or
32 marital status, or be restricted, modified, excluded or reduced on the
33 basis of the presence of any sensory, mental, or physical handicap of
34 the insured or prospective insured. <u>Subject to the provisions of</u>
35 <u>subsection (2) of this section t</u>hese provisions shall not prohibit fair
36 discrimination on the basis of sex, or marital status, or the presence
37 of any sensory, mental, or physical handicap when bona fide statistical
38 differences in risk or exposure have been substantiated.

1 (2) With respect to disability policies issued or renewed on or
2 after July 1, 1994, that provide coverage against loss arising from
3 medical, surgical, hospital, or emergency care services:
4 (a) Policies shall guarantee continuity of coverage. Such
5 provision, which shall be included in every policy, shall provide that:
6 (i) The policy may be canceled or nonrenewed without the prior
7 written approval of the commissioner only for nonpayment of premium or
8 as permitted under RCW 48.18.090; and
9 (ii) The policy may be canceled or nonrenewed because of a change
10 in the physical or mental condition or health of a covered person only
11 with the prior written approval of the commissioner. Such approval
12 shall be granted only when the insurer has discharged its obligation to
13 continue coverage for such person by obtaining coverage with another
14 insurer, health care service contractor, or health maintenance
15 organization, which coverage is comparable in terms of premiums and
16 benefits as defined by rule of the commissioner.
17 (b) It is an unfair practice for a disability insurer to modify the
18 coverage provided or rates applying to an in-force disability insurance
19 policy and to fail to make such modification in all such issued and
20 outstanding policies.
21 (c) Subject to rules adopted by the commissioner, it is an unfair
22 practice for a disability insurer to:
23 (i) Cease the sale of a policy form unless it has received prior
24 written authorization from the commissioner and has offered all
25 policyholders covered under such discontinued policy the opportunity to
26 purchase comparable coverage without health screening; or
27 (ii) Engage in a practice that subjects policyholders to rate
28 increases on discontinued policy forms unless such policyholders are
29 offered the opportunity to purchase comparable coverage without health
30 screening.
31 The insurer may limit an offer of comparable coverage without
32 health screening to a period not less than thirty days from the date
33 the offer is first made.

34 NEW SECTION. **Sec. 230.** A new section is added to chapter 48.44
35 RCW to read as follows:
36 (1) With respect to all health care service contracts issued or
37 renewed on or after July 1, 1994, except limited health care service
38 contracts as defined in RCW 48.44.035:

1 (a) Contracts shall guarantee continuity of coverage. Such provision, which shall be included in every contract, shall provide that:

4 (i) The contract may be canceled or nonrenewed without the prior written approval of the commissioner only for nonpayment of premiums, for violation of published policies of the contractor which have been approved by the commissioner, for persons who are entitled to become eligible for medicare benefits and fail to subscribe to a medicare supplement plan offered by the contractor, for failure of such subscriber to pay any deductible or copayment amount owed to the contractor and not the provider of health care services, for fraud, or for a material breach of the contract; and

13 (ii) The contract may be canceled or nonrenewed because of a change in the physical or mental condition or health of a covered person only with the prior written approval of the commissioner. Such approval shall be granted only when the contractor has discharged its obligation to continue coverage for such person by obtaining coverage with another insurer, health care service contractor, or health maintenance organization, which coverage is comparable in terms of premiums and benefits as defined by rule of the commissioner.

21 (b) It is an unfair practice for a contractor to modify the coverage provided or rates applying to an in-force contract and to fail to make such modification in all such issued and outstanding contracts.

24 (c) Subject to rules adopted by the commissioner, it is an unfair practice for a health care service contractor to:

26 (i) Cease the sale of a contract form unless it has received prior written authorization from the commissioner and has offered all subscribers covered under such discontinued contract the opportunity to purchase comparable coverage without health screening; or

30 (ii) Engage in a practice that subjects subscribers to rate increases on discontinued contract forms unless such subscribers are offered the opportunity to purchase comparable coverage without health screening.

34 (2) The health care service contractor may limit an offer of comparable coverage without health screening to a period not less than thirty days from the date the offer is first made.

37 NEW SECTION. **Sec. 231.** A new section is added to chapter 48.46 RCW to read as follows:

(1) With respect to all health maintenance agreements issued or renewed on or after July 1, 1994, and in addition to the restrictions and limitations contained in RCW 48.46.060(4):

(a) Agreements shall guarantee continuity of coverage. Such provision, which shall be included in every agreement, shall provide that the agreement may be canceled or nonrenewed because of a change in the physical or mental condition or health of a covered person only with the prior written approval of the commissioner. Such approval shall be granted only when the organization has discharged its obligation to continue coverage for such person by obtaining coverage with another insurer, health care service contractor, or health maintenance organization, which coverage is comparable in terms of premiums and benefits as defined by rule of the commissioner.

(b) It is an unfair practice for an organization to modify the coverage provided or rates applying to an in-force agreement and to fail to make such modification in all such issued and outstanding agreements.

(c) Subject to rules adopted by the commissioner, it is an unfair practice for a health maintenance organization to:

(i) Cease the sale of an agreement form unless it has received prior written authorization from the commissioner and has offered all enrollees covered under such discontinued agreement the opportunity to purchase comparable coverage without health screening; or

(ii) Engage in a practice that subjects enrollees to rate increases on discontinued agreement forms unless such enrollees are offered the opportunity to purchase comparable coverage without health screening.

(2) The health maintenance organization may limit an offer of comparable coverage without health screening to a period not less than thirty days from the date the offer is first made.

Sec. 232. RCW 48.44.260 and 1979 c 133 s 3 are each amended to read as follows:

Every authorized health care service contractor, upon canceling, denying, or refusing to renew any individual health care service contract, shall, upon written request, directly notify in writing the applicant or ((~~insured~~)) subscriber, as the case may be, of the reasons for the action by the health care service contractor. Any benefits, terms, rates, or conditions of such a contract which are restricted, excluded, modified, increased, or reduced ((~~because of the presence of~~

~~a sensory, mental, or physical handicap~~)) shall, upon written request, be set forth in writing and supplied to the ((~~insured~~)) subscriber. The written communications required by this section shall be phrased in simple language which is readily understandable to a person of average intelligence, education, and reading ability.

Sec. 233. RCW 48.46.380 and 1983 c 106 s 16 are each amended to read as follows:

Every authorized health maintenance organization, upon canceling, denying, or refusing to renew any individual health maintenance agreement, shall, upon written request, directly notify in writing the applicant or enrolled participant as appropriate, of the reasons for the action by the health maintenance organization. Any benefits, terms, rates, or conditions of such agreement which are restricted, excluded, modified, increased, or reduced ((~~because of the presence of a sensory, mental, or physical handicap~~)) shall, upon written request, be set forth in writing and supplied to the individual. The written communications required by this section shall be phrased in simple language which is readily understandable to a person of average intelligence, education, and reading ability.

NEW SECTION. **Sec. 234.** The following acts or parts of acts are each repealed:

(1) RCW 48.46.160 and 1975 1st ex.s. c 290 s 17; and

(2) RCW 48.46.905 and 1975 1st ex.s. c 290 s 25.

NEW SECTION. **Sec. 235.** RCW 48.44.410 and 1986 c 223 s 12 are each repealed, effective July 1, 1994.

NEW SECTION. **Sec. 236.** A new section is added to chapter 48.20 RCW to read as follows:

Whenever the provisions of this chapter governing the sale and content of disability insurance conflict with the provision of sections 301 through 306 and 328 through 347 of this act, sections 301 through 306 and 328 through 347 of this act shall control.

NEW SECTION. **Sec. 237.** A new section is added to chapter 48.21 RCW to read as follows:

1 Whenever the provisions of this chapter governing the sale and
2 content of disability insurance conflict with the provision of sections
3 301 through 306 and 328 through 347 of this act, sections 301 through
4 306 and 328 through 347 of this act shall control.

5 NEW SECTION. **Sec. 238.** A new section is added to chapter 48.44
6 RCW to read as follows:
7 Whenever the provisions of this chapter governing the sale and
8 content of health care service contracts conflict with the provision of
9 sections 301 through 306 and 328 through 347 of this act, sections 301
10 through 306 and 328 through 347 of this act shall control.

11 NEW SECTION. **Sec. 239.** A new section is added to chapter 48.46
12 RCW to read as follows:
13 Whenever the provisions of this chapter governing the sale and
14 content of health maintenance agreements conflict with the provision of
15 sections 301 through 306 and 327 through 346 of this act, sections 301
16 through 306 and 327 through 346 of this act shall control.

17 **H. LONG-TERM HEALTH CARE PARTNERSHIP**

18 NEW SECTION. **Sec. 240.** The legislature recognizes that the
19 elderly are the fastest-growing age group nation-wide and in Washington
20 state, increasing in absolute terms and as a percentage of the total
21 population. In addition, the older population itself is aging. The
22 over eighty-five years of age group of elderly are growing faster than
23 any other group. This is in large part due to the substantial advances
24 in medical technology that have increased the elderly's life expectancy
25 and have changed their prevalent causes of death. Living longer has
26 meant that chronic conditions have become major causes of death,
27 disability, and functional dependency. These conditions can effect the
28 individual for years, impairing their ability to function and
29 necessitating high use of long-term care and health care resources to
30 manage, not cure, the conditions. On the average, the elderly's health
31 care and long-term care utilization and expenditures are much greater
32 than those of the nonelderly. While the elderly spend nearly three
33 times the amount the population as a whole spends on health care, per
34 capita, their largest source of out-of-pocket expenditures is for
35 nursing home care. Currently, almost half of all the nursing home

1 expenditures in the United States are financed by public tax dollars
2 through the medicaid program. Almost all of the remaining expenditures
3 nation-wide for nursing homes are financed privately and are primarily
4 paid directly by individual out-of-pocket payments. Since private
5 health insurance for long-term care has not been a major component of
6 the financing for long-term care, the majority of the aged in our state
7 face the risk of financial ruin from an extended nursing home stay.
8 The legislature finds that the aged in nursing homes often "spend
9 down" their income and become dependent on tax-supported medicaid
10 nursing home care. Approximately half of the people that medicaid pays
11 for in nursing homes were not initially poor, but spent down their
12 assets as a result of catastrophic nursing home bills. The current
13 financing dilemma is likely to worsen. Additional demands are expected
14 to be made on the long-term care system. At the same time, the public
15 sector's ability to finance increased long-term care needs through tax-
16 supported programs, will decline. The lack of elderly persons
17 protected by private insurance further encourages them to seek medicaid
18 eligibility, often by transferring their assets to family members. As
19 a result, assets are lost that might be used advantageously to add to
20 their income, for more appropriate housing, or for health and social
21 services, to improve the quality of their lives, to prevent or delay
22 institutional placement, and to prevent their becoming indigent.
23 The legislature further finds that the private long-term care
24 insurance, as regulated and provided in this state, provides a proven
25 and viable option for protecting many of our state's elderly from the
26 devastating financial impact of a nursing home admission. If a
27 sufficient quantity of long-term care policies were purchased, it could
28 also reduce the state's large and growing burden for financing long-
29 term care.
30 It is the purpose and intent of this chapter to provide a realistic
31 approach to financing needed long-term care to the elderly by
32 encouraging the private market to be an appealing and effective partner
33 in long-term care financing and structuring linkages between private
34 insurance options and access to an improved medicaid system. The
35 approach will build upon the significant responsibilities and
36 experience that we have developed in the finance and delivery of long-
37 term care to address the challenge of coordinating the role of the
38 private sector with rapidly changing public programs.

NEW SECTION. **Sec. 241.** The office of insurance commissioner shall, from July 1, 1993, to July 1, 2000, coordinate a pilot program entitled the Washington long-term care partnership, whereby private insurance and medicaid funds shall be combined to finance long-term care. This program will allow an individual to purchase a precertified long-term care insurance policy in an amount commensurate with his or her assets. Notwithstanding any provision of law, the resources of such an individual, to the extent such resources are equal to the amount of long-term care insurance benefit payments as provided in this section, shall not be considered by the department of social and health services in a determination of: (1) His or her eligibility for medicaid, (2) the amount of any medicaid payment, or (3) in any subsequent recovery by the state of a payment for medical services.

NEW SECTION. **Sec. 242.** The department of social and health services shall seek appropriate amendments to its medicaid regulations or any other regulations to allow protection of resources and income pursuant to section 240 of this act. The protection assets shall be provided, to the extent approved by the federal health care financing administration, for any purchaser of a precertified long-term care policy delivered, issued for delivery, or renewed from January 1, 1994, to December 31, 1999, inclusive, or the termination of the program, whichever is sooner. The projections shall last for the life of the purchaser. The department of social and health services shall count insurance benefit payments toward resource exclusion to the extent such payments are for: (1) Services medicaid approves or covers for its recipients; (2) the lower of the actual charge and the amount paid by the insurance company; (3) nursing home care or formal services delivered to those insured in the community as part of a care plan approved by a coordination assessment and monitoring agency approved by the department of social and health services; and (4) services provided after the individual meets the coverage requirements for long-term care benefits established by the department of social and health services for this program. The secretary of social and health services shall adopt rules, in accordance with current law, to implement the provisions of this chapter relating to determining eligibility of applicants for medicaid and the coverage requirements for long-term care benefits.

1 NEW SECTION. **Sec. 243.** The insurance commissioner may precertify
2 only those long-term care insurance policies that: (1) Alert the
3 purchaser to the availability of consumer information and public
4 education provided by the department on aging and adult services
5 pursuant to section 244 of this act; (2) offer the option of home and
6 community-based services in lieu of nursing home care; (3) in all home
7 care plans, offer case management services delivered by a coordination,
8 assessment, and monitoring agency, approved by the department of social
9 and health services or by a home health care agency separately licensed
10 as a coordination, assessment, and monitoring agency under this
11 chapter; (4) offer automatic inflation protection or optional periodic
12 per diem upgrades until the insured begins to receive long-term care
13 benefits; (5) provide for the keeping of records and an explanation of
14 benefit reports on insurance payments that count toward medicaid
15 resource exclusion; and (6) provide the management information and
16 reports necessary to document the extent of medicaid resource
17 protection offered and to evaluate the Washington long-term care
18 partnership. No policy may be precertified if it requires prior
19 hospitalization or a prior stay in a nursing home as a condition of
20 providing long-term care benefits. The insurance commissioner shall
21 adopt rules to carry out the precertification provisions of this
22 chapter.

23 NEW SECTION. **Sec. 244.** The insurance commissioner shall require
24 its senior health insurance department advisors program to educate
25 consumers as to: (1) The need for long-term care; (2) mechanisms for
26 financing such care; (3) the availability of long-term care insurance;
27 and (4) the asset protection provided under this chapter. In addition
28 the department of social and health services shall provide to the
29 extent possible public information to assist individuals in choosing
30 appropriate insurance coverage.

31 NEW SECTION. **Sec. 245.** The department of social and health
32 services and the insurance commissioner shall seek the federal
33 approvals necessary to carry out the purposes of this chapter. Each
34 year, on January 1st, the insurance commissioner shall report to the
35 legislature on the progress of the program. The report shall include:
36 (1) The success in implementing the public and private partnership; (2)
37 the number of policies precertified; (3) the number, age, and financial

circumstances of individuals purchasing precertified policies; (4) the number of individuals seeking consumer information services; (5) the extent and type of benefits paid under precertified policies that could count toward medicaid resource protection; (6) estimates of impact on present and future medicaid expenditures; (7) the cost-effectiveness of the program; and (8) a determination regarding the appropriateness of continuing the program.

NEW SECTION. **Sec. 246.** Sections 240 through 245 of this act shall constitute a new chapter in Title 48 RCW.

I. UNIFORM ELECTRONIC CLAIMS PROCESSING

NEW SECTION. **Sec. 247.** A new section is added to chapter 48.20 RCW to read as follows:

APPLICATION TO DISABILITY INSURANCE POLICIES. (1) After January 1, 1995, all disability insurance policies that provide coverage for hospital or medical expenses shall use for all billing purposes in 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, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1995, the forms developed under section 256 of this act shall be used by providers of health care and carriers under this chapter.

NEW SECTION. **Sec. 248.** A new section is added to chapter 48.21 RCW to read as follows:

APPLICATION TO GROUP DISABILITY INSURANCE POLICIES. (1) After January 1, 1995, all group disability insurance policies that provide coverage for hospital or medical expenses shall use for all billing purposes in 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, eyeglasses, transportation, or vocational services.

1 (2) As of January 1, 1995, the forms developed under section 256 of
2 this act shall be used by providers of health care and carriers under
3 this chapter.

4 NEW SECTION. **Sec. 249.** A new section is added to chapter 48.44
5 RCW to read as follows:
6 APPLICATION TO HEALTH CARE INSURANCE CONTRACTS. (1) After January
7 1, 1995, all health care insurance contracts that provide coverage for
8 hospital or medical expenses shall use for all billing purposes in
9 electronic format either the health care financing administration
10 (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82
11 form, or its successor. For billing purposes, this subsection does not
12 apply to pharmacists, dentists, eyeglasses, transportation, or
13 vocational services.
14 (2) As of January 1, 1995, the forms developed under section 256 of
15 this act shall be used by providers of health care and carriers under
16 this chapter.

17 NEW SECTION. **Sec. 250.** A new section is added to chapter 48.46
18 RCW to read as follows:
19 APPLICATION TO HEALTH MAINTENANCE AGREEMENTS. (1) After January 1,
20 1995, all health maintenance agreements that provide coverage for
21 hospital or medical expenses shall use for all billing purposes in
22 electronic format either the health care financing administration
23 (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82
24 form, or its successor. For billing purposes, this subsection does not
25 apply to pharmacists, dentists, eyeglasses, transportation, or
26 vocational services.
27 (2) As of January 1, 1995, the forms developed under section 256 of
28 this act shall be used by providers of health care and carriers under
29 this chapter.

30 NEW SECTION. **Sec. 251.** A new section is added to chapter 48.84
31 RCW to read as follows:
32 APPLICATION TO LONG-TERM CARE PROVIDERS. (1) After January 1,
33 1995, all providers of long-term care that provide coverage for
34 hospital or medical expenses shall use for all billing purposes in
35 electronic format either the health care financing administration
36 (HCFA) 1500 form, or its successor, or the uniform bill (UB) 82 form,

1 or its successor. For billing purposes, this subsection does not apply
2 to pharmacists, dentists, eyeglasses, transportation, or vocational
3 services.
4 (2) As of January 1, 1995, the forms developed under section 256 of
5 this act shall be used by providers of health care and carriers under
6 this chapter.

7 NEW SECTION. **Sec. 252.** A new section is added to chapter 41.05
8 RCW to read as follows:
9 APPLICATION TO STATE HEALTH CARE AUTHORITY. After July 1, 1995,
10 the health care financing administration (HCFA) 1500 form, or its
11 successor, and the uniform billing (UB) 82 form, or its successor,
12 shall be used in electronic format for state-paid health care services
13 provided through the health care authority. The forms developed under
14 section 256 of this act shall be used for billing purposes for
15 pharmacists, dentists, eyeglasses, transportation, or vocational
16 services.

17 NEW SECTION. **Sec. 253.** A new section is added to chapter 74.09
18 RCW to read as follows:
19 APPLICATION TO THE MEDICAL ASSISTANCE PROGRAM. After July 1, 1995,
20 the health care financing administration (HCFA) 1500 form, or its
21 successor, and the uniform billing (UB) 82 form, or its successor,
22 shall be used in electronic format for state-paid health care services
23 provided by the department. The forms developed under section 256 of
24 this act shall be used for billing purposes for pharmacists, dentists,
25 eyeglasses, transportation, or vocational services.

26 NEW SECTION. **Sec. 254.** A new section is added to Title 51 RCW to
27 read as follows:
28 APPLICATION TO LABOR AND INDUSTRIES. After July 1, 1995, the
29 health care financing administration (HCFA) 1500 form, or its
30 successor, and the uniform billing (UB) 82 form, or its successor,
31 shall be used in electronic format for state-paid health care services
32 provided under this title. The forms developed under section 256 of
33 this act shall be used for billing purposes for pharmacists, dentists,
34 eyeglasses, transportation, or vocational services.

NEW SECTION. **Sec. 255.** A new section is added to chapter 70.47 RCW to read as follows:

APPLICATION TO BASIC HEALTH PLAN. After July 1, 1995, 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 electronic format for state-paid health care services provided under the basic health plan. The forms developed under section 256 of this act shall be used for billing purposes for pharmacists, dentists, eyeglasses, transportation, or vocational services.

NEW SECTION. **Sec. 256.** A new section is added to chapter 70.170 RCW to read as follows:

JOINT AGENCY RULES. By January 1, 1994, the council shall develop and adopt by rule electronic format billing forms to be used for pharmacists, dentists, 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.

NEW SECTION. **Sec. 257.** A new section is added to chapter 70.170 RCW to read as follows:

The council shall by rule adopt a uniform approach to health care claims processing, information requirements, definition of terms coding, and submission and payment mechanisms to be used by all providers and health care payers subject to this chapter.

PART III.
A. THE WASHINGTON HEALTH SERVICES COMMISSION

NEW SECTION. **Sec. 301.** CREATION OF COMMISSION--MEMBERSHIP--TERMS OF OFFICE--VACANCIES--SALARIES. (1) There is created an agency of state government to be known as the Washington health services commission. The commission shall consist of five members, appointed by the governor, with the consent of the senate. One member shall be designated by the governor as chair and shall serve at the pleasure of the governor. Of the initial members, one shall be appointed to a term of three years, one shall be appointed to a term of four years, and one shall be appointed to a term of five years. Thereafter, members shall be appointed to five-year terms. Vacancies shall be filled by

1 appointment for the remainder of the unexpired term of the position
2 being vacated.
3 (2) Members of the commission shall have no pecuniary interest in
4 any business subject to regulation by the commission and shall be
5 subject to chapter 42.18 RCW, the executive branch conflict of interest
6 act.
7 (3) Members of the commission shall occupy their positions on a
8 full-time basis and are exempt from the provisions of chapter 41.06
9 RCW. Commission members and the professional commission staff are
10 subject to the public disclosure provisions of chapter 42.17 RCW.
11 Members shall be paid a salary to be fixed by the governor in
12 accordance with RCW 43.03.040. A majority of the members of the
13 commission constitutes a quorum for the conduct of business.

14 <u>NEW SECTION.</u> **Sec. 302.** STAKEHOLDERS' COMMITTEE. (1)(a) In an
15 effort to ensure effective participation in the commission's
16 deliberations, the chair shall appoint a stakeholders' committee. The
17 chair may also appoint ad hoc and special committees for a specified
18 time period.
19 (b) The chair shall also appoint health services effectiveness
20 panels for specified periods of time to provide technical guidance
21 related to appropriate and effective health services, use of technology
22 and practice guidelines, and development of the uniform benefits
23 package. Panels should include technical experts, such as general
24 practitioners, specialty physicians or providers, health service
25 researchers, health ethicists, epidemiologists, and public health
26 experts who reflect the state's ethnic and cultural diversity.
27 (2) Members of committees and panels shall serve without
28 compensation for their services but shall be reimbursed for their
29 expenses while attending meetings on behalf of the commission in
30 accordance with RCW 43.03.050 and 43.03.060.

31 <u>NEW SECTION.</u> **Sec. 303.** POWERS AND DUTIES OF THE CHAIR. The chair
32 shall be the chief administrative officer and the appointing authority
33 of the commission and has the following powers and duties:
34 (1) Direct and supervise the commission's administrative and
35 technical activities in accordance with the provisions of this chapter
36 and rules and policies adopted by the commission;

1 (2) Employ no more than ten full-time employees of the commission,
2 representative of ethnic diversity, in accordance with chapter 41.06
3 RCW, and prescribe their duties;
4 (3) Enter into contracts on behalf of the commission;
5 (4) Accept and expend gifts, donations, grants, and other funds
6 received by the commission;
7 (5) Delegate administrative functions of the commission to
8 employees of the commission as the chair deems necessary to ensure
9 efficient administration;
10 (6) Subject to approval of the commission, appoint advisory
11 committees and undertake studies, research, and analysis necessary to
12 support activities of the commission;
13 (7) Preside at meetings of the commission; and
14 (8) Perform such other administrative and technical duties as are
15 consistent with chapter . . ., Laws of 1993 (this act) and the rules
16 and policies of the commission.

17 NEW SECTION. **Sec. 304.** POWERS AND DUTIES OF THE COMMISSION. The
18 commission has the following powers and duties:
19 (1) Ensure that all residents of Washington state are enrolled in
20 a managed care health plan to receive the uniform benefits package,
21 that shall include a schedule of covered basic health care services,
22 including physician services, inpatient and outpatient hospital
23 services, prescription drugs and medications, prenatal and postnatal
24 care, and other services that may be necessary for basic health care,
25 regardless of age, sex, family structure, ethnicity, race, health
26 condition, geographic location, employment, or economic status by July
27 1, 1998.
28 (2) Adopt necessary rules in accordance with chapter 34.05 RCW to
29 carry out the purposes of chapter . . ., Laws of 1993 (this act),
30 provided that an initial set of draft rules establishing at least the
31 commission's organization structure, levels of and standards for
32 certified health plan certification, must be submitted in draft form to
33 appropriate committees of the legislature by December 1, 1994.
34 (3) Develop and implement, if necessary, one or more medical risk
35 adjustment mechanisms to minimize financial incentives for certified
36 health plans to enroll individuals who present lower health risks and
37 avoid enrolling individuals who present higher health risks, and to

1 minimize financial incentives for employer hiring practices that
2 discriminate against individuals who present higher health risks.
3 (4) Design a mechanism to assure minors have access to confidential
4 health care services as currently provided in RCW 70.24.110 and
5 71.34.030.
6 (5) Monitor the actual growth in total annual health services
7 costs.
8 (6) Establish reporting requirements for health care facilities,
9 and health care providers to periodically report to the commission
10 regarding major capital expenditures. The commission shall review and
11 monitor such reports and shall report to the legislature regarding
12 major capital expenditures on at least an annual basis.
13 (7) Establish criteria that the Washington health care facilities
14 authority shall use to authorize the issuance of bonds pursuant to
15 chapter 70.37 RCW. Upon the publication of such criteria, the
16 authority may not issue bonds without commission approval.
17 (8) Require all managed health care systems, health care service
18 contractors, health maintenance organizations, disability insurers,
19 certified health plans, any state-paid or administered health care
20 program, and providers to use only health care financing
21 administration-approved paper claim forms, ANSI X12, or a subsequent
22 generation, electronic standards for the submission of electronic
23 claims and drop out red ink, or other specialized ink, on paper claim
24 forms to facilitate electronic scanning of claims.
25 (9) Adopt criteria and develop policy for personal health data and
26 information systems as provided in chapter 70.170 RCW.
27 (10) Evaluate and monitor the extent to which racial and ethnic
28 minorities have access and to receive health services within the state,
29 and develop strategies to address barriers to access.
30 (11) Develop standards for the certification process to certify
31 health plans to provide the uniform benefits package, according to the
32 provisions for certified health plans under chapter . . ., Laws of 1993
33 (this act).
34 (12)(a) Monitor the progress of the United States congress as it
35 deliberates reform of the health care system, to ascertain potential
36 opportunities for enhancing Washington state's health care system.
37 (b) Develop a process whereby all residents, businesses, and
38 government would make payments to certified health plans sufficient to
39 assure access to basic and affordable health benefits for all the

1 state's residents by July 1, 1998. The recommended process shall be
2 consistent with existing federal law and be submitted to the
3 legislature for its approval no later than December 1, 1994.
4 (13) Establish guidelines for providers dealing with terminal or
5 static conditions, taking into consideration the ethics of providers,
6 patient and family wishes, costs, and survival possibilities.
7 (14) Undertake or facilitate evaluations of health care reform,
8 including analysis of fiscal and economic impacts including in-
9 migration, the effectiveness of managed care and managed competition,
10 and effects of reform on access and quality of service. Fiscal and
11 economic impact analysis shall be conducted by the office of financial
12 management.
13 (15) Evaluate the extent to which Taft-Hartley health care trusts
14 provide benefits to certain individuals in the state; review the
15 federal laws under which these joint employee-employer entities are
16 organized; and make appropriate recommendations to the governor and the
17 legislature about how these trusts can be brought under the provisions
18 of chapter . . ., Laws of 1993 (this act) when it is fully implemented.

19 NEW SECTION. **Sec. 305.** CONFLICT OF INTEREST STANDARDS. The
20 Washington health services commission established by section 301 of
21 this act, in consultation with the secretary of health, and the health
22 care disciplinary authorities under RCW 18.130.040(2)(b), shall
23 establish standards and monetary penalties in rule prohibiting provider
24 investments and referrals that present a conflict of interest resulting
25 from inappropriate financial gain for the provider or his or her
26 immediate family. These standards are not intended to inhibit the
27 efficient operation of managed health care systems or certified health
28 plans. The commission shall report to the health policy committees of
29 the senate and house of representatives by December 1, 1994, on the
30 development of the standards and any recommended statutory changes
31 necessary to implement the standards.

32 NEW SECTION. **Sec. 306.** CONTINUOUS QUALITY IMPROVEMENT AND TOTAL
33 QUALITY MANAGEMENT. To ensure the highest quality health services at
34 the lowest total cost, the commission shall establish a total quality
35 management system of continuous quality improvement. Such endeavor
36 shall be based upon the recognized quality science for continuous
37 quality improvement. The commission shall impanel a committee composed

of persons from the private sector and related sciences who have broad knowledge and successful experiences in continuous quality improvement and total quality management applications. It shall be the responsibility of the committee to develop standards for a Washington state health services supplier certification process and recommend such standards to the commission for review and adoption. Once adopted, the commission shall establish a schedule, with full compliance no later than July 1, 1996, whereby all health service providers and health service facilities shall be certified prior to providing uniform benefits package services.

B. PRACTICE INDICATORS

NEW SECTION. **Sec. 307.** A new section is added to chapter 43.70 RCW to read as follows:

PRACTICE INDICATORS. The department of health shall consult with health care providers, purchasers, managed care delivery systems, certified health plans, health professional regulatory authorities under RCW 18.130.040, appropriate research and clinical experts, and consumers of health care services to identify specific practice areas where practice indicators and risk management protocols have been developed. Practice indicators shall be based upon expert consensus and best available scientific evidence. The department shall:

(1) Develop a definition of expert consensus and best available scientific evidence so that practice indicators can serve as a standard for excellence in the provision of health care services.

(2) Establish a process to identify and evaluate practice indicators and risk management protocols as they are developed by the appropriate professional, scientific, and clinical communities.

(3) Recommend the use of practice indicators and risk management protocols in quality assurance, utilization review, or provider payment to the health services commission.

C. HEALTH CARE LIABILITY REFORMS

Sec. 308. RCW 4.56.250 and 1986 c 305 s 301 are each amended to read as follows:

Notwithstanding the opinion of the state supreme court in *Sofie v. Fibreboard Corp.*, 112 Wn.2d 636 (1989) the legislature still believes

that controlling the cost of noneconomic damages must be a fundamental part of any health care reform. With the respect due our supreme court, a co-equal branch of our state government, the state legislature hereby amends RCW 4.56.250 to provide more information to the civil jury while reaffirming its belief in the constitutionality and appropriateness of RCW 4.56.250.

(1) As used in this section, the following terms have the meanings indicated unless the context clearly requires otherwise.

(a) "Economic damages" means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, loss of use of property, cost of replacement or repair, cost of obtaining substitute domestic services, loss of employment, and loss of business or employment opportunities.

(b) "Noneconomic damages" means subjective, nonmonetary losses, including, but not limited to pain, suffering, inconvenience, mental anguish, disability or disfigurement incurred by the injured party, emotional distress, loss of society and companionship, loss of consortium, injury to reputation and humiliation, and destruction of the parent-child relationship.

(c) "Bodily injury" means physical injury, sickness, or disease, including death.

(d) "Average annual wage" means the average annual wage in the state of Washington as determined under RCW 50.04.355.

(2) In no action seeking damages for personal injury or death may a claimant recover a judgment for noneconomic damages exceeding an amount determined by multiplying 0.43 by the average annual wage and by the life expectancy of the person incurring noneconomic damages, as the life expectancy is determined by the life expectancy tables adopted by the insurance commissioner. For purposes of determining the maximum amount allowable for noneconomic damages, a claimant's life expectancy shall not be less than fifteen years. The limitation contained in this subsection applies to all claims for noneconomic damages made by a claimant who incurred bodily injury. Claims for loss of consortium, loss of society and companionship, destruction of the parent-child relationship, and all other derivative claims asserted by persons who did not sustain bodily injury are to be included within the limitation on claims for noneconomic damages arising from the same bodily injury.

(3) If a case is tried to a jury, the jury shall ((~~not~~)) be informed of the limitation contained in subsection (2) of this section.

1 NEW SECTION. **Sec. 309.** CERTIFICATE OF MERIT REQUIRED. (1) The
2 claimant's attorney shall file the certificate specified in subsection
3 (2) of this section within thirty days of filing or service, whichever
4 occurs later, for any action for damages arising out of injuries
5 resulting from health care by a health care provider, as defined in RCW
6 7.70.020.
7 (2) The certificate issued by the claimant's attorney shall
8 declare:
9 (a) That the attorney has reviewed the facts of the case;
10 (b) That the attorney has consulted with at least one qualified
11 expert who holds a license, certificate, or registration issued by this
12 state or another state in the same profession as that of the defendant,
13 who practices in the same specialty or subspecialty as the defendant,
14 and whom the attorney reasonably believes is knowledgeable in the
15 relevant issues involved in the particular action;
16 (c) The identity of the expert and the expert's license,
17 certification, or registration;
18 (d) That the expert is willing and available to testify to
19 admissible facts or opinions; and
20 (e) That the attorney has concluded on the basis of such review and
21 consultation that there is reasonable and meritorious cause for the
22 filing of such action.
23 (3) Where a certificate is required under this section, and where
24 there are multiple defendants, the certificate or certificates must
25 state the attorney's conclusion that on the basis of review and expert
26 consultation, there is reasonable and meritorious cause for the filing
27 of such action as to each defendant.
28 (4) The provisions of this section are not applicable to a
29 plaintiff who is not represented by an attorney.
30 (5) Violation of this section is grounds for either dismissal of
31 the case or sanctions against the attorney, which may include an order
32 to pay to the defendant or defendants the amount of reasonable expense
33 incurred including a reasonable attorneys' fee, or both, as the court
34 deems appropriate.

35 **Sec. 310.** RCW 18.72.400 and 1991 c 3 s 171 are each amended to
36 read as follows:
37 (1) The secretary of health shall allocate all appropriated funds
38 to accomplish the purposes of this chapter.

1 (2) Upon a showing by the secretary of health, on behalf of the
2 medical disciplinary board, that expenditures in excess of levels
3 authorized by legislative appropriation are necessary to meet
4 unanticipated public demand for investigation of, and disciplinary
5 action against, unsafe or impaired physicians or surgeons, the office
6 of financial management may authorize necessary expenditures from the
7 medical disciplinary account in excess of appropriated levels.

8 **Sec. 311.** RCW 43.70.320 and 1991 sp.s. c 13 s 18 are each amended
9 to read as follows:
10 (1) There is created in the state treasury an account to be known
11 as the health professions account. All fees received by the department
12 for health professions licenses, registration, certifications,
13 renewals, or examinations and the civil penalties assessed and
14 collected by the department under RCW 18.130.190(4) shall be forwarded
15 to the state treasurer who shall credit such moneys to the health
16 professions account.
17 (2) All expenses incurred in carrying out the health professions
18 licensing activities of the department shall be paid from the account
19 as authorized by legislative appropriation. Upon a showing by the
20 department, on behalf of an individual health profession regulatory
21 board, that expenditures in excess of levels authorized by legislative
22 appropriation are necessary to meet unanticipated public demand for
23 investigation of, and disciplinary action against, unsafe or impaired
24 health care practitioners, the office of financial management may
25 authorize necessary expenditures from the health professions account in
26 excess of appropriated levels. Any residue in the account shall be
27 accumulated and shall not revert to the general fund at the end of the
28 biennium.
29 (3) The secretary shall biennially prepare a budget request based
30 on the anticipated costs of administering the health professions
31 licensing activities of the department which shall include the
32 estimated income from health professions fees.

33 **Sec. 312.** RCW 18.130.160 and 1986 c 259 s 8 are each amended to
34 read as follows:
35 FINDING OF UNPROFESSIONAL CONDUCT--ORDERS--SANCTIONS--STAY--COSTS.
36 Upon a finding that a license holder or applicant has committed
37 unprofessional conduct or is unable to practice with reasonable skill

and safety due to a physical or mental condition, the disciplining authority may issue an order providing for one or any combination of the following:

(1) Revocation of the license;

(2) Suspension of the license for a fixed or indefinite term;

(3) Restriction or limitation of the practice;

(4) Requiring the satisfactory completion of a specific program of remedial education or treatment;

(5) The monitoring of the practice by a supervisor approved by the disciplining authority;

(6) Censure or reprimand;

(7) Compliance with conditions of probation for a designated period of time;

(8) Payment of a fine for each violation of this chapter, not to exceed ((~~one~~)) five thousand dollars per violation. Funds received shall be placed in the health professions account;

(9) Denial of the license request;

(10) Corrective action;

(11) Refund of fees billed to and collected from the consumer.

Any of the actions under this section may be totally or partly stayed by the disciplining authority. In determining what action is appropriate, the disciplining authority must first consider what sanctions are necessary to protect or compensate the public. Only after such provisions have been made may the disciplining authority consider and include in the order requirements designed to rehabilitate the license holder or applicant. All costs associated with compliance with orders issued under this section are the obligation of the license holder or applicant.

Sec. 313. RCW 18.130.190 and 1991 c 3 s 271 are each amended to read as follows:

(1) The secretary shall investigate complaints concerning practice by unlicensed persons of a profession or business for which a license is required by the chapters specified in RCW 18.130.040. In the investigation of the complaints, the secretary shall have the same authority as provided the secretary under RCW 18.130.050. The secretary shall issue a cease and desist order to a person after notice and hearing and upon a determination that the person has violated this subsection. If the secretary makes a written finding of fact that the

1 public interest will be irreparably harmed by delay in issuing an
2 order, the secretary may issue a temporary cease and desist order. The
3 cease and desist order shall not relieve the person so practicing or
4 operating a business without a license from criminal prosecution
5 therefor, but the remedy of a cease and desist order shall be in
6 addition to any criminal liability. The cease and desist order is
7 conclusive proof of unlicensed practice and may be enforced under RCW
8 7.21.060. This method of enforcement of the cease and desist order may
9 be used in addition to, or as an alternative to, any provisions for
10 enforcement of agency orders set out in chapter 34.05 RCW.
11 (2) The attorney general, a county prosecuting attorney, the
12 secretary, a board, or any person may in accordance with the laws of
13 this state governing injunctions, maintain an action in the name of
14 this state to enjoin any person practicing a profession or business for
15 which a license is required by the chapters specified in RCW 18.130.040
16 without a license from engaging in such practice or operating such
17 business until the required license is secured. However, the
18 injunction shall not relieve the person so practicing or operating a
19 business without a license from criminal prosecution therefor, but the
20 remedy by injunction shall be in addition to any criminal liability.
21 (3) Unlicensed practice of a profession or operating a business for
22 which a license is required by the chapters specified in RCW
23 18.130.040, unless otherwise exempted by law, constitutes a gross
24 misdemeanor. All fees, fines, forfeitures, and penalties collected or
25 assessed by a court because of a violation of this section shall be
26 remitted to the health professions account.
27 (4) In addition to the remedies provided in this section, the
28 secretary is authorized to impose a civil penalty of up to five
29 thousand dollars on a person engaged, without a license, in a
30 profession or business for which a license is required by the chapters
31 specified in RCW 18.130.040. The imposition of the civil penalty shall
32 occur only upon a finding by the secretary, after affording an
33 opportunity for a hearing, that there has been a failure or refusal to
34 obtain a license as required in any of the chapters specified in RCW
35 18.130.040.

36 NEW SECTION. **Sec. 314.** A new section is added to chapter 18.130
37 RCW to read as follows:

1 MALPRACTICE INSURANCE COVERAGE MANDATE. Except to the extent that
2 liability insurance is not available, every licensed health care
3 practitioner whose services are included in the uniform benefits
4 package, as determined by the health services commission by rule, and
5 whose scope of practice includes independent practice, shall, as a
6 condition of licensure and relicensure, be required to provide evidence
7 of a minimum level of malpractice insurance coverage. On or before
8 January 1, 1994, the department shall designate by rule:
9 (1) Those health professions whose scope of practice includes
10 independent practice;
11 (2) For each health profession whose scope of practice includes
12 independent practice, whether malpractice insurance is available; and
13 (3) If such insurance is available, the appropriate minimum level
14 of mandated coverage.

15 NEW SECTION. **Sec. 315.** A new section is added to chapter 48.22
16 RCW to read as follows:
17 RISK MANAGEMENT TRAINING OF INDEPENDENT HEALTH CARE PRACTITIONERS.
18 Effective July 1, 1994, a casualty insurer's issuance of a new medical
19 malpractice policy or renewal of an existing medical malpractice policy
20 to a physician or other independent health care practitioner shall be
21 conditioned upon that practitioner's participation in, and completion
22 of, health care liability risk management training. The risk
23 management training shall provide information related to avoiding
24 adverse health outcomes resulting from substandard practice and
25 minimizing damages associated with the adverse health outcomes that do
26 occur. For purposes of this section, "independent health care
27 practitioners" means those health care practitioner licensing
28 classifications designated by the department of health in rule pursuant
29 to section 314 of this act.

30 NEW SECTION. **Sec. 316.** A new section is added to chapter 48.05
31 RCW to read as follows:
32 RISK MANAGEMENT TRAINING OF INDEPENDENT HEALTH CARE PRACTITIONERS.
33 Effective July 1, 1994, each health care provider, facility, or health
34 maintenance organization that self-insures for liability risks related
35 to medical malpractice and employs physicians or other independent
36 health care practitioners in Washington state shall condition each
37 physician's and practitioner's liability coverage by that entity upon

that physician's or practitioner's participation in risk management training offered by the provider, facility, or health maintenance organization to its employees. The risk management training shall provide information related to avoiding adverse health outcomes resulting from substandard practice and minimizing damages associated with those adverse health outcomes that do occur. For purposes of this section, "independent health care practitioner" means those health care practitioner licensing classifications designated by the department of health in rule pursuant to section 314 of this act.

Sec. 317. RCW 70.41.200 and 1991 c 3 s 336 are each amended to read as follows:

(1) Every hospital shall maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The program shall include at least the following:

(a) The establishment of a quality ((~~assurance~~)) improvement committee with the responsibility to review the services rendered in the hospital, both retrospectively and prospectively, in order to improve the quality of medical care of patients and to prevent medical malpractice. The committee shall oversee and coordinate the quality improvement and medical malpractice prevention program and shall insure that information gathered pursuant to the program is used to review and to revise hospital policies and procedures((~~. At least one member of the committee shall be a member of the governing board of the hospital who is not otherwise affiliated with the hospital in an employment or contractual capacity~~));

(b) A medical staff privileges sanction procedure through which credentials, physical and mental capacity, and competence in delivering health care services are periodically reviewed as part of an evaluation of staff privileges;

(c) The periodic review of the credentials, physical and mental capacity, and competence in delivering health care services of all persons who are employed or associated with the hospital;

(d) A procedure for the prompt resolution of grievances by patients or their representatives related to accidents, injuries, treatment, and other events that may result in claims of medical malpractice;

(e) The maintenance and continuous collection of information concerning the hospital's experience with negative health care outcomes

and incidents injurious to patients, patient grievances, professional liability premiums, settlements, awards, costs incurred by the hospital for patient injury prevention, and safety improvement activities;

(f) The maintenance of relevant and appropriate information gathered pursuant to (a) through (e) of this subsection concerning individual physicians within the physician's personnel or credential file maintained by the hospital;

(g) Education programs dealing with quality improvement, patient safety, injury prevention, staff responsibility to report professional misconduct, the legal aspects of patient care, improved communication with patients, and causes of malpractice claims for staff personnel engaged in patient care activities; and

(h) Policies to ensure compliance with the reporting requirements of this section.

(2) Any person who, in substantial good faith, provides information to further the purposes of the quality improvement and medical malpractice prevention program or who, in substantial good faith, participates on the quality ((~~assurance~~)) improvement committee shall not be subject to an action for civil damages or other relief as a result of such activity.

(3) Information and documents, including complaints and incident reports, created specifically for, and collected, and maintained ((~~about health care providers arising out of the matters that are under review or have been evaluated~~)) by a ((~~review~~)) quality improvement committee ((~~conducting quality assurance reviews~~)) are not subject to discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or ((~~board~~)) who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts which form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; ((~~(b)~~)) (c) in any civil action by a health care provider

regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality ((~~assurance~~)) improvement committees regarding such health care provider; ((~~(c)~~)) (d) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or ((~~(d)~~)) (e) in any civil action, discovery and introduction into evidence of the patient's medical records required by regulation of the department of health to be made regarding the care and treatment received.

(4) The department of health shall adopt such rules as are deemed appropriate to effectuate the purposes of this section.

(5) The medical disciplinary board or the board of osteopathic medicine and surgery, as appropriate, may review and audit the records of committee decisions in which a physician's privileges are terminated or restricted. Each hospital shall produce and make accessible to the board the appropriate records and otherwise facilitate the review and audit. Information so gained shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (3) of this section. Failure of a hospital to comply with this subsection is punishable by a civil penalty not to exceed two hundred fifty dollars.

(6) Violation of this section shall not be considered negligence per se.

Sec. 318. RCW 70.41.230 and 1991 c 3 s 337 are each amended to read as follows:

(1) Prior to granting or renewing clinical privileges or association of any physician or hiring a physician, a hospital or facility approved pursuant to this chapter shall request from the physician and the physician shall provide the following information:

(a) The name of any hospital or facility with or at which the physician had or has any association, employment, privileges, or practice;

(b) If such association, employment, privilege, or practice was discontinued, the reasons for its discontinuation;

(c) Any pending professional medical misconduct proceedings or any pending medical malpractice actions in this state or another state, the substance of the allegations in the proceedings or actions, and any

1 additional information concerning the proceedings or actions as the
2 physician deems appropriate;
3 (d) The substance of the findings in the actions or proceedings and
4 any additional information concerning the actions or proceedings as the
5 physician deems appropriate;
6 (e) A waiver by the physician of any confidentiality provisions
7 concerning the information required to be provided to hospitals
8 pursuant to this subsection; and
9 (f) A verification by the physician that the information provided
10 by the physician is accurate and complete.
11 (2) Prior to granting privileges or association to any physician or
12 hiring a physician, a hospital or facility approved pursuant to this
13 chapter shall request from any hospital with or at which the physician
14 had or has privileges, was associated, or was employed, the following
15 information concerning the physician:
16 (a) Any pending professional medical misconduct proceedings or any
17 pending medical malpractice actions, in this state or another state;
18 (b) Any judgment or settlement of a medical malpractice action and
19 any finding of professional misconduct in this state or another state
20 by a licensing or disciplinary board; and
21 (c) Any information required to be reported by hospitals pursuant
22 to RCW 18.72.265.
23 (3) The medical disciplinary board shall be advised within thirty
24 days of the name of any physician denied staff privileges, association,
25 or employment on the basis of adverse findings under subsection (1) of
26 this section.
27 (4) A hospital or facility that receives a request for information
28 from another hospital or facility pursuant to subsections (1) and (2)
29 of this section shall provide such information concerning the physician
30 in question to the extent such information is known to the hospital or
31 facility receiving such a request, including the reasons for
32 suspension, termination, or curtailment of employment or privileges at
33 the hospital or facility. A hospital, facility, or other person
34 providing such information in good faith is not liable in any civil
35 action for the release of such information.
36 (5) Information and documents, including complaints and incident
37 reports, created specifically for, and collected, and maintained
38 ((~~about health care providers arising out of the matters that are under~~
39 ~~review or have been evaluated~~)) by a ((~~review~~)) quality improvement

committee ((~~conducting quality assurance reviews~~)) are not subject to discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or ((~~board~~)) who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts which form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; ((~~(b)~~)) (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality ((~~assurance~~)) improvement committees regarding such health care provider; ((~~(c)~~)) (d) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or ((~~(d)~~)) (e) in any civil action, discovery and introduction into evidence of the patient's medical records required by regulation of the department of health to be made regarding the care and treatment received.

(6) Hospitals shall be granted access to information held by the medical disciplinary board and the board of osteopathic medicine and surgery pertinent to decisions of the hospital regarding credentialing and recredentialing of practitioners.

(7) Violation of this section shall not be considered negligence per se.

NEW SECTION. **Sec. 319.** A new section is added to chapter 43.70 RCW to read as follows:

COORDINATED QUALITY IMPROVEMENT PROGRAM. (1)(a) Health care institutions and medical facilities, other than hospitals, that are licensed by the department, and certified health plans approved pursuant to section 331 of this act may maintain a coordinated quality improvement program for the improvement of the quality of health care

1 services rendered to patients and the identification and prevention of
2 medical malpractice as set forth in RCW 70.41.200.
3 (b) All such programs shall comply with the requirements of RCW
4 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to
5 reflect the structural organization of the institution, facility, or
6 certified health plan, unless an alternative quality improvement
7 program substantially equivalent to RCW 70.41.200(1)(a) is developed.
8 All such programs, whether complying with the requirement set forth in
9 RCW 70.41.200(1)(a) or in the form of an alternative program, must be
10 approved by the department before the discovery limitations provided in
11 subsections (3) and (4) of this section shall apply. In reviewing
12 plans submitted by licensed entities that are associated with
13 physicians' offices, the department shall ensure that the discovery
14 limitations of this section are applied only to information and
15 documents related specifically to quality improvement activities
16 undertaken by the licensed entity.
17 (2) Physician groups of ten or more physicians may maintain a
18 coordinated quality improvement program for the improvement of the
19 quality of health care services rendered to patients and the
20 identification and prevention of medical malpractice as set forth in
21 RCW 70.41.200. All such programs shall comply with the requirements of
22 RCW 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to
23 reflect the structural organization of the physician group. All such
24 programs must be approved by the department before the discovery
25 limitations provided in subsections (3) and (4) of this section shall
26 apply.
27 (3) Any person who, in substantial good faith, provides information
28 to further the purposes of the quality improvement and medical
29 malpractice prevention program or who, in substantial good faith,
30 participates on the quality improvement committee shall not be subject
31 to an action for civil damages or other relief as a result of such
32 activity.
33 (4) Information and documents, including complaints and incident
34 reports, created specifically for, and collected, and maintained by a
35 quality improvement committee are not subject to discovery or
36 introduction into evidence in any civil action, and no person who was
37 in attendance at a meeting of such committee or who participated in the
38 creation, collection, or maintenance of information or documents
39 specifically for the committee shall be permitted or required to

1 testify in any civil action as to the content of such proceedings or
2 the documents and information prepared specifically for the committee.
3 This subsection does not preclude: (a) In any civil action, the
4 discovery of the identity of persons involved in the medical care that
5 is the basis of the civil action whose involvement was independent of
6 any quality improvement activity; (b) in any civil action, the
7 testimony of any person concerning the facts that form the basis for
8 the institution of such proceedings of which the person had personal
9 knowledge acquired independently of such proceedings; (c) in any civil
10 action by a health care provider regarding the restriction or
11 revocation of that individual's clinical or staff privileges,
12 introduction into evidence information collected and maintained by
13 quality improvement committees regarding such health care provider; (d)
14 in any civil action, disclosure of the fact that staff privileges were
15 terminated or restricted, including the specific restrictions imposed,
16 if any and the reasons for the restrictions; or (e) in any civil
17 action, discovery and introduction into evidence of the patient's
18 medical records required by rule of the department of health to be made
19 regarding the care and treatment received.
20 (5) The department of health shall adopt rules as are necessary to
21 implement this section.

22 NEW SECTION. **Sec. 320.** MEDICAL MALPRACTICE REVIEW. (1) The
23 administrator for the courts shall coordinate a collaborative effort to
24 develop a voluntary system for review of medical malpractice claims by
25 health services experts prior to the filing of a cause of action under
26 chapter 7.70 RCW.
27 (2) The system shall have at least the following components:
28 (a) Review would be initiated, by agreement of the injured claimant
29 and the health care provider, at the point at which a medical
30 malpractice claim is submitted to a malpractice insurer or a self-
31 insured health care provider.
32 (b) By agreement of the parties, an expert would be chosen from a
33 pool of health services experts who have agreed to review claims on a
34 voluntary basis.
35 (c) The mutually agreed upon expert would conduct an impartial
36 review of the claim and provide his or her opinion to the parties.
37 (d) A pool of available experts would be established and maintained
38 for each category of health care practitioner by the corresponding

1 practitioner association, such as the Washington state medical
2 association and the Washington state nurses association.
3 (3) The administrator for the courts shall seek to involve at least
4 the following organizations in a collaborative effort to develop the
5 informal review system described in subsection (2) of this section:
6 (a) The Washington defense trial lawyers association;
7 (b) The Washington state trial lawyers association;
8 (c) The Washington state medical association;
9 (d) The Washington state nurses association;
10 (e) The Washington state hospital association;
11 (f) The Washington state physicians insurance exchange and
12 association;
13 (g) The Washington casualty company;
14 (h) The doctor's agency;
15 (i) Group health cooperative of Puget Sound;
16 (j) The University of Washington;
17 (k) Washington osteopathic medical association;
18 (l) Washington state chiropractic association;
19 (m) Washington association of naturopathic physicians; and
20 (n) The department of health.
21 (4) On or before January 1, 1994, the administrator for the courts
22 shall provide a report on the status of the development of the system
23 described in this section to the governor and the appropriate
24 committees of the senate and the house of representatives.

25 NEW SECTION. **Sec. 321.** A new section is added to chapter 7.70 RCW
26 to read as follows:
27 MANDATORY MEDIATION OF HEALTH CARE MALPRACTICE CLAIMS. (1) All
28 causes of action, whether based in tort, contract, or otherwise, for
29 damages arising from injury occurring as a result of health care
30 provided after the effective date of this section shall be subject to
31 mandatory mediation prior to trial.
32 (2) The supreme court shall by rule adopt procedures to implement
33 mandatory mediation of actions under this chapter. The rules shall
34 address, at a minimum:
35 (a) Procedures for the appointment of, and qualifications of,
36 mediators. A mediator shall have experience or expertise related to
37 actions arising from injury occurring as a result of health care, and
38 be a member of the state bar association who has been admitted to the

bar for a minimum of five years or who is a retired judge. The parties may stipulate to a nonlawyer mediator. The court may prescribe additional qualifications of mediators. Mediators shall be compensated in the same amount and manner as judges pro tempore of the superior court unless the parties agree to a different amount or manner of compensation;

(b) The number of days following the filing of a claim under this chapter within which a mediator must be selected;

(c) The method by which a mediator is selected. The rule shall provide for designation of a mediator by the superior court if the parties are unable to agree upon a mediator;

(d) The number of days following the selection of a mediator within which a mediation conference must be held;

(e) A means by which mediation of an action under this chapter may be waived by a mediator who has determined that the claim is not appropriate for mediation; and

(f) Any other matters deemed necessary by the court.

(3) Mediators shall not impose discovery schedules upon the parties.

NEW SECTION. **Sec. 322.** A new section is added to chapter 7.70 RCW to read as follows:

MANDATORY MEDIATION OF HEALTH CARE MALPRACTICE. The making of a written, good faith request for mediation of a dispute related to damages for injury occurring as a result of health care provided prior to filing a cause of action under this chapter shall toll the statute of limitations provided in RCW 4.16.350.

NEW SECTION. **Sec. 323.** A new section is added to chapter 7.70 RCW to read as follows:

MANDATORY MEDIATION OF HEALTH CARE MALPRACTICE CLAIMS. Section 321 of this act may not be construed to abridge the right to trial by jury following an unsuccessful attempt at mediation.

Sec. 324. RCW 5.60.070 and 1991 c 321 s 1 are each amended to read as follows:

(1) If there is a court order to mediate ((~~or~~)), a written agreement between the parties to mediate, or if mediation is mandated under section 321 of this act, then any communication made or materials

submitted in, or in connection with, the mediation proceeding, whether made or submitted to or by the mediator, a mediation organization, a party, or any person present, are privileged and confidential and are not subject to disclosure in any judicial or administrative proceeding except:

(a) When all parties to the mediation agree, in writing, to disclosure;

(b) When the written materials or tangible evidence are otherwise subject to discovery, and were not prepared specifically for use in and actually used in the mediation proceeding;

(c) When a written agreement to mediate permits disclosure;

(d) When disclosure is mandated by statute;

(e) When the written materials consist of a written settlement agreement or other agreement signed by the parties resulting from a mediation proceeding;

(f) When those communications or written materials pertain solely to administrative matters incidental to the mediation proceeding, including the agreement to mediate; or

(g) In a subsequent action between the mediator and a party to the mediation arising out of the mediation.

(2) When there is a court order ((~~or~~)), a written agreement to mediate, or when mediation is mandated under section 321 of this act, as described in subsection (1) of this section, the mediator or a representative of a mediation organization shall not testify in any judicial or administrative proceeding unless:

(a) All parties to the mediation and the mediator agree in writing; or

(b) In an action described in subsection (1)(g) of this section.

NEW SECTION. **Sec. 325.** The legislature finds that in *Sofie v. Fibreboard Corp., 112 Wn.2d 636 (1989),* the Washington state supreme court struck down the limit on noneconomic damages enacted by the legislature in 1986, because the court found that the statutory limitation on noneconomic damages interfered with the jury's province to determine damages, and thus violated a plaintiff's constitutionally protected right to trial by jury.

The legislature further finds that reforms in existing law for actions involving fault are necessary and proper to avoid catastrophic

economic consequences for state and local governmental entities as well as private individuals and businesses.

Therefore, the legislature declares that to remedy the economic inequities which may arise from *Sofie*, defendants in actions involving fault should be held financially liable in closer proportion to their respective degree of fault. To treat them differently is unfair and inequitable.

It is further the intent of the legislature to partially eliminate causes of action based on joint and several liability as provided by this act for the purpose of reducing costs associated with the civil justice system.

Sec. 326. RCW 4.22.070 and 1986 c 305 s 401 are each amended to read as follows:

(1) For the purposes of this section, the term "economic damages" means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, loss of use of property, cost of replacement or repair, cost of obtaining substitute domestic services, loss of employment, and loss of business or employment opportunities. "Economic damages" does not include subjective, nonmonetary losses such as pain and suffering, mental anguish, emotional distress, disability and disfigurement, inconvenience, injury to reputation, humiliation, destruction of the parent-child relationship, the nature and extent of an injury, loss of consortium, society, companionship, support, love, affection, care, services, guidance, training, instruction, and protection.

(2) In all actions involving fault of more than one entity, the trier of fact shall determine the percentage of the total fault which is attributable to every entity which caused the claimant's damages, including the claimant or person suffering personal injury or incurring property damage, defendants, third-party defendants, entities released by the claimant, entities immune from liability to the claimant and entities with any other individual defense against the claimant. Judgment shall be entered against each defendant except those who have been released by the claimant or are immune from liability to the claimant or have prevailed on any other individual defense against the claimant in an amount which represents that party's proportionate share of the claimant's total damages. The liability of each defendant shall be several only and shall not be joint except:

(a) A party shall be responsible for the fault of another person or for payment of the proportionate share of another party where both were acting in concert or when a person was acting as an agent or servant of the party.

(b) If the trier of fact determines that the claimant or party suffering bodily injury or incurring property damages was not at fault, the defendants against whom judgment is entered shall be jointly and severally liable for the sum of their proportionate shares of the claimant's ((~~total~~)) economic damages.

((~~(2)~~)) (3) If a defendant is jointly and severally liable under one of the exceptions listed in subsections (1)(a) or (1)(b) of this section, such defendant's rights to contribution against another jointly and severally liable defendant, and the effect of settlement by either such defendant, shall be determined under RCW 4.22.040, 4.22.050, and 4.22.060.

((~~(3)~~)) (4)(a) Nothing in this section affects any cause of action relating to hazardous wastes or substances or solid waste disposal sites.

(b) Nothing in this section shall affect a cause of action arising from the tortious interference with contracts or business relations.

(c) Nothing in this section shall affect any cause of action arising from the manufacture or marketing of a fungible product in a generic form which contains no clearly identifiable shape, color, or marking.

NEW SECTION. **Sec. 327.** A new section is added to chapter 4.24 RCW to read as follows:

No person may maintain a cause of action or receive an award of damages or imposition of a penalty based on the claim that, but for the intentional or negligent conduct of another, he or she or a child would have been aborted or otherwise not born.

The failure or refusal of a person to perform or have an abortion shall not be a defense in an action. The failure or refusal of a person to perform or have an abortion shall not be considered in awarding damages or imposing a penalty.

Nothing in this section shall preclude a cause of action for a claim based on the failure of a contraceptive method or sterilization procedure. Nothing in this section shall preclude a cause of action based on a claim that, but for the negligent conduct of another, tests

or treatment would have been provided or would have been provided properly which would have made possible the prevention, cure, or amelioration of a disease, defect, deficiency, or handicap. Nothing in this section shall preclude a medical malpractice cause of action otherwise based on the intentional, reckless, or negligent conduct of another. Abortion shall not be considered a contraceptive method or a means of preventing, curing, or ameliorating a disease, defect, deficiency, or handicap.

D. HEALTH INSURANCE PURCHASING COOPERATIVES

NEW SECTION. **Sec. 328.** HEALTH INSURANCE PURCHASING COOPERATIVES--DESIGNATION OF REGIONS BY COMMISSION, INFORMATION SYSTEMS, MINIMUM STANDARDS, AND RULES. (1) The health service commission shall designate regions within the state in which competing health insurance purchasing cooperatives shall operate, based upon population, assuming that each cooperative must serve no less than one hundred thousand persons; geographic factors; market conditions; and other factors deemed appropriate by the commission. The commission may designate certain regions of the state as areas where only one cooperative may operate upon a determination that an insufficient population base exists within such region to efficiently support more than one cooperative.

(2) Every health insurance purchasing cooperative shall:

(a) Admit all individuals, public or private employers, or other groups wishing to participate in the cooperative consistent with the charter and bylaws of the cooperative as approved by the insurance commissioner;

(b) Make available for purchase by cooperative members health care programs offered by certified health plans operating within the cooperative's region;

(c) Be operated as a member-governed and owned, nonprofit cooperative;

(d) Provide for centralized enrollment and premium collection and distribution among certified health plans;

(e) Serve as an ombudsman for its members to resolve inquiries, complaints, or other concerns with certified health plans; and

(f) Consider ways in which they can develop, encourage, and provide incentives for employee wellness programs.

(3) Every health insurance purchasing cooperative may assist members in selecting certified health plans and for this purpose may devise a rating system or similar system to judge the quality and cost-effectiveness of certified health plans.

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

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

(6) The commission may adopt rules necessary for the implementation of this section.

NEW SECTION. **Sec. 329.** LICENSING AND REGULATION OF HEALTH INSURANCE PURCHASING COOPERATIVES BY THE INSURANCE COMMISSIONER. (1) No person may operate a health insurance purchasing cooperative without having first obtained a certificate of authority from the insurance commissioner.

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

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

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

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

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

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

(3) The commissioner shall approve applications for certificates in accordance with the order received. Once the maximum number of cooperatives have been issued certificates of authority in each region in accordance with the rules adopted by the health services commission, the insurance commissioner may not issue any new certificate until or

unless a previously authorized cooperative surrenders or loses its certificate of authority.

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

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

E. CERTIFIED HEALTH PLANS

NEW SECTION. **Sec. 330.** CERTIFIED HEALTH PLANS--REGISTRATION REQUIRED--PENALTY. (1) On or after July 1, 1997, no person or entity in this state shall, by mail or otherwise, sell the uniform benefits package as defined by the commission without being certified as a certified health plan by the insurance commissioner.

(2) On or after July 1, 1997, the uniform benefits package shall be purchased only from entities certified as certified health plans.

(3) On or after July 1, 1997, the uniform benefits package shall be the minimum benefits package of any certified health plan.

NEW SECTION. **Sec. 331.** HEALTH PLAN CERTIFICATION STANDARDS. A certified health plan shall:

(1) Provide the benefits included in the uniform benefits package to enrolled Washington residents for a premium not to exceed the maximum established by the commission, or provider charges that exceed the maximum charges established by the commission. Certified health plans shall utilize community-rating principles in determining rates and premiums for the uniform benefits package. The community-rating principles required by this section shall allow adjustments for age, geography, and gender. Certified health plans may also allow favorable premium adjustments attributable to wellness and preventive programs, nonsmoking, and other factors approved by the commission;

(2) Accept for enrollment any state resident within the plan's service area and provide or assure the provision of all services within

1 the uniform benefits package regardless of factors referenced in RCW
2 49.60.020, including age, sex, family structure, ethnicity, race,
3 health condition, geographic location, employment status, socioeconomic
4 status, or other condition or situation;
5 (3) If the plan provides benefits through contracts with, ownership
6 of, or management of health care facilities and contracts with or
7 employs health care providers, demonstrate to the satisfaction of the
8 insurance commissioner in consultation with the department of health
9 and the commission that its facilities and personnel are adequate to
10 provide the benefits prescribed in the uniform benefits package to
11 enrolled Washington residents, and that it is financially capable of
12 providing such residents with, or has made adequate contractual
13 arrangements with health care providers and facilities to provide
14 enrollees with such benefits. Nothing in this chapter prohibits a
15 certified health plan from offering the uniform benefits package where
16 such obligations are protected by the Washington life and disability
17 insurance guaranty association in place of the provider contracts
18 otherwise required under section 338 of this act;
19 (4) Comply with portability of benefits requirements prescribed by
20 the insurance commissioner;
21 (5) Provide all enrollees with instruction and informational
22 materials to increase individual and family awareness of injury and
23 illness prevention; encourage assumption of personal responsibility for
24 protecting personal health; and stimulate discussion about the use and
25 limits of medical care in improving the health of individuals and
26 communities;
27 (6) Include in all of its contracts issued for uniform benefits
28 package coverage a subrogation provision that allows the certified
29 health plan to recover the costs of uniform benefits package services
30 incurred to care for an enrollee injured by a negligent third party.
31 The costs recovered shall be limited to:
32 (a) If the certified health plan has not intervened in the action
33 by an injured enrollee against a negligent third party, then the amount
34 of costs the certified health plan can recover shall be limited to the
35 excess remaining after the enrollee has been fully compensated for his
36 or her loss minus a proportionate share of the enrollee's costs and
37 fees in bringing the action. The proportionate share shall be
38 determined by:

1 (i) The fees and costs approved by the court in which the action
2 was initiated; or
3 (ii) The written agreement between the attorney and client that
4 established fees and costs when fees and costs are not addressed by the
5 court.
6 When fees and costs have been approved by a court, after notice to
7 the certified health plan, the certified health plan shall have the
8 right to be heard on the matter of attorneys' fees and costs or its
9 proportionate share;
10 (b) If the certified health plan has intervened in the action by an
11 injured enrollee against a negligent third party, then the amount of
12 costs the certified health plan can recover shall be the excess
13 remaining after the enrollee has been fully compensated for his or her
14 loss or the amount of the plan's incurred costs, whichever is less;
15 (7) Establish and maintain a grievance procedure approved by the
16 commissioner, to provide a reasonable and effective resolution of
17 complaints initiated by enrollees concerning any matter relating to the
18 provision of benefits under the uniform benefits package, access to
19 health care services, and quality of services. Each certified health
20 plan shall respond to complaints filed with the insurance commissioner
21 within fifteen working days. The insurance commissioner in
22 consultation with the commission shall establish standards for
23 grievance procedures and resolution; and
24 (8) Comply with the provisions of chapter 48.30 RCW prohibiting
25 unfair and deceptive acts and practices to the extent such provisions
26 are not modified or superseded by the provisions of chapter . . ., Laws
27 of 1993 (this act) and be prohibited from offering or supplying
28 incentives that would have the effect of avoiding the requirements of
29 subsection (2) of this section.

30 <u>NEW SECTION.</u> **Sec. 332.** CERTIFIED HEALTH PLANS--REGISTRATION
31 REQUIRED--PENALTY. (1) No person or entity in this state may, by mail
32 or otherwise, act or hold himself or herself out to be a certified
33 health plan as defined by the commission without being registered with
34 the insurance commissioner.
35 (2) Anyone violating subsection (1) of this section is liable for
36 a fine not to exceed ten thousand dollars and imprisonment not to
37 exceed six months for each instance of such violation.

1 NEW SECTION. **Sec. 333.** ELIGIBILITY REQUIREMENTS FOR CERTIFICATE
2 OF REGISTRATION--APPLICATION REQUIREMENTS. Any corporation,
3 cooperative group, partnership, association, or groups of health
4 professionals licensed by the state of Washington, public hospital
5 district, or public institutions of higher education are entitled to a
6 certificate from the insurance commissioner as a certified health plan
7 if it:
8 (1) Submits an application for certification as a certified health
9 plan, which shall be verified by an officer or authorized
10 representative of the applicant, being in a form as the insurance
11 commissioner prescribes in consultation with the health services
12 commission;
13 (2) Meets the minimum net worth requirements set forth in section
14 339 of this act and the funding reserve requirements set forth in
15 section 340 of this act;
16 (3) A certified health plan may establish the geographic boundaries
17 in which they will obligate themselves to deliver the services required
18 under the uniform benefits package and include such information in
19 their application for certification, but the commissioner shall review
20 such boundaries and may disapprove, in conformance to guidelines
21 adopted by the commission, those which have been clearly drawn to be
22 exclusionary within a health care catchment area.

23 NEW SECTION. **Sec. 334.** ISSUANCE OF CERTIFICATE--GROUNDS FOR
24 REFUSAL. The commissioner shall issue a certificate as a certified
25 health plan to an applicant within one hundred twenty days of such
26 filing unless the commissioner notifies the applicant within such time
27 that such application is not complete and the reasons therefor; or that
28 the commissioner is not satisfied that:
29 (1) The basic organization document of the applicant permits the
30 applicant to conduct business as a certified health plan;
31 (2) The applicant has demonstrated the intent and ability to assure
32 that the health services will be provided in a manner to assure both
33 their availability and accessibility;
34 (3) The organization is financially responsible and may be
35 reasonably expected to meet its obligations to its enrolled
36 participants.

1 NEW SECTION. **Sec. 335.** PREMIUMS AND ENROLLEE PAYMENT AMOUNTS--
2 FILING OF PREMIUMS AND ENROLLEE PAYMENT AMOUNTS--ADDITIONAL CHARGES
3 PROHIBITED. (1) The insurance commissioner shall verify that the
4 certified health plans charge no more than the maximum premium during
5 the course of financial and market conduct examinations or more
6 frequently if justified in the opinion of the insurance commissioner or
7 upon request by the health services commission.
8 (2) The certified health plans shall file the premium schedules
9 with the insurance commissioner, within thirty days of establishment by
10 the health services commission.

11 NEW SECTION. **Sec. 336.** ANNUAL STATEMENT FILING--CONTENTS--PENALTY
12 FOR FAILURE TO FILE--ACCURACY REQUIRED. (1) Every certified health
13 plan shall annually not later than March 1 of the calendar year, file
14 with the insurance commissioner a statement verified by at least two of
15 its principal officers showing its financial condition as of December
16 31 of the preceding year.
17 (2) Such annual report shall be in such form as the insurance
18 commissioner shall prescribe and shall include:
19 (a) A financial statement of the certified health plan, including
20 its balance sheet and receipts and disbursements for the preceding
21 year;
22 (b) A report of the names and addresses of all officers, directors,
23 or trustees of the certified health plan during the preceding year, and
24 the amount of wages, expense reimbursements, or other payments to such
25 individuals. For partnership and professional service corporations, a
26 report shall be made for partners or shareholders as to any
27 compensation or expense reimbursement received by them for services,
28 other than for services and expenses relating directly for patient
29 care;
30 (c) The number of residents enrolled and terminated during the
31 report period. Additional information regarding the enrollment and
32 termination pattern for a certified health plan may be required by the
33 commissioner to demonstrate compliance with the open enrollment and
34 free access requirements of chapter . . ., Laws of 1993 (this act).
35 The insurance commissioner shall specify additional information to be
36 reported, which may include but not be limited to age, sex, location,
37 and health status information;

(d) Such other information relating to the performance of the certified health plan or the health care facilities or providers with which it has contracted as reasonably necessary to the proper and effective administration of this chapter in accordance with rules;

(e) Disclosure of any financial interests held by officers and directors in any providers associated with the certified health plan or provider of the certified health plan.

(3) The commissioner may require quarterly reporting of financial information, such information to be furnished in a format prescribed by the commissioner in consultation with the commission.

(4) The commissioner may for good reason allow a reasonable extension of time within which such annual statement shall be filed.

(5) The commissioner may suspend or revoke the certificate of a certified health plan for failing to file its annual statement when due or during any extension of time therefor that the commissioner, for good cause, may grant.

(6) The commissioner shall publish and make available to the health services commission an annual summary report of at least the information required in subsections (2) and (3) of this section.

(7) No person may knowingly file with any public official or knowingly make, publish, or disseminate any financial statement of a certified health plan that does not accurately state the certified health plan's financial condition.

NEW SECTION. **Sec. 337.** PENALTY FOR VIOLATIONS. A certified health plan that, or person who, violates any provision of this chapter is guilty of a gross misdemeanor, unless the penalty is otherwise specifically provided.

NEW SECTION. **Sec. 338.** PROVIDER CONTRACTS--ENROLLED RESIDENT'S LIABILITY, COMMISSIONER'S REVIEW. (1) Subject to subsection (2) of this section, every contract between a certified health plan and its providers of health care services shall be in writing and shall set forth that in the event the certified health plan fails to pay for health care services as set forth in the uniform benefits package, the enrollee is not liable to the provider for any sums owed by the certified health plan. Every such contract shall provide that this requirement shall survive termination of the contract.

1 (2) The provisions of subsection (1) of this section shall not
2 apply to emergency care from a provider who is not a contracting
3 provider with the certified health plan, or to emergent and urgently
4 needed out-of-area services.
5 (3) The certified health plan shall file the contracts with the
6 insurance commissioner for approval thirty days prior to use.

7 NEW SECTION. **Sec. 339.** MINIMUM NET WORTH--REQUIREMENTS TO
8 MAINTAIN--DETERMINATION OF AMOUNT. (1) Every certified health plan
9 must maintain a minimum net worth equal to the greater of:
10 (a) One million dollars; or
11 (b) Two percent of annual premium revenues as reported on the most
12 recent annual financial statement filed with the insurance commissioner
13 on the first one hundred fifty million dollars of premium and one
14 percent of annual premium on the premium in excess of one hundred fifty
15 million dollars; or
16 (c) An amount equal to the sum of three months' uncovered
17 expenditures as reported on the most recent financial statement filed
18 with the commissioner.
19 (2)(a) In determining net worth, no debt may be considered fully
20 subordinated unless the subordination clause is in a form acceptable to
21 the commissioner. An interest obligation relating to the repayment of
22 a subordinated debt must be similarly subordinated.
23 (b) The interest expenses relating to the repayment of a fully
24 subordinated debt may not be considered uncovered expenditures.
25 (c) A subordinated debt incurred by a note meeting the requirements
26 of this section, and otherwise acceptable to the insurance
27 commissioner, may not be considered a liability and shall be recorded
28 as equity.
29 (3) Every certified health plan shall, in determining liabilities,
30 include an amount estimated in the aggregate to provide for unearned
31 premiums and for the payment of claims for health care expenditures
32 that have been incurred, whether reported or unreported, that are
33 unpaid and for which such organization is or may be liable and to
34 provide for the expense of adjustment or settlement of such claims.
35 The claims shall be computed in accordance with rules adopted by
36 the insurance commissioner in consultation with the health services
37 commission.

1 NEW SECTION. **Sec. 340.** FUNDED RESERVE REQUIREMENTS. (1) Each
2 certified health plan obtaining certification from the insurance
3 commissioner under sections 330 through 345 of this act shall provide
4 and maintain a funded reserve of one hundred fifty thousand dollars.
5 The funded reserve shall be deposited with the insurance commissioner
6 or with any organization acceptable to the commissioner in the form of
7 cash, securities eligible for investment under chapter 48.13 RCW,
8 approved surety bond, or any combination of these, and must be equal to
9 or exceed one hundred fifty thousand dollars. The funded reserve shall
10 be established as an assurance that the uncovered expenditures
11 obligations of the certified health plan to the enrolled Washington
12 residents shall be performed.
13 (2) All income from reserves on deposit with the commissioner shall
14 belong to the depositing certified health plan and shall be paid to it
15 as it becomes available.
16 (3) Funded reserves required by this section shall be considered an
17 asset in determining the plan's net worth.

18 NEW SECTION. **Sec. 341.** EXAMINATION OF CERTIFIED HEALTH PLANS,
19 POWERS OF COMMISSIONER, DUTIES OF PLANS, INDEPENDENT AUDIT REPORTS.
20 (1) The insurance commissioner shall make an examination of the
21 operations of a certified health plan as often as the commissioner
22 deems it necessary in order to assure the financial security and health
23 and safety of the enrolled residents. The insurance commissioner shall
24 make an examination of a certified health plan not less than once every
25 three calendar years.
26 (2) Every certified health plan shall submit its books and records
27 relating to its operation for financial condition and market conduct
28 examinations and in every way facilitate them. The quality or
29 appropriateness of medical services and systems shall be examined by
30 the department of health except that the insurance commissioner may
31 review such areas to the extent that such items impact the financial
32 condition or the market conduct of the certified health plan. For the
33 purpose of the examinations the insurance commissioner may issue
34 subpoenas, administer oaths, and examine the officers and principals of
35 the certified health plans concerning their business.
36 (3) The insurance commissioner may elect to accept and rely on
37 audit reports made by an independent certified public accountant for
38 the certified health plan in the course of that part of the insurance

commissioner's examination covering the same general subject matter as the audit. The commissioner may incorporate the audit report in his or her report of the examination.

(4) Certified health plans shall be equitably assessed to cover the cost of financial condition and market conduct examinations, the costs of adopting rules, and the costs of enforcing the provisions of this chapter. The assessments shall be levied not less frequently than once every twelve months and shall be in an amount expected to fund the examinations, adoption of rules, and enforcement of the provisions of this chapter including a reasonable margin for cost variations. The assessments shall be established by rules adopted by the commissioner in consultation with the health services commission but may not exceed five and one-half cents per month per resident enrolled in the certified health plan. The minimum assessment shall be one thousand dollars. Assessment receipts shall be deposited in the insurance commissioner's regulatory account in the state treasury and shall be used for the purpose of funding the examinations authorized in subsection (1) of this section. Assessments received shall be used to pay a pro rata share of the costs, including overhead of regulating certified health plans. Amounts remaining in the separate account at the end of a biennium shall be applied to reduce the assessments in succeeding biennia.

NEW SECTION. **Sec. 342.** INSOLVENCY--COMMISSIONER'S DUTIES, CONTINUATION OF BENEFITS, ALLOCATION OF COVERAGE. (1) In the event of insolvency of a certified health plan and upon order of the commissioner, all other certified health plans shall offer the enrolled Washington residents of the insolvent certified health plan the opportunity to enroll in a solvent certified health plan. Enrollment shall be without prejudice for any preexisting condition and shall be continuous provided the resident enrolls in the new certified health plan within thirty days of the date of insolvency and otherwise complies with the certified health plan's managed care procedures within the thirty-day open enrollment period.

(2) The insurance commissioner, in consultation with the health services commission, shall establish guidelines for the equitable distribution of the insolvent certified health plan's enrollees to the remaining certified health plans. The guidelines may include limitations to enrollment based on financial conditions, provider

delivery network, administrative capabilities of the certified health plan, and other reasonable measures of the certified health plan's ability to provide benefits to the newly enrolled residents.

(3) Each certified health plan shall have a plan for handling insolvency that allows for continuation of benefits for the duration of the coverage period for which premiums have been paid and continuation of benefits to enrolled Washington residents who are confined on the date of insolvency in an inpatient facility until their discharge or transfer to a new certified health plan as provided in subsection (1) of this section. The plan shall be approved by the insurance commissioner at the time of certification and shall be submitted for review and approval on an annual basis. The commissioner shall approve such a plan if it includes:

(a) Insurance to cover the expenses to be paid for continued benefits after insolvency;

(b) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the certified health plan's insolvency for which premium payment has been made and until the enrolled participant is transferred to a new certified health plan in accordance with subsection (1) of this section. Such extension of coverage shall not obligate the provider of service beyond thirty days following the date of insolvency;

(c) Use of the funded reserve requirements as provided under section 340 of this act;

(d) Acceptable letters of credit or approved surety bonds; or

(e) Other arrangements the insurance commissioner and certified health plan mutually agree are appropriate to assure that benefits are continued.

NEW SECTION. **Sec. 343.** FINANCIAL FAILURE, SUPERVISION OF COMMISSIONER--PRIORITY OF DISTRIBUTION OF ASSETS. (1) Any rehabilitation, liquidation, or conservation of a certified health plan shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the insurance commissioner under the law governing the rehabilitation, liquidation, or conservation of insurance companies. The insurance commissioner may apply for an order directing the insurance commissioner to rehabilitate, liquidate, or conserve a certified health plan upon one or more of the grounds set forth in RCW 48.31.030,

1 48.31.050, and 48.31.080. Enrolled residents shall have the same
2 priority in the event of liquidation or rehabilitation as the law
3 provides to policyholders of an insurer.
4 (2) For purposes of determining the priority of distribution of
5 general assets, claims of enrolled residents shall have the same
6 priority as established by RCW 48.31.280 for policyholders of insurance
7 companies.
8 (3) A provider who is obligated by statute or agreement to hold
9 enrolled residents harmless from liability for services provided under
10 and covered by a certified health plan shall have a priority of
11 distribution of the general assets immediately following that of
12 enrolled residents as described in this section, and immediately
13 proceeding the priority of distribution described in RCW
14 48.31.280(2)(e).

15 NEW SECTION. **Sec. 344.** GRIEVANCE PROCEDURE. A certified health
16 plan shall establish and maintain a grievance procedure approved by the
17 commissioner, to provide a reasonable and effective resolution of
18 complaints initiated by enrolled Washington residents concerning any
19 matter relating to the provision of benefits under the uniform benefits
20 package, access to health care services, and quality of services. Each
21 certified health plan shall respond to complaints filed with the
22 insurance commissioner within twenty working days. The insurance
23 commissioner in consultation with the health care commission shall
24 establish standards for grievance procedures and resolution.

25 NEW SECTION. **Sec. 345.** EXEMPTION. The provisions of sections 330
26 through 344 of this act do not apply to any disability insurance
27 company, health care service contractor, or health maintenance
28 organization authorized to do business in Washington.

29 NEW SECTION. **Sec. 346.** ENFORCEMENT AUTHORITY OF COMMISSIONER.
30 For the purposes of chapter . . ., Laws of 1993 (this act), the
31 insurance commissioner shall have the same powers and duties of
32 enforcement as are provided in Title 48 RCW.

33 **F. STATE RESIDENT PARTICIPATION**

1 NEW SECTION. **Sec. 347.** INDIVIDUAL PARTICIPATION. (1) All
2 residents of the state of Washington are required to participate in a
3 certified health plan no later than July 1, 1998. This participation
4 requirement may be waived if imposition of the requirement would
5 constitute a violation of the freedom of religion provisions set forth
6 in the First Amendment, United States Constitution and Article I,
7 section 11 of the state Constitution. Residents of the state of
8 Washington who work in another state for an out-of-state employer shall
9 be deemed to have satisfied the requirements of this section if they
10 receive health insurance coverage through such employer.
11 (2) The commission shall monitor the enrollment of individuals into
12 certified health plans and shall make public periodic reports
13 concerning the number of persons enrolled and not enrolled, the reasons
14 why individuals are not enrolled, recommendations to reduce the number
15 of persons not enrolled, and recommendations regarding enforcement of
16 this provision.

17 **G. EXCLUSIONS AND STUDIES**

18 NEW SECTION. **Sec. 348.** CODE REVISIONS AND WAIVERS. (1) The
19 commission shall consider the analysis of state and federal laws that
20 would need to be repealed, amended, or waived to implement chapter
21 . . ., Laws of 1993 (this act), and report its recommendations, with
22 proposed revisions to the Revised Code of Washington, to the governor,
23 and appropriate committees of the legislature by January 1, 1994.
24 (2) The governor, in consultation with the commission, shall take
25 the following steps in an effort to receive waivers or exemptions from
26 federal statutes necessary to fully implement chapter . . ., Laws of
27 1993 (this act) to include, but not be limited to:
28 (a) Negotiate with the United States congress and the federal
29 department of health and human services, health care financing
30 administration to obtain a statutory or regulatory waiver of provisions
31 of the medicaid statute, Title XIX of the federal social security act
32 that currently constitute barriers to full implementation of provisions
33 of chapter . . ., Laws of 1993 (this act) related to access to health
34 services for low-income residents of Washington state. Such waivers
35 shall include any waiver needed to implement managed care programs.
36 Waived provisions may include and are not limited to: Categorical
37 eligibility restrictions related to age, disability, blindness, or

1 family structure; income and resource limitations tied to financial
2 eligibility requirements of the federal aid to families with dependent
3 children and supplemental security income programs; administrative
4 requirements regarding single state agencies, choice of providers, and
5 fee for service reimbursement programs; and other limitations on health
6 services provider payment methods.
7 (b) Negotiate with the United States congress and the federal
8 department of health and human services, health care financing
9 administration to obtain a statutory or regulatory waiver of provisions
10 of the medicare statute, Title XVIII of the federal social security act
11 that currently constitute barriers to full implementation of provisions
12 of chapter . . ., Laws of 1993 (this act) related to access to health
13 services for elderly and disabled residents of Washington state. Such
14 waivers shall include any waivers needed to implement managed care
15 programs. Waived provisions include and are not limited to:
16 Beneficiary cost-sharing requirements; restrictions on scope of
17 services; and limitations on health services provider payment methods.
18 (c) Negotiate with the United States congress and the federal
19 department of health and human services to obtain any statutory or
20 regulatory waivers of provisions of the United States public health
21 services act necessary to ensure integration of federally funded
22 community and migrant health clinics and other health services funded
23 through the public health services act into the health services system
24 established pursuant to chapter . . ., Laws of 1993 (this act). The
25 commission shall request in the waiver that funds from these sources
26 continue to be allocated to federally funded community and migrant
27 health clinics to the extent that such clinics' patients are not yet
28 enrolled in certified health plans.
29 (3) On or before December 1, 1995, the commission shall report the
30 following to the governor and appropriate committees of the
31 legislature:
32 (a) The status of its efforts to obtain the waivers provided in
33 subsection (2) of this section;
34 (b) The extent to which chapter . . ., Laws of 1993 (this act) can
35 be implemented, given the status of waivers requested or granted.

36 **H. WORKERS' COMPENSATION**

1 <u>NEW SECTION.</u> **Sec. 349.** WORKERS' COMPENSATION MEDICAL BENEFITS.
2 (1) On or before January 1, 1995, the department of labor and
3 industries, in coordination with the commission, and the workers'
4 compensation advisory committee, shall complete a study related to the
5 medical services component of the workers' compensation program of the
6 department of labor and industries. The goal of the study shall be to
7 determine whether and how the medical services component of the
8 workers' compensation program can be modified to provide appropriate
9 medical services to injured workers in a more cost-effective manner.
10 In conducting the study, consideration shall be given to at least the
11 following factors: Workers' choice of health care providers, twenty-
12 four hour coverage, the required benefits structure, necessary statute
13 changes, the use of managed care to provide medical services to injured
14 workers, the quasi-judicial system that overlays treatment, and the
15 relationship between return to work efforts, medical services, and
16 disability prevention. The study shall evaluate at least the following
17 options:
18 (a) Whether the medical services component of the workers'
19 compensation program should be maintained within the department of
20 labor and industries, and its purchasing and other practices modified
21 to control costs and increase efficacy of health services provided to
22 injured workers;
23 (b) Whether the medical services component of the workers'
24 compensation program should be administered by the health care
25 authority;
26 (c) Whether the medical services component of the workers'
27 compensation program should be included in the services offered by
28 certified health plans through employer sponsorship as provided in
29 chapter ..., Laws of 1993 (this act). Any recommendation proposing the
30 inclusion of workers' compensation medical services in the services
31 offered by certified health plans shall assure that (i) no less than
32 ninety-seven percent of state residents have access to the uniform
33 benefits package as required in chapter . . ., Laws of 1993 (this act),
34 (ii) the uniform benefits package provides benefits which are medically
35 necessary under the workers' compensation program in 1993, including
36 payment for medical determinations of disability under Title 51 RCW,
37 (iii) time loss benefits and rehabilitative services will not be
38 reduced as a result of the transfer, and (iv) the employees' share of

1 the workers' compensation medical aid fund contribution will be
2 returned to employees as increased wages.
3 (2) The department of labor and industries may immediately
4 implement pilot projects to assess the effects of purchasing the
5 medical aid component of workers' compensation through managed care
6 arrangements on the cost, quality comparability, and employer/employee
7 satisfaction with various consolidation proposals. In completing these
8 pilot projects, the department shall be granted exemptions from the
9 requirements of Title 51 RCW which may prohibit implementation of the
10 pilot projects. The projects shall conclude no later than January 1,
11 1995.
12 (3) The department of labor and industries shall present the
13 recommendations to the governor and the appropriate committees of the
14 legislature by January 1, 1995.

15 **I. MISCELLANEOUS**

16 NEW SECTION. **Sec. 350.** SHORT TITLE. This act may be known and
17 cited as the Washington health services act of 1993.

18 **Sec. 351.** RCW 42.17.2401 and 1991 c 200 s 404 are each amended to
19 read as follows:
20 For the purposes of RCW 42.17.240, the term "executive state
21 officer" includes:
22 (1) The chief administrative law judge, the director of
23 agriculture, the administrator of the office of marine safety, the
24 administrator of the Washington basic health plan, the director of the
25 department of services for the blind, the director of the state system
26 of community and technical colleges, the director of community
27 development, the secretary of corrections, the director of ecology, the
28 commissioner of employment security, the chairman of the energy
29 facility site evaluation council, the director of the energy office,
30 the secretary of the state finance committee, the director of financial
31 management, the director of fisheries, the executive secretary of the
32 forest practices appeals board, the director of the gambling
33 commission, the director of general administration, the secretary of
34 health, the administrator of the Washington state health care
35 authority, the executive secretary of the health care facilities
36 authority, the executive secretary of the higher education facilities

authority, the director of the higher education personnel board, the executive secretary of the horse racing commission, the executive secretary of the human rights commission, the executive secretary of the indeterminate sentence review board, the director of the department of information services, the director of the interagency committee for outdoor recreation, the executive director of the state investment board, the director of labor and industries, the director of licensing, the director of the lottery commission, the director of the office of minority and women's business enterprises, the director of parks and recreation, the director of personnel, the executive director of the public disclosure commission, the director of retirement systems, the director of revenue, the secretary of social and health services, the chief of the Washington state patrol, the executive secretary of the board of tax appeals, the director of trade and economic development, the secretary of transportation, the secretary of the utilities and transportation commission, the director of veterans affairs, the director of wildlife, the president of each of the regional and state universities and the president of The Evergreen State College, each district and each campus president of each state community college;

(2) Each professional staff member of the office of the governor;

(3) Each professional staff member of the legislature; and

(4) Central Washington University board of trustees, board of trustees of each community college, each member of the state board for community and technical colleges ((~~education~~)), state convention and trade center board of directors, committee for deferred compensation, Eastern Washington University board of trustees, Washington economic development finance authority, The Evergreen State College board of trustees, forest practices appeals board, forest practices board, gambling commission, Washington health care facilities authority, each member of the Washington health services commission, higher education coordinating board, higher education facilities authority, higher education personnel board, horse racing commission, state housing finance commission, human rights commission, indeterminate sentence review board, board of industrial insurance appeals, information services board, interagency committee for outdoor recreation, state investment board, liquor control board, lottery commission, marine oversight board, oil and gas conservation committee, Pacific Northwest electric power and conservation planning council, parks and recreation commission, personnel appeals board, personnel board, board of pilotage

1 ((~~[commissioners]~~)) commissioners, pollution control hearings board,
2 public disclosure commission, public pension commission, shorelines
3 hearing board, ((~~state~~)) public employees' benefits board, board of tax
4 appeals, transportation commission, University of Washington board of
5 regents, utilities and transportation commission, Washington state
6 maritime commission, Washington public power supply system executive
7 board, Washington State University board of regents, Western Washington
8 University board of trustees, and wildlife commission.

9 **Sec. 352.** RCW 43.20.050 and 1992 c 34 s 4 are each amended to read
10 as follows:
11 (1) The state board of health shall provide a forum for the
12 development of public health policy in Washington state. It is
13 authorized to recommend to the secretary means for obtaining
14 appropriate citizen and professional involvement in all public health
15 policy formulation and other matters related to the powers and duties
16 of the department. It is further empowered to hold hearings and
17 explore ways to improve the health status of the citizenry.
18 (a) At least every five years, the state board shall convene
19 regional forums to gather citizen input on public health issues.
20 (b) Every two years, in coordination with the development of the
21 state biennial budget, the state board shall prepare the state public
22 health report that outlines the health priorities of the ensuing
23 biennium. The report shall:
24 (i) Consider the citizen input gathered at the ((~~health~~)) forums;
25 (ii) Be developed with the assistance of local health departments;
26 (iii) Be based on the best available information collected and
27 reviewed according to RCW 43.70.050 and recommendations from the
28 council;
29 (iv) Be developed with the input of state health care agencies. At
30 least the following directors of state agencies shall provide timely
31 recommendations to the state board on suggested health priorities for
32 the ensuing biennium: The secretary of social and health services, the
33 health care authority administrator, the insurance commissioner, the
34 superintendent of public instruction, the director of labor and
35 industries, the director of ecology, and the director of agriculture;
36 (v) Be used by state health care agency administrators in preparing
37 proposed agency budgets and executive request legislation;

(vi) Be submitted by the state board to the governor by ((~~June~~)) January 1 of each even-numbered year for adoption by the governor. The governor, no later than ((~~September~~)) March 1 of that year, shall approve, modify, or disapprove the state public health report.

(c) In fulfilling its responsibilities under this subsection, the state board ((~~shall~~)) may create ad hoc committees or other such committees of limited duration as necessary. ((~~Membership should include legislators, providers, consumers, bioethicists, medical economics experts, legal experts, purchasers, and insurers, as necessary.~~))

(2) In order to protect public health, the state board of health shall:

(a) Adopt rules necessary to assure safe and reliable public drinking water and to protect the public health. Such rules shall establish requirements regarding:

(i) The design and construction of public water system facilities, including proper sizing of pipes and storage for the number and type of customers;

(ii) Drinking water quality standards, monitoring requirements, and laboratory certification requirements;

(iii) Public water system management and reporting requirements;

(iv) Public water system planning and emergency response requirements;

(v) Public water system operation and maintenance requirements;

(vi) Water quality, reliability, and management of existing but inadequate public water systems; and

(vii) Quality standards for the source or supply, or both source and supply, of water for bottled water plants.

(b) Adopt rules and standards for prevention, control, and abatement of health hazards and nuisances related to the disposal of wastes, solid and liquid, including but not limited to sewage, garbage, refuse, and other environmental contaminants; adopt standards and procedures governing the design, construction, and operation of sewage, garbage, refuse and other solid waste collection, treatment, and disposal facilities;

(c) Adopt rules controlling public health related to environmental conditions including but not limited to heating, lighting, ventilation, sanitary facilities, cleanliness and space in all types of public facilities including but not limited to food service establishments,

schools, institutions, recreational facilities and transient accommodations and in places of work;

(d) Adopt rules for the imposition and use of isolation and quarantine;

(e) Adopt rules for the prevention and control of infectious and noninfectious diseases, including food and vector borne illness, and rules governing the receipt and conveyance of remains of deceased persons, and such other sanitary matters as admit of and may best be controlled by universal rule; and

(f) Adopt rules for accessing existing data bases for the purposes of performing health related research.

(3) The state board may delegate any of its rule-adopting authority to the secretary and rescind such delegated authority.

(4) All local boards of health, health authorities and officials, officers of state institutions, police officers, sheriffs, constables, and all other officers and employees of the state, or any county, city, or township thereof, shall enforce all rules adopted by the state board of health. In the event of failure or refusal on the part of any member of such boards or any other official or person mentioned in this section to so act, he shall be subject to a fine of not less than fifty dollars, upon first conviction, and not less than one hundred dollars upon second conviction.

(5) The state board may advise the secretary on health policy issues pertaining to the department of health and the state.

NEW SECTION. **Sec. 353.** RCW 18.32.675 and 1935 c 112 s 19 are each repealed.

NEW SECTION. **Sec. 354.** SEVERABILITY. 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. 355.** SAVINGS CLAUSE. The enactment of this act does not have the effect of terminating, or in any way modifying, any obligation or any liability, civil or criminal, which was already in existence on the effective date of this act.

1 NEW SECTION. **Sec. 356.** CAPTIONS. Captions used in this act do
2 not constitute any part of the law.

3 NEW SECTION. **Sec. 357.** CODIFICATION. Sections 301 through 306,
4 327 through 345, and 347 of this act shall constitute a new chapter in
5 Title 43 RCW.

6 NEW SECTION. **Sec. 358.** RESERVATION OF LEGISLATIVE AUTHORITY. The
7 legislature reserves the right to amend or repeal all or any part of
8 this act at any time and there shall be no vested private right of any
9 kind against such amendment or repeal. All the rights, privileges, or
10 immunities conferred by this act or any acts done pursuant thereto
11 shall exist subject to the power of the legislature to amend or repeal
12 this act at any time.

13 NEW SECTION. **Sec. 359.** EFFECTIVE DATE CLAUSE. This act is
14 necessary for the immediate preservation of the public peace, health,
15 or safety, or support of the state government and its existing public
16 institutions, and shall take effect immediately."

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