H-0672.2

HOUSE BILL 1329

State of Washington 53rd Legislature 1993 Regular Session

By Representatives Dellwo, Dyer, Flemming, Pruitt and R. Meyers

Read first time 01/22/93. Referred to Committee on Health Care.

AN ACT Relating to health care reform; amending RCW 70.170.010, 70.170.020, 70.170.030, 70.170.040, 70.170.050, 70.170.100, 70.170.110, 7.70.070, 43.70.050, 43.70.060, 43.70.070, and 18.19.160; reenacting and amending RCW 18.64.080; adding a new section to chapter 43.70 RCW; adding new sections to Title 51 RCW; adding new sections to chapter 7.70 RCW; adding a new chapter to Title 43 RCW; adding a new chapter to Title 70 RCW; creating a new section; recodifying RCW 70.170.010, 70.170.020, 70.170.030, 70.170.040, 70.170.050, 70.170.100, and 70.170.110; repealing RCW 19.68.010, 19.68.020, 19.68.030, 19.68.040, 48.20.002, 48.20.012, 48.20.013, 48.20.015, 48.20.022, 48.20.032, 48.20.042, 48.20.050, 48.20.052, 48.20.062, 48.20.072, 48.20.082, 48.20.092, 48.20.102, 48.20.112, 48.20.122, 48.20.132, 48.20.142, 48.20.152, 48.20.162, 48.20.172, 48.20.192, 48.20.202, 48.20.212, 48.20.222, 48.20.232, 48.20.242, 48.20.252, 48.20.262, 48.20.272, 48.20.282, 48.20.292, 48.20.302, 48.20.312, 48.20.322, 48.20.340, 48.20.350, 48.20.360, 48.20.380, 48.20.390, 48.20.393, 48.20.395, 48.20.397, 48.20.410, 48.20.411, 48.20.412, 48.20.414, 48.20.416, 48.20.420, 48.20.430, 48.20.450, 48.20.460, 48.20.470, 48.20.480, 48.20.490, 48.20.500, 48.20.510, 48.20.520, 48.20.530, 48.21.010, 48.21.015, 48.21.020, 48.21.030, 48.21.040, 48.21.045, 48.21.050, 48.21.060, 48.21.070, 48.21.075, 48.21.080, 48.21.090, 48.21.100,

48.21.110, 48.21.120, 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.144, 48.21.146, 48.21.150, 48.21.155, 48.21.160, 48.21.180, 48.21.190, 48.21.195, 48.21.197, 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240, 48.21.244, 48.21.250, 48.21.260, 48.21.270, 48.21.280, 48.21.290, 48.21.300, 48.21.310, 48.21.320, 48.21.330, 48.41.010, 48.41.020, 48.41.030, 48.41.040, 48.41.050, 48.41.060, 48.41.070, 48.41.080, 48.41.090, 48.41.100, 48.41.110, 48.41.120, 48.41.130, 48.41.140, 48.41.150, 48.41.160, 48.41.170, 48.41.180, 48.41.190, 48.41.200, 48.41.210, 48.41.900, 48.41.910, 48.44.010, 48.44.011, 48.44.015, 48.44.020, 48.44.023, 48.44.026, 48.44.030, 48.44.033, 48.44.035, 48.44.037, 48.44.040, 48.44.050, 48.44.055, 48.44.057, 48.44.060, 48.44.070, 48.44.080, 48.44.090, 48.44.095, 48.44.100, 48.44.110, 48.44.120, 48.44.130, 48.44.140, 48.44.145, 48.44.150, 48.44.160, 48.44.164, 48.44.166, 48.44.170, 48.44.180, 48.44.200, 48.44.210, 48.44.212, 48.44.220, 48.44.225, 48.44.230, 48.44.240, 48.44.245, 48.44.250, 48.44.260, 48.44.270, 48.44.290, 48.44.299, 48.44.300, 48.44.309, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344, 48.44.350, 48.44.360, 48.44.370, 48.44.380, 48.44.390, 48.44.400, 48.44.410, 48.44.420, 48.44.430, 48.44.440, 48.44.450, 48.44.460, 48.44.470, 48.45.005, 48.45.010, 48.45.020, 48.45.030, 48.46.010, 48.46.020, 48.46.023, 48.46.027, 48.46.030, 48.46.040, 48.46.060, 48.46.066, 48.46.070, 48.46.080, 48.46.090, 48.46.100, 48.46.110, 48.46.120, 48.46.130, 48.46.135, 48.46.140, 48.46.150, 48.46.160, 48.46.170, 48.46.180, 48.46.200, 48.46.210, 48.46.220, 48.46.225, 48.46.235, 48.46.240, 48.46.243, 48.46.245, 48.46.247, 48.46.250, 48.46.260, 48.46.270, 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.300, 48.46.310, 48.46.320, 48.46.340, 48.46.350, 48.46.355, 48.46.360, 48.46.370, 48.46.375, 48.46.380, 48.46.390, 48.46.400, 48.46.410, 48.46.420, 48.46.430, 48.46.440, 48.46.450, 48.46.460, 48.46.470, 48.46.480, 48.46.490, 48.46.500, 48.46.510, 48.46.520, 48.46.530, 48.46.540, 48.46.900, 48.46.905, 48.46.910, 48.46.920, 70.38.015, 70.38.025, 70.38.095, 70.38.105, 70.38.111, 70.38.115, 70.38.125, 70.38.135, 70.38.155, 70.38.156, 70.38.157, 70.38.158, 70.38.220, 70.38.905, 70.38.910, 70.38.911, 70.38.914, 70.38.915, 70.38.916, 70.38.918, 70.38.919, 70.38.920, 70.43.010, 70.43.020, 70.43.030, 70.170.060, 70.170.070, 70.170.080, 70.170.090, 18.06.190, 18.22.082, 18.25.040, 18.29.045, 18.32.215, 18.34.115, 18.35.085, 18.36A.120, 18.50.065, 18.52.130, 18.53.035, 18.55.105, 18.57.130, 18.59.070,

18.71.090, 18.74.060, 18.78.072, 18.83.170, 18.88.150, 18.108.095, 18.138.050, 51.48.280, and 74.09.240; prescribing penalties; providing effective dates; and declaring an emergency.

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

PART I - ADMINISTRATION

NEW SECTION. **Sec. 101.** LEGISLATIVE FINDINGS. The legislature finds that:

(1) The regulation of the health care delivery system is fragmented among several different state agencies;

(2) A single regulator, holding office at the pleasure of the governor, is more likely to be effective and accountable to the people than a commission of citizens appointed from time to time by the governor;

(3) Some professionally controlled boards adopt rules and take other actions that are not consistent with the public interest, but instead are motivated by the economic self-interest of the professionals they regulate.

NEW SECTION. **Sec. 102.** OFFICE OF THE HEALTH CARE COMMISSIONER. (1) There is created an office of health care commissioner. The office shall be vested with all powers and duties granted or transferred to it by this chapter and such other powers and duties as may be authorized by law. The main administrative office of the office shall be located in the city of Olympia. The commissioner may establish administrative facilities in other locations, if deemed necessary for the efficient operation of the office.

(2) In accordance with the administrative procedure act, chapter 34.05 RCW, the office shall ensure an opportunity for consultation, review, and comment by those involved in the health care system either as consumers or otherwise before the adoption of standards, guidelines, and rules. When the subject matter of such standards, guidelines, and rules are within the subject matter of an advisory committee created under section 110 of this act, the commissioner shall first ask for the advice of the committees except where doing so is impracticable because of time considerations. In such case, the commissioner shall ask the advisory committee for advice and reconsider the decision in light of the advice, making such corrections as are indicated.

(3) The commissioner may create administrative divisions within the office as necessary. The commissioner shall have complete charge of and

supervisory powers over the office, except where the commissioner's authority is specifically limited by law.

(4) The commissioner shall in accordance with chapter 41.06 RCW appoint personnel necessary to carry out the duties of the office.

(5) All persons who administer the necessary divisions, offices, bureaus, and programs, and seven additional employees are exempt from the provisions of chapter 41.06 RCW. The officers and employees appointed under this subsection shall be paid salaries to be fixed by the governor in accordance with the procedure established by law for the fixing of salaries for officers exempt from the state civil service law.

NEW SECTION. **Sec. 103.** DEFINITIONS. As used in this chapter and chapter 70.-- RCW (sections 201 through 214 of this act):

(1) "Office" means office of health care commissioner.

(2) "Commissioner" means the health care commissioner of the office of health care commissioner.

NEW SECTION. **Sec. 104.** COMMISSIONER OF HEALTH CARE. The executive head and appointing authority of the office shall be the commissioner of health care. The commissioner shall be appointed by, and serve at the pleasure of, the governor. The commissioner shall be paid a salary to be fixed by the governor in accordance with RCW 43.03.040.

NEW SECTION. **Sec. 105.** COMMISSIONER'S POWERS. In addition to other powers granted the commissioner by law, the commissioner may:

(1) Adopt, in accordance with chapter 34.05 RCW, rules necessary to carry out the duties of the office;

(2) Appoint advisory committees as required by section 110 of this act and additional advisory committees as may be necessary to carry out the provisions of this chapter. Advisory committees within the office that are not required by section 110 of this act shall be reviewed by the commissioner on a biennial basis to determine if the advisory committee is needed. The criteria specified in RCW 43.131.070 shall be used to determine whether such advisory committee shall be continued;

(3) Undertake studies, research, and analysis necessary to carry out the duties of the office;

(4) Delegate powers, duties, and functions of the office to employees of the office as the commissioner deems necessary to carry out the duties of the office;

(5) Enter into contracts on behalf of the office to carry out the duties of the office;

(6) Regulate health care service plans under chapter 43.-- RCW (sections 101 through 148 of this act);

(7) Accept gifts, grants, or other funds.

NEW SECTION. **Sec. 106.** TRANSFER OF POWERS AND DUTIES FROM OTHER STATE DEPARTMENTS. (1) The following powers and duties of the department of health under the following statutes are hereby transferred to the office of the health care commissioner: RCW 43.70.050, 43.70.060, and 43.70.070.

(2) The following powers and duties of the office of insurance commissioner under the following statutes are hereby transferred to the office of the health care commissioner: Any powers conferred by Title 48 RCW to the extent to which such powers relate to insurance for health care as defined in RCW 70.170.020 (as recodified by this act). However the commissioner may enter into an agreement with the insurance commissioner under which the insurance commissioner would assume, in whole or in part, the solvency compliance or examination functions transferred by this section or conferred by chapter 43.-- RCW (sections 101 through 148 of this act).

(3) All references to the secretary of health or department of health or insurance commissioner in the Revised Code of Washington shall be construed to mean the health care commissioner or office of health care commissioner when referring to the functions transferred by this section.

(4) Where feasible, the health care commissioner, insurance commissioner, department and secretary of health, and the secretary of social and health services shall consult in order that, to the fullest extent possible, agencies concerned with the delivery of health care services may integrate their efforts and endorse policies in common.

NEW SECTION. **Sec. 107.** AUTHORITY TO ADMINISTER OATHS AND ISSUE SUBPOENAS--PROVISIONS GOVERNING SUBPOENAS. The commissioner shall have full authority:

(1) To administer oaths and take testimony, to issue subpoenas requiring the attendance of witnesses before the commissioner together with all books, memoranda, papers, and other documents, articles, or instruments, and to compel the disclosure by witnesses of all facts known to them relative to the matters under investigation; and

(2) To issue subpoenas issued in adjudicative proceedings, which shall be governed by RCW 34.05.588(1). Subpoenas issued in the conduct of investigations required or authorized by other statutory provisions or necessary in the enforcement of other statutory provisions shall be governed by RCW 34.05.588(2).

NEW SECTION. **Sec. 108.** FEDERAL LAW AND PREEMPTION. (1) In furtherance of the policy of this state to cooperate with the federal government in health care delivery programs, the office of health care commissioner shall adopt rules as are necessary to entitle this state to participate in federal funds or comply with preemption provisions of federal law unless the same be expressly prohibited by law. Sections or provisions of the laws of this state that may be susceptible to more than one construction shall be interpreted in favor of the construction most likely to satisfy federal laws entitling this state to federal funds or avoiding preemption.

(2) To the extent to which it is now or hereafter necessary to obtain waivers of federal laws or regulations to implement any of the duties of the office, the commissioner is hereby empowered to seek such waivers with the written approval of the governor.

NEW SECTION. **Sec. 109.** OFFICE OF HEALTH CONSUMER ASSISTANCE CREATED--DUTIES. There is created in the office an office of health care consumer assistance.

The office of health care consumer assistance shall establish a state-wide hotline and shall assist and serve as an advocate for consumers.

NEW SECTION. **Sec. 110.** APPOINTMENT OF ADVISORY COMMITTEES. (1) The commissioner shall appoint and consult regularly with advisory committees who shall address the following subjects:

(a) Access to health care;

(b) Financing of health care;

(c) Health care cost management;

(d) Data collection and analysis;

(e) Risk management, practice parameters, and medical technology; and

(f) Long-term care.

With the exception of the data committee, which shall be appointed in accord with RCW 70.170.030 (as recodified by this act), each committee shall have five members, all of whom shall be recognized experts with demonstrated practical experience in the fields being addressed.

(2) The commissioner shall also appoint a consumer advisory committee to be composed of five consumers broadly representative of the state's population, none of whom shall be health care professionals of any kind, work for health care facilities, programs, or insurers, nor be a member of a family that derives any substantial portion of its income from the provision of health services.

(3) With the approval of the commissioner, each committee may, subject to its budget, appoint subcommittees composed of its members or others who shall address topics within the committee's charge and report back to the committee who, in turn, shall pass on the committee's recommendations to the commissioner.

(4) While serving as advisory committee members, members are entitled to travel expenses in accordance with RCW 43.03.050 and 43.03.060.

(5) All committee members shall serve at the pleasure of the commissioner. The chair and vice-chair of each committee shall be designated by the commissioner. Members shall serve one-year terms, up to a maximum of five years on any one committee.

Sec. 111. RCW 70.170.010 and 1989 1st ex.s. c 9 s 501 are each amended to read as follows:

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

state health policy the information necessary for the analysis of health care issues.

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

(3) The legislature further finds that access to health care is among the state's goals and the provision of such care should be among the purposes of health care providers and facilities. Therefore, the legislature intends that charity care requirements and related enforcement provisions for hospitals be explicitly established.

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

Sec. 112. RCW 70.170.020 and 1989 1st ex.s. c 9 s 502 are each amended to read as follows:

As used in this chapter:

(1) "((~~Council~~)) Committee" means the health care ((~~access and cost control council~~)) data advisory committee created by this chapter.

(2) "((~~Department~~)) Office" means ((~~department of health~~)) the office of health care commissioner.

(3) "Hospital" means any health care institution which is required to qualify for a license under RCW 70.41.020(2); or as a psychiatric hospital under chapter 71.12 RCW.

(4) "((~~Secretary~~)) Commissioner" means ((~~secretary of health~~)) health care commissioner.

(5) "Charity care" means necessary hospital health care rendered to indigent persons, to the extent that the persons are unable to pay for the care or to pay deductibles or co-insurance amounts required by a third-party payer, as determined by the ((~~department~~)) office.

(6) "Sliding fee schedule" means a hospital-determined, publicly available schedule of discounts to charges for persons deemed eligible

for charity care; such schedules shall be established after consideration of guidelines developed by the ((~~department~~)) office.

(7) "Special studies" means studies which have not been funded through the ((~~department's~~)) office's biennial or other legislative appropriations.

(8) "Health care" means all care, goods, or services provided to persons by providers of care intended to ascertain, improve, or maintain the health of such persons. It specifically includes, not by way of limitation, the care, goods, or services of health care practitioners, programs, facilities, or other health care entities subject to the jurisdiction of Washington state law.

(9) "Providers" means all health care practitioners, programs, facilities, or other health care entities subject to the jurisdiction of Washington state law.

(10) "Health care payers" includes all state health care payment programs as well as all health care service plans and other payers subject to state jurisdiction, including out-of-state group policies with certificates of coverage for residents of the state of Washington.

(11) "Reporters" means providers and health care payers as defined in this section.

Sec. 113. RCW 70.170.030 and 1989 1st ex.s. c 9 s 503 are each amended to read as follows:

(1) There is created the health care ((~~access and cost control council~~)) data advisory committee within the department of health consisting of the following: The director of the department of labor and industries; the administrator of the health care authority; the secretary of social and health services; the administrator of the basic health plan; a person representing the governor on matters of health policy; the secretary of health; and ((~~one member from the public-at-large to be selected by the governor who shall represent individual consumers of health care~~)) nine public members composed of the following: One representative of large employers and one representative of small employers appointed by the health care commissioner from lists of at least three names for each position from both a recognized state-wide organization of employers representing a majority of employers and a recognized organization of private employer health care purchasers; one representative of employed persons appointed by the commissioner and selected from a list of not less than

three names submitted to the commissioner by an organization, state-wide in scope, which through its affiliates embraces a cross-section and a majority of the organized labor in this state; a physician regulated under chapter 18.57 or 18.71 RCW, appointed by the commissioner and selected from a list of not less than three names submitted to the commissioner by a recognized state-wide organization of physicians representing a cross-section and a majority of practicing physicians in the state; the administrator of a hospital regulated under chapter 70.41 RCW appointed by the commissioner and selected from a list of not less than three names submitted to the commissioner by a state-wide organization representing a majority of hospitals in this state; and three representatives of health care service plans appointed by the commissioner. The ((~~public~~)) consumer member shall not have any fiduciary obligation to any health care facility or any financial interest in the provision of health care services. Public members shall serve two-year terms and the commissioner shall designate four of the other initial appointees to serve one-year terms in order to provide staggered terms. A person appointed to fill a vacancy shall be appointed in the same manner as the person they are replacing. Members employed by the state shall serve without pay and participation in the ((~~council's~~)) committee's work shall be deemed performance of their employment. The public member shall be compensated in accordance with RCW 43.03.240 and shall be reimbursed for related travel expenses in accordance with RCW 43.03.050 and 43.03.060.

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

(3) ((~~Four~~)) Eight members shall constitute a quorum, but ((~~a vacancy on the council shall not impair its power to act~~)) at least four of that number must be public members. No action of the ((~~council~~)) committee shall be effective unless four members concur therein.

Sec. 114. RCW 70.170.040 and 1989 1st ex.s. c 9 s 504 are each amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

The ((~~department~~)) office shall report its findings and recommendations to the governor and the appropriate committees of the legislature not later than July 1, 1991.

Sec. 115. RCW 70.170.050 and 1989 1st ex.s. c 9 s 505 are each amended to read as follows:

The ((~~department~~)) committee shall have the authority to respond to requests of others for special studies or analysis. The ((~~department~~)) committee may require such sponsors to pay any or all of the reasonable costs associated with such requests that might be approved, but in no event may costs directly associated with any such special study be charged against the funds generated by the assessment authorized under ((~~RCW 70.170.080~~)) this chapter.

NEW SECTION. **Sec. 116.** (1) The committee shall fund the creation and maintenance of the data base and studies provided for in RCW 70.170.100 and 70.170.110 (as recodified by this act) from a surcharge levied on the data acquired through a process of electronic claims payment and fees paid by users of the information. For surcharges levied on the data, the assessment may not amount to more than four one-hundredths of one percent of the gross billed amount for the service that is the subject matter of the data. Surcharges on the users of data shall be fair and financially sound.

(2) Budgetary requirements in excess of income must be financed by a general fund appropriation of the legislature or from other public or private sources.

(3) All moneys collected under this section shall be deposited by the state treasurer in the health care data collection account, which is created in the state treasury. This account is the successor to the hospital data collection account, the balance of which shall be placed in the health care data collection account.

(4) The committee may also charge, receive, and dispense funds or authorize any contractor or outside sponsor to charge for and reimburse the costs associated with special studies as specified in RCW 70.170.050 (as recodified by this act).

(5) Any amounts raised by the collection of assessments provided for in this section that are not required to meet appropriations in the

omnibus appropriations act for the current fiscal year shall be available to the committee in succeeding years.

Sec. 117. RCW 70.170.100 and 1990 c 269 s 12 are each amended to read as follows:

(1) The ((~~department~~)) committee is responsible for the development, implementation, and custody of a state-wide ((~~hospital~~)) health care data system. As part of the design stage for development of the system, the ((~~department~~)) committee 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 this chapter. The ((~~department~~)) committee shall identify a set of ((~~hospital~~)) health care data elements and report specifications which satisfy these needs. The ((~~council shall review the design of the data system and may direct the department to~~)) committee shall contract with a private vendor ((~~for assistance in the design of the data system~~)) in the state of Washington for all 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~~)) committee'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, 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~~)) committee shall identify ((~~hospital~~)) health care data elements relating to both ((~~hospital~~)) finances and the use of ((~~services by patients~~)) health care by consumers. Data elements ((~~relating to hospital finances~~)) shall be reported ((~~by hospitals in conformance~~)) as the committee directs, by reporters in conformity with a uniform system of reporting as ((~~specified~~)) established by the ((~~department and shall include 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 this chapter, 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~~)) committee. The uniform system shall be adopted by reporters. The committee shall permit reporting by electronic transmission or hard copy as is practical and economical to reporters, but shall in no event require that data be aggregated in any form or reported in hard copy to the committee by providers who are practitioners such as physicians and dentists.

((~~(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 this chapter. Data reporting requirements may reflect differences ((~~in hospital size; urban or rural location; scope, type, and method of providing service; financial structure; or other~~)) that involve pertinent distinguishing ((~~factors~~)) features as determined by the committee by rule. So far as ((~~possible~~)) is practicable, 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~~)) committee may require both annual reports and condensed quarterly reports((~~, so as to achieve both accuracy and timeliness in reporting~~)) from reporters who are not practitioners, such as physicians and dentists, so as to achieve both accuracy and timeliness in reporting, but shall craft the requirements with due regard to the data reporting burdens of reporters who are small businesses.

((~~(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)~~)) (5) Until such time as the state-wide ((~~hospital~~)) health care data system and first data plan are developed and implemented and ((~~hospitals~~)) reporters are able to comply with reporting requirements, the ((~~department shall~~)) committee may continue to 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~~)) the 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~~)) previously required by this chapter.

((~~(8)~~)) (6) The ((~~hospital~~)) health care data collected ((~~and~~)), maintained, and studied by the ((~~department~~)) committee shall be available for retrieval in original or processed form to public and private requestors 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 shall be funded by a fee schedule developed by the ((~~department~~)) committee, which reflects the direct cost of retrieving the data in the requested form.

(7) All persons subject to the jurisdiction of the state shall comply with committee requirements established by rule in the acquisition of the data. Persons not subject to the jurisdiction of the state shall be requested to cooperate with the acquisition of the data.

(8) The committee shall recommend to the commissioner rules for safeguarding the privacy of patients whose data is reported to the state.

(9) The committee shall also promulgate guidelines regarding the collection and analysis of the data regarding the quality of the data and quality and objectivity of analysis. The committee may require

disclosures to recipients of data or analysis that clearly identifies the assumptions and limitations of either.

Sec. 118. 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 consistent with the purposes of this chapter. 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.~~)) The committee may contract with a private vendor in the state of Washington to provide studies or reports that the committee chooses to conduct, consistent with the purposes of this chapter. The commissioner may perform the studies and any other studies, consistent with the purposes of this chapter. The studies or reports shall be funded out of the health care data collection account in the state treasury. These reports ((~~shall~~)) may include:

(1) Consumer guides on purchasing ((~~hospital~~)) or consuming health care ((~~services~~)) and publications providing verifiable and useful comparative information to ((~~consumers on hospitals and hospital~~)) the public on health care services;

(2) Reports for use by classes of purchasers, 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) Other reports the advisory committee believes will assist the public in understanding the prudent and cost-effective use of the health care delivery system.

NEW SECTION. **Sec. 119.** ADMINISTRATION. (1) The commissioner shall adopt rules on uniform billing forms for all health care providers subject to state law that shall be accepted by all health

care payers and service plans, public or private, subject to state law. To the greatest extent possible, the commissioner shall use, in either paper or electronic format, either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. The commissioner may add additional data items to the forms.

(2) The commissioner may by rule require payers who are subject to state jurisdiction to adopt reimbursement systems, such as resource-based relative value scale for practitioners and diagnostic-related groups for facilities, where the commissioner finds that the adoption of the systems would reduce administrative costs and be fair to providers. However, under no circumstances shall the commissioner fix, set, peg, restrict, or in any way set the amounts of reimbursement to be used in or produced by the systems.

NEW SECTION. **Sec. 120.** HEALTH CARE SERVICE PLANS--DEFINITIONS. For the purposes of chapter 43.-- RCW (sections 101 through 148 of this act), the following definitions shall apply:

(1) "Health care services" means all care, goods, or services provided to persons by providers of care intended to ascertain, improve, or maintain the health of the persons. It specifically includes the care, goods, or services of health care practitioners, programs, facilities, or other health care entities subject to the jurisdiction of Washington state law.

(2) "Providers" means all health care practitioners, programs, facilities, or other health care entities subject to the jurisdiction of Washington state.

(3) "Health care service plan" or "service plan" means a corporation, cooperative group, or association, that accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing the persons with health care services or indemnity against expenditures for health care expenses.

(4) "Participating provider" means a provider that has contracted in writing with a service plan to accept payment from, and to look solely to, such service plan, according to the terms of the subscriber contract for health care services rendered to a person who has previously paid, or on whose behalf prepayment has been made, to the service plan for the services.

(5) "Enrolled participant" means a person or group of persons who have entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a service plan to receive health care services.

(6) "Uncovered expenditures" means the costs to the service plan for health care services that are the obligation of the service plan for which an enrolled participant would also be liable in the event of the service plan's insolvency and for which no alternative arrangements have been made as provided in this chapter. The term does not include expenditures for covered services when a provider has agreed not to bill the enrolled participant even though the provider is not paid by the service plan, or for services that are guaranteed, insured, or assumed by a person or organization other than the service plan.

(7) "Copayment" means an amount specified in a group or individual contract that is an obligation of an enrolled participant for a specific service that is not fully prepaid.

(8) "Deductible" means the amount an enrolled participant is responsible to pay before the service plan begins to pay the costs associated with treatment.

(9) "Group contract" means a contract for health care services that by its terms limits eligibility to members of a specific group. The group contract may include coverage for dependents.

(10) "Individual contract" means a contract for health care services issued to and covering an individual. An individual contract may include dependents.

(11) "Carrier" means a service plan, insurer, or other entity responsible for the payment of benefits or provision of services under a group or individual contract.

(12) "Replacement coverage" means the benefits provided by a succeeding carrier.

(13) "Insolvent" or "insolvency" means that the organization has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

(14) "Fully subordinated debt" means those debts that meet the requirements of section 136 of this act and are recorded as equity.

(15) "Net worth" means the excess of total admitted assets as defined in RCW 48.12.010 over total liabilities but the liabilities shall not include fully subordinated debt.

NEW SECTION. **Sec. 121.** HEALTH CARE SERVICE CONTRACTORS, HEALTH MAINTENANCE ORGANIZATIONS, AND DISABILITY INSURERS. (1) All disability insurers, health care service contractors, health maintenance organizations, or entities doing business under chapter 48.45 RCW the day before the effective date of this section are deemed to be registered as service plans under sections 120 through 148 of this act on the effective date of this section.

(2) Contracts, agreements, and forms lawfully in use as of the effective date of this section are deemed approved under this chapter. However, the commissioner may by rule require that the contracts, agreements, and forms be amended to conform with sections 120 through 148 of this act.

(3) Out-of-state group contracts under which certificates of coverage shall be delivered in this state are subject to the rule-making authority of the commissioner, which includes prohibiting the out-of-state group contracts.

NEW SECTION. **Sec. 122.** REGISTRATION BY SERVICE PLANS REQUIRED--PENALTY. (1) No person may in this state, by mail or otherwise, act as or hold himself or herself out to be a service plan, as defined herein without being duly registered with the commissioner. At the written option of the applicant, such service plan may instead refer to itself as a health maintenance organization.

(2) A violation of this section is a gross misdemeanor.

(3) "Person", for the purposes of this section, includes corporations, cooperative groups, or associations as included in section 120(3) of this act.

NEW SECTION. **Sec. 123.** REGISTRATION WITH COMMISSIONER--FEE. (1) Every service plan that enters into agreements that require prepayment for health care services shall register with the insurance commissioner on forms to be prescribed and provided by the commissioner. The registrants shall state their name, address, type of organization, area of operation, type or types of health care services provided, and other information as may reasonably be required by the commissioner and shall file with the registration a copy of all contracts being offered and a schedule of all rates charged. No registrant shall change rates, modify a contract, or offer a new contract, until he or she has filed

a copy of the changed rate schedule, modified contract, or new contract with the commissioner.

(2) The commissioner shall charge a fee of ten thousand dollars for the filing of each original registration statement and may require each registrant to file a current reregistration statement annually thereafter.

(3) An application not disapproved within one hundred eighty days shall be deemed approved. The notice of disapproval shall contain all the grounds that the commissioner could rely on in making the disapproval.

NEW SECTION. **Sec. 124.** REFUSAL TO REGISTER SERVICE PLAN IF NAME CONFUSING WITH EXISTING SERVICE PLAN OR INSURANCE COMPANY. The commissioner shall refuse to accept the registration of a corporation, cooperative group, or association seeking to act as a service plan if, in his or her discretion, the commissioner finds that the name of the corporation, cooperative group, or association would be confused with the name of an existing registered service plan or authorized insurance company.

NEW SECTION. **Sec. 125.** CERTIFICATE OF REGISTRATION NOT AN ENDORSEMENT--DISPLAY IN SOLICITATION PROHIBITED. The granting of a certificate of registration to a service plan is permissive only, and does not constitute an endorsement by the commissioner of a person or thing related to the service plan. No person may advertise or display a certificate of registration for use as an inducement in a solicitation.

NEW SECTION. **Sec. 126.** EXAMINATION OF SERVICE PLANS--DUTIES OF SERVICE PLAN, POWERS OF COMMISSIONER--INDEPENDENT AUDIT REPORTS. (1) The commissioner may make an examination of the operations of a service plan as often as necessary in order to carry out the purposes of this chapter.

(2) Every service plan shall submit its books and records relating to its operation for financial condition and market conduct examinations and in every way facilitate the examinations. For the purpose of examinations, the commissioner may issue subpoenas, administer oaths, and examine the officers and principals of the service plan.

(3) The commissioner may elect to accept and rely on audit reports made by an independent certified public accountant for the service plan in the course of that part of the commissioner's examination covering the same general subject matter as the audit. The commissioner may incorporate the audit report in the report of the examination.

(4) Whenever a service plan applies for initial admission, the commissioner may make, or cause to be made, an examination of the applicant's business and affairs. Whenever such an examination is made, the provisions of chapter 48.03 RCW that are not inconsistent with this chapter are applicable. In lieu of making an examination himself or herself the commissioner may, in the case of a foreign service plan, accept an examination report of the applicant by the regulatory official in the state of domicile of the service plan.

NEW SECTION. **Sec. 127.** REVOCATION, SUSPENSION, REFUSAL OF REGISTRATION--HEARING--CEASE AND DESIST ORDERS, INJUNCTIVE ACTION--GROUNDS. The commissioner may, subject to a hearing under chapter 34.05 RCW, if one is demanded, revoke, suspend, or refuse to accept or renew registration from a service plan, or may issue a cease and desist order, or bring an action in a court of competent jurisdiction to enjoin a service plan from doing further business in this state, if the service plan:

(1) Fails to comply with a provision of this chapter or a proper order or rule of the commissioner.

(2) Is found by the commissioner to be in such financial condition that its further transaction of business in this state would jeopardize the payment of claims and refunds to subscribers.

(3) Has refused to remove or discharge a director or officer who has been convicted of a crime involving fraud, dishonesty, or like moral turpitude, after written request by the commissioner for the removal, and expiration of a reasonable time as specified in the request.

(4) Usually compels claimants under contracts either to accept less than the amount due them or to bring suit against the service plan to secure full payment of the amount due.

(5) Is affiliated with and under the same general management, or interlocking directorate, or ownership as another service plan that operates in this state without being registered, except as is permitted by this chapter.

(6) Refuses to be examined, or if its directors, officers, employees, or representatives refuse to submit to examination or to produce accounts, records, and files for examination by the commissioner if required, or refuses to perform a legal obligation relative to the examination.

(7) Fails to pay a final judgment rendered against the service plan in this state upon a contract, bond, recognizance, or undertaking issued or guaranteed by it, within thirty days after the judgment became final or within thirty days after time for taking an appeal has expired, or within thirty days after dismissal of an appeal before final determination, whichever date is the later.

(8) Is found by the commissioner, after investigation or upon receipt of reliable information, to be managed by persons, whether by its directors, officers, or by other means, who are incompetent or untrustworthy or so lacking in health care contracting or related managerial experience as to make the operation hazardous to the subscribing public; or that there is good reason to believe it is affiliated directly or indirectly through ownership, control, or other business relations, with a person or persons whose business operations are or have been marked, to the detriment of contract holders or stockholders, or investors or creditors or subscribers or of the public, by bad faith or by manipulation of assets, or of accounts, or of reinsurance.

NEW SECTION. **Sec. 128.** NOTICE OF SUSPENSION, REVOCATION, OR REFUSAL TO BE GIVEN SERVICE PLAN--AUTHORITY OF AGENTS. Upon the suspension, revocation, or refusal of a service plan's registration, the commissioner shall give notice to the service plan and shall suspend, revoke, or refuse the authority of its agents to represent the service plan in this state and give notice of the suspension, revocation, or refusal to the agents.

NEW SECTION. **Sec. 129.** FINE IN ADDITION TO OR IN LIEU OF SUSPENSION, REVOCATION, OR REFUSAL. After hearing or upon stipulation by the registrant and in addition to or in lieu of the suspension, revocation, or refusal to renew a registration of a service plan the commissioner may levy a fine against the party involved for each offense in an amount not less than fifty dollars and not more than ten thousand dollars. The order levying the fine shall specify the period

within which the fine must be fully paid. The period shall not be less than fifteen nor more than thirty days from the date of the order. If a service plan fails to pay a fine when due, the commissioner shall revoke the registration of the registrant, if not already revoked, and the fine shall be recovered in a civil action brought on behalf of the commissioner by the attorney general. A fine collected under civil action shall be paid by the commissioner to the state treasurer for deposit in the general fund.

NEW SECTION. **Sec. 130.** UNLAWFUL ACTS. (1) No person may knowingly file with a public official or knowingly make, publish, or disseminate a financial statement of a service plan that does not accurately state the service plan's financial condition.

(2) No person may knowingly make, publish, or disseminate false, deceptive, or misleading representations or advertising in the conduct of the business of a service plan, or relative to the business of a service plan, or to a person engaged in the business of a service plan.

(3) No person may knowingly make, issue, or circulate, or cause to be made, issued, or circulated, a misrepresentation of the terms of a contract, or the benefits or advantages promised by a contract, or use the name or title of a contract or class of contract misrepresenting the nature of the contract.

(4) No service plan nor a person representing a service plan may by misrepresentation or misleading comparisons induce or attempt to induce a member of a service plan to terminate or retain a contract or membership.

(5) Violation of this section is a gross misdemeanor.

NEW SECTION. **Sec. 131.** FUTURE DIVIDENDS OR REFUNDS--WHEN PERMISSIBLE. No service plan nor an individual acting on behalf of a service plan may guarantee or agree to the payment of future dividends or future refunds of unused charges or savings in a specific or approximate amounts or percentages in respect to a contract being offered to the public, except in a group contract containing an experience refund provision.

NEW SECTION. **Sec. 132.** FINANCIAL INTERESTS OF SERVICE PLANS, RESTRICTED--EXCEPTIONS, REGULATIONS. (1) No person having authority in the investment or disposition of the funds of a service plan and no

officer or director of a service plan may accept, except for the service plan, or be the beneficiary of a fee, brokerage, gift, commission, or other emolument because of a sale of health care service agreements or an investment, loan, deposit, purchase, sale, payment, or exchange made by or for the service plan, or be pecuniarily interested in the plan in any capacity; except, that such a person may procure a loan from the service plan directly upon approval by two-thirds of its directors and upon the pledge of securities eligible for the investment of the service plan's funds under this chapter.

(2) The commissioner may, by rule or hearing, from time to time, define and permit additional exceptions to the prohibition contained in subsection (1) of this section solely to enable payment of reasonable compensation to a director who is not otherwise an officer or employee of the service plan, or to a corporation or firm in which the director is interested, for necessary services performed or sales or purchases made to or for the service plan in the ordinary course of the service plan's business and in the usual private professional or business capacity of the director or the corporation or firm.

NEW SECTION. **Sec. 133.** IMMUNITY FROM LIBEL OR SLANDER. There is no liability on the part of, and no cause of action shall arise against, the commissioner, the commissioner's agents, or members of the commissioner's staff, or against a service plan, its authorized representatives, its agents, its employees, furnishing to the service plan information as to reasons for cancellation or refusal to issue or renew, for libel or slander on the basis of a statement made by the commissioner, the commissioner's agents, or members of the commissioner's staff in a written notice of cancellation or refusal to issue or renew, or in other communications, oral or written, specifying the reasons for cancellation or refusal to issue or renew or the providing of information pertaining to the cancellation, refusal, or nonrenewal, or for statements made or evidence submitted in a hearing conducted in connection with the action.

NEW SECTION. **Sec. 134.** UNDERWRITING OF INDEMNITY BY INSURANCE POLICY, BOND, SECURITIES, OR CASH DEPOSIT. (1) If health care services that are promised in an agreement are not to be performed by the service plan or by a participating provider, provision shall be made

for reimbursement or indemnity of the enrolled participants in the event of the insolvency of the service plan.

(2) The reimbursement or indemnity shall either be underwritten by:

(a) An insurance company authorized to write casualty or other appropriate insurance in the state; or

(b) Guaranteed by a surety company authorized to do business in this state; or

(c) Guaranteed by a deposit of cash or securities eligible for investment by insurers under chapter 48.13 RCW, with the commissioner, as provided in this section.

(3)(a) If the reimbursement or indemnity is underwritten by an insurance company, the contract or policy of insurance may designate the service plan as the named insured, but shall be for the benefit of the persons who have previously paid, or on whose behalf prepayment has been made, for the health care services.

(b) If the reimbursement or indemnity is guaranteed by a surety company, the surety bond shall designate the state of Washington as the named obligee, but the bond shall be for the benefit of the persons who have previously paid, or on whose behalf prepayment has been made, for such health care services, and shall be in an amount as the commissioner shall direct, but in no event in a sum greater than the amount of one hundred fifty thousand dollars or the amount necessary to cover incurred but unpaid reimbursement or indemnity benefits as reported in the last annual statement filed with the commissioner, and adjusted to reflect known or anticipated increases or decreases during the ensuing year, plus an amount of unearned prepayments applicable to reimbursement or indemnity benefits satisfactory to the commissioner, whichever amount is greater.

(c) A copy of the insurance policy or surety bond, as the case may be, and a modification of the policy or bond, shall be filed with the commissioner.

(d) If the reimbursement or indemnity is guaranteed by a deposit of cash or securities, the deposit shall be in an amount as the commissioner shall compute in the same manner as directed in (b) of this subsection. The cash or security deposit shall be held in trust by the insurance commissioner and shall be for the benefit of the enrolled participants.

NEW SECTION. **Sec. 135.** FINANCIAL FAILURE--SUPERVISION OF COMMISSIONER--PRIORITY OF DISTRIBUTION OF ASSETS. (1) Rehabilitation, liquidation, or conservation of a service plan shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the commissioner under the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate, or conserve a service plan upon one or more of the grounds set out in RCW 48.31.030, 48.31.050, and 48.31.080.

(2) For purpose of determining the priority of distribution of general assets, claims of enrolled participants and enrolled participants' beneficiaries shall have the same priority as established by RCW 48.31.280 for policyholders and beneficiaries of insureds of insurance companies. If an enrolled participant is liable to a provider for services provided under and covered by the health care plan, that liability shall have the status of an enrolled participant claim for distribution of general assets.

(3) A provider who is obligated by statute or agreement to hold enrolled participants harmless from liability for services provided under and covered by a health care plan has a priority of distribution of the general assets immediately following that of enrolled participants and enrolled participants' beneficiaries as described in this section, and immediately preceding the priority of distribution described in chapter 48.31 RCW.

NEW SECTION. **Sec. 136.** MINIMUM NET WORTH--REQUIREMENT TO MAINTAIN--DETERMINATION OF AMOUNT. (1)(a) Every service plan must have a net worth of five hundred thousand dollars at the time of initial registration under this chapter. The commissioner is authorized to establish standards for reviewing a service plan's financial integrity if the net worth falls beneath that amount.

(b) A service plan that fails to maintain the required net worth shall cure that defect in compliance with an order of the commissioner rendered in conformity with rules adopted under chapter 34.05 RCW. The commissioner may take appropriate action to assure that the continued operation of the service plan will not be hazardous to its enrolled participants.

(2) A service plan registered before September 1, 1993, must achieve the net worth requirement required in subsection (1) of this section by July 1, 1994.

(3)(a) In determining net worth, no debt may be considered fully subordinated unless the subordination is in a form acceptable to the commissioner. An interest obligation relating to the repayment of a subordinated debt must be similarly subordinated.

(b) The interest expenses relating to the repayment of a fully subordinated debt shall not be considered uncovered expenditures.

(c) A subordinated debt incurred by a note meeting the requirement of this section, and otherwise acceptable to the commissioner, shall not be considered a liability, and shall be recorded as equity.

(4) Every service plan shall, in determining liabilities, include an amount estimated in the aggregate to provide for unearned premiums and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of the claims. Liabilities shall be computed in accordance with rules adopted by the commissioner upon reasonable consideration of the ascertained experience and character of the service plan.

(5) All income from reserves on deposit with the commissioner shall belong to the depositing service plan and shall be paid to the plan as the income becomes available.

(6) Funded reserve required by this chapter shall be considered an asset of the service plan in determining the organization’s net worth.

(7) A service plan that has made a securities deposit with the commissioner may, at its option, withdraw the securities deposit or a part of the deposit after first having deposited or provided in lieu of the deposit an approved surety bond, a deposit of cash or securities, or combination of these or other deposits of equal amount and value to that withdrawn. Securities and surety bonds are subject to approval by the commissioner before being substituted.

NEW SECTION. **Sec. 137.** LIMITED HEALTH CARE SERVICE--UNCOVERED EXPENDITURES. (1) For purposes of this section only, "limited health care service" means dental care services, vision care services, mental health services, chemical dependency services, pharmaceutical services, and other services as may be determined by the commissioner to be

limited health services. "Limited health services" does not include hospital, medical, surgical, emergency, or out-of-area services, except as those services are provided incidentally to the limited health services set forth in this subsection.

(2) For purposes of this section only, a "limited service plan" means a service plan that offers one and only one limited health care service.

(3) Uncovered expenditures of limited service plans that have had a certificate of registration for less than three years shall be either insured or guaranteed by a foreign or domestic carrier admitted in the state of Washington or by another carrier acceptable to the commissioner. All limited service plans shall also deposit with the commissioner one-half of one percent of their projected premium for the next year in cash, approved surety bond, securities, or other form acceptable to the commissioner.

(4) Uncovered expenditures of limited service plans that have had a certificate of registration for three years or more shall be assured by depositing with the insurance commissioner twenty-five percent of their last year's uncovered expenditures as reported to the commissioner and adjusted to reflect any anticipated increases or decreases during the ensuing year plus an amount for unearned prepayments; in cash, approved surety bond, securities, or other form acceptable to the commissioner. Compliance with subsection (3) of this section constitutes compliance with this requirement.

(5) Limited service plans need not comply with sections 128, 129, 203, 205, and 206 of this act.

NEW SECTION. **Sec. 138.** INSOLVENCY--COMMISSIONER'S DUTIES--PARTICIPANTS' OPTIONS--ALLOCATION OF COVERAGE. (1)(a) In the event of insolvency of a service plan and upon order of the commissioner, all other service plans then having active enrolled participants under a group plan with the affected agreement holder that participated in the enrollment process with the insolvent service plan at a group's last regular enrollment period shall offer the eligible enrolled participants of the insolvent service plan the opportunity to enroll in an existing group plan without medical underwriting during a thirty-day open enrollment period, commencing on the date of the insolvency. Eligible enrolled participants are not subject to preexisting condition limitations except to the extent that a waiting period for a

preexisting condition has not been satisfied under the insolvent service plan's group plan.

(b) An open enrollment is not required where the agreement holder participates in a self-insured, self-funded, or other health plan exempt from commissioner rule, unless the plan administrator and agreement holder voluntarily agree to offer a simultaneous open enrollment and extend coverage under the same enrollment terms and conditions as are applicable to carriers under this section and rules adopted under this section. If an exempt plan was offered during the last regular open enrollment period, then the carrier may offer the agreement holder the same coverage as any self-insured plan or plans offered by the agreement holder without regard to coverage, benefit, or provider requirements mandated by this chapter for the duration of the current agreement period.

(c) In the event of insolvency of a service plan and if no other service plan has active enrolled participants under a group plan with the affected agreement holder, or if the commissioner determines that the other service plans lack sufficient health care delivery resources to assure that health services will be available or accessible to all of the group enrollees of the insolvent service plan, then the commissioner shall allocate equitably the insolvent service plan's group agreements for these groups among all service plans that operate within a portion of the insolvent service plan's area, taking into consideration the health care delivery resources of each service plan. Each service plan to which a group or groups are allocated shall offer the agreement holder, without medical underwriting, the service plan's existing coverage that is most similar to each group's coverage with the insolvent service plan at rates determined in accordance with the successor service plan's existing rating methodology. The eligible enrolled participants are not subject to preexisting condition limitations except to the extent that a waiting period for a preexisting condition has not been satisfied under the insolvent service plan's group plan. An offering by a service plan is not required where the agreement holder participates in a self-insured, self-funded, or other health plan exempt from commissioner rule. The service plan may offer the agreement holder the same coverage as a self-insured plan or plans offered by the agreement holder without regard to coverage, benefit, or provider requirements mandated by this chapter for the duration of the current agreement period.

(2) The commissioner shall also allocate equitably the insolvent service plan's nongroup enrolled participants who are unable to obtain coverage among all service plans that operate within a portion of the insolvent service plan's service area, taking into consideration the health care delivery resources of the service plan. Each service plan to which nongroup enrolled participants are allocated shall offer the nongroup enrolled participants the service plan's existing comprehensive conversion plan, without additional medical underwriting, at rates determined in accordance with the successor service plan's existing rating methodology. The eligible enrolled participants are not subject to preexisting condition limitations except to the extent that a waiting period for a preexisting condition has not been satisfied under the insolvent service plan's plan.

(3) Agreements covering participants allocated under subsections (1)(b) and (2) of this section to service plans under this section may be rerated after ninety days of coverage.

(4) A limited service plan shall not be required to offer services other than its one limited health care service to an enrolled participant of an insolvent service plan.

NEW SECTION. **Sec. 139.** CONTRACTS FOR SERVICES--EXAMINATION OF CONTRACT FORMS BY COMMISSIONER--GROUNDS FOR DISAPPROVAL--LIABILITY OF PARTICIPANT. (1) A service plan may enter into contracts with or for the benefit of persons or groups of persons that require prepayment for health care services by or for such persons in consideration of the service plan providing one or more health care services to the persons. The activity is not subject to the laws relating to insurance.

(2) The commissioner may on examination, subject to the right of the service plan to demand and receive a hearing under chapter 34.05 RCW, disapprove a contract form for any of the following grounds:

(a) If it contains or incorporates by reference an inconsistent, ambiguous or misleading clause, or exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract;

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

(c) If purchase of health care services under the plan is being solicited by deceptive advertising;

(d) If the benefits provided in the plan are unreasonable in relation to the amount charged for the contract;

(e) If the plan contains unreasonable restrictions on the treatment of patients;

(f) If the plan violates a provision of this chapter; or

(g) If the plan fails to conform to rules adopted by the commissioner under chapter 34.05 RCW.

(3)(a) Every contract between a service plan and a participating provider of health care services must be in writing and shall state that in the event the service plan fails to pay for health care services as provided in the contract, the enrolled participant shall not be liable to the provider for sums owed by the service plan. Every contract shall provide that this requirement shall survive termination of the contract.

(b) No participating provider, agent, trustee, or assignee may maintain an action against an enrolled participant to collect sums owed by the service plan.

(4) A form submitted for approval is deemed approved if not disapproved by the commissioner within thirty days with the reasons stated in writing to the service plan.

(5) Subject to the right of the service plan to demand and receive a hearing under chapter 34.05 RCW, the commissioner may disapprove the contract form if it is in violation of this chapter or if it fails to conform to minimum provisions or standards required by the commissioner by rule under chapter 34.05 RCW.

NEW SECTION. **Sec. 140.** PROVIDER CONTRACTS TO BE FILED WITH COMMISSIONER. (1) Forms of contracts between service plans and participating providers must be filed with the insurance commissioner prior to use.

(2) A contract form not disapproved within fifteen days of filing is deemed approved, except that the commissioner may extend the approval period an additional fifteen days upon giving notice before the expiration of the initial fifteen-day period. The commissioner may, at any time, approve the contract form for immediate use. Approval may be subsequently withdrawn for cause occurring after the approval or deemed approval.

(3) Subject to the right of the service plan to demand and receive a hearing under chapter 34.05 RCW, the commissioner may disapprove the

contract form if it is in violation of this chapter or if it fails to conform to minimum provisions or standards required by the commissioner by rule under chapter 34.05 RCW.

NEW SECTION. **Sec. 141.** MASTER LISTS OF SERVICE PLAN'S PARTICIPATING PROVIDERS--FILING WITH COMMISSIONER--NOTICE OF TERMINATION OR PARTICIPATION. Every service plan shall file with its annual statement to the commissioner a master list of the participating providers with whom or with which the service plan has executed contracts of participation, certifying that each participating provider has executed the contract of participation. The service plan shall on the first day of each month notify the commissioner in writing in case of the termination of a contract, and of participating providers who have entered into a participating contract during the preceding month.

NEW SECTION. **Sec. 142.** SERVICE PLAN TO FILE WITH COMMISSIONER LISTS OF ITS PARTICIPANTS--NOTICE OF TERMINATION. Every service plan shall file with the commissioner lists of the participants with whom or with which the service plan has executed contracts of participation, certifying that each participant has executed a contract of participation. The service plan shall immediately notify the commissioner in writing in case of the termination of a contract.

NEW SECTION. **Sec. 143.** MODIFICATION OF BASIS OF AGREEMENT, ENDORSEMENT REQUIRED. If an individual health care service agreement is issued on a basis other than as applied for, an endorsement setting forth the modification must accompany and be attached to the agreement. No agreement is effective unless the endorsement is signed by the applicant, and a signed copy of the agreement returned to the service plan.

NEW SECTION. **Sec. 144.** TERMINATION, RENEWAL, AND OTHER FEATURES. (1) The commissioner may adopt rules regulating the enrollment, renewal, and termination processes for all enrolled participants.

(2) The commissioner may adopt rules establishing the rights of enrolled participants enrolling lawful dependents under their coverages.

NEW SECTION. **Sec. 145.** ANNUAL FINANCIAL STATEMENT--FILING--PENALTY FOR FAILURE TO FILE. (1) Every service plan shall annually, within one hundred twenty days of the closing date of its fiscal year, file with the commissioner a statement, verified by at least two of the principal officers of the service plan, showing its financial condition as of the closing date of its fiscal year. The statement must be in a form as provided or prescribed by the commissioner. The commissioner may, for good reason, allow a reasonable extension of the time within which the annual statement shall be filed.

(2) The commissioner may suspend or revoke the certificate of registration of a service plan failing to file its annual statement when due or during an extension of time that the commissioner, for good cause, may grant.

NEW SECTION. **Sec. 146.** PAYMENTS FOR SERVICES. (1) Payment by check for claims under a health care service contract for health care services provided by persons regulated by Title 18 RCW, where the provider is not a participating provider under a contract with the service plan, shall be made out to both the provider and the enrolled participant, with the provider as the first named payee, jointly, to require endorsement by each.

(2) Payment shall be made in the single name of the enrolled participant if the enrolled participant as part of his or her claim furnishes evidence of prepayment to the provider.

(3) Nothing in this section precludes a service plan from voluntarily issuing payment in the single name of the provider.

NEW SECTION. **Sec. 147.** AGENT--DEFINITION--LICENSE REQUIRED--APPLICATION, ISSUANCE, RENEWAL, FEES--PENALTIES INVOLVING LICENSE. (1) "Agent," as used in sections 128 through 148 and 201 through 214 of this act, means a person appointed or authorized by a service plan to solicit applications for health care service contracts on the service plan’s behalf.

(2) No person may act as or hold himself or herself out to be an agent of a service plan unless licensed as a disability insurance agent by this state and appointed by the service plan on whose behalf solicitations are to be made. The health care commissioner may, by rule, authorize other persons to function in the agent role. The rules may be similar to chapter 48.17 RCW and rules adopted under chapter

48.17 RCW. These authorized persons are subject to the regulation of the health care commissioner.

(3) Initial and renewal applications, appointments, and qualifications for licenses, and the initial and subsequent fees and issuance of a license shall be in accordance with the provisions of chapter 48.17 RCW that are applicable to a disability insurance agent.

(4) A person holding a valid license in this state as a service plan agent on June 30, 1993, is not required to requalify by an examination for the renewal of the license under this chapter, but is subject to regulation by either the insurance commissioner or health care commissioner as provided in this chapter.

(5) The insurance commissioner or commissioner may revoke, suspend, or refuse to issue or renew an agent's license to solicit applications for service plans, or levy a fine upon the licensee, in accordance with those provisions of chapter 48.17 RCW or this chapter that are applicable to a disability insurance agent.

NEW SECTION. **Sec. 148.** TAXES. (1) All service plans, in lieu of other state or local taxes shall pay a business and occupations tax of one and one-half percent plus an assessment to fund the commissioner's regulation of service plans of one-quarter of one percent. The revenue raised by the assessment shall be appropriated as necessary to the commissioner's office for that purpose. The revenue raised by the assessment shall not be spent on any other purpose. The commissioner may by rule, reduce the assessment in a year, by the amount of revenue in the account from previous years.

(2) The state treasurer is directed to open an account of the state to receive and hold assessments raised under subsection (1) of this section. Revenue shall be disbursed from the fund in accord with legislative appropriation.

(3) Applicable provisions of chapters 82.04 and 82.32 RCW apply to this section.

PART II - ACCESS TO HEALTH CARE

NEW SECTION. **Sec. 201.** LEGISLATIVE FINDINGS. The legislature finds:

(1) Each citizen of the state of Washington must have access to adequate, basic health care insurance that protects against financial ruin due to illness or injury;

(2) Health care system reform must build on the strengths of the current system; and

(3) Health care costs must be more effectively managed, and the rate of increase brought down.

NEW SECTION. **Sec. 202.** HEALTH CARE INSURANCE. (1) Subject to subsection (2) of this section, a resident of the state of Washington must have health care coverage under one of the following programs:

(a) A federal program;

(b) From an employer;

(c) Purchased through the personal health care program as established under section 203 of this act.

(2) Subject to section 203(2) of this act, the health care commissioner by rule may create classes of exemptions from this requirement for the following:

(a) Part-time residents;

(b) Migrant workers;

(c) Nonresident aliens; or

(d) Other persons with health care coverage satisfactory to the health care commissioner.

No group may be exempted unless the health care commissioner is assured that the persons will not consume health care services under circumstances in which the cost of providing services would likely be shifted to covered persons unless the administrative costs of detecting and enrolling the persons would outweigh the cost shift.

NEW SECTION. **Sec. 203.** ALL RESIDENTS TO ARRANGE HEALTH CARE INSURANCE. (1) Subject to section 202 of this act, all residents of Washington have the obligation of arranging health care coverage for themselves and their dependents who are also residents of Washington. The health care commissioner may by rule permit residents to cover their dependents who live outside the state, but all such coverage shall be paid for in full by the resident before coverage is commenced, continued, or renewed.

(2) Every health care provider who provides services to a resident without health care insurance shall submit a claim to the health care

commissioner on a form provided by the health care commissioner. The health care commissioner shall make payment to the provider from a fee schedule the health care commissioner shall establish by rule, which shall reflect the rates of reimbursement for the region of the state involved.

(3) The health care commissioner shall by rule condition access to state programs, privileges, and licenses on each resident having health care insurance coverage.

(4) Subject to section 202 of this act, the health care commissioner shall by rule arrange for health care coverage for residents obtaining care without coverage and assess premiums, plus an interest rate of six percent, back to the resident's last day of proven coverage. The health care commissioner may pursue the premiums in a civil suit filed in a court of competent jurisdiction in the state. The health care commissioner may recover reasonable attorneys' fees and costs upon substantially prevailing.

(5)(a) The health care commissioner shall by rule arrange a reporting system of insureds by all health care service plans subject to state jurisdiction.

(b) The health care commissioner shall request the cooperation of those not subject to state jurisdiction to report its insureds or those who are otherwise covered.

(c) The health care commissioner shall establish by rule programs meant to identify residents without coverage and assist them in finding coverage.

(6) By December 31, 1994, the health care commissioner shall report to the senate and the house of representatives of the legislature his or her recommendations as to penalties for those who fail to obtain coverage for themselves and their dependents.

NEW SECTION. **Sec. 204.** HEALTH INSURANCE REFORM. (1) The health care commissioner shall adopt rules ensuring that persons insured by health care service plans subject to the state's jurisdiction have coverages that:

(a) Are portable from one source of coverage to another;

(b) Do not exclude coverage because of preexisting conditions or waiting periods; and

(c) As to benefits covered in the personal health plan in section 205 of this act, are community-rated. Benefits that are in excess of

the personal health plan and written in supplemental coverages under section 205 of this act, may be rated as to age and sex as well.

(2) The health care commissioner shall adopt rules that are consistent with the concept of private, as opposed to social, insurance; sound private sector insurance business practices; and do not result in unfair shifting of costs from one carrier to another or from one insured to another except as clearly required by this chapter.

NEW SECTION. **Sec. 205.** PERSONAL HEALTH CARE PROGRAM--PARTICIPATING CARE PLANS. (1) The health care commissioner shall create a state-administered insurance program to provide personal health plan coverage to all residents not otherwise insured.

(2)(a) The coverage shall be provided by private managed care plans available in the various regions of the state. For this purpose, managed care refers to a variety of techniques or organizational structures used by health care delivery systems to control health care costs and promote continuous quality improvement in the delivery of health care. Managed care may be achieved by: Prospective assessment of care; general rules governing medical decision making; benefit design; or by provider selection. Managed care does not necessarily require individual patient care management by a physician "gatekeeper," or health maintenance organization systems of health care delivery.

(b) The health care commissioner shall by rule define market regions in the state.

(c) All plans shall include a prohibition on providers billing patients for anything other than copayments allowed under the health care commissioner’s rules.

(3)(a) Each insurance carrier shall offer a standard benefit package called a personal health plan, the benefits, copayments, and rates of which shall be set as provided in this subsection by the health care commissioner by rule. No service a carrier offers in the personal health plan may be offered in another policy of the carrier.

(b) Before the beginning of each state fiscal year, the health care commissioner shall consult with an advisory committee, which shall, after suitable public input, report to the health care commissioner a list of health services, ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. The recommendation shall be accompanied by a report of an independent actuary retained

each year by the health care commissioner, after competitive bidding, in accord with state competitive bidding practices. The actuary shall determine rates necessary to cover each of the costs of the services rated on a state-wide basis. The health care commissioner shall then set a rate, which may include quarterly adjustments, to be used to purchase services for persons subject to section 206 of this act. The health care commissioner shall also set standard copayments to be charged by all carriers for the personal health plan.

(c) For the personal health plan, carriers shall compete on the basis of how far down the list of ranked benefits they can deliver coverage for services for the health care commissioner's stipulated rate and level of copayments. Carriers must go down the list of ranked services in the order adopted by the health care commissioner. Carriers may change how far down they will go down the list for contract years beginning during each quarter of the state fiscal year. No carrier may offer different benefits for the state-set premium for individual customers assigned by the health care commissioner. All changes must be keyed to fiscal year quarters and announced and filed with the health care commissioner ten days in advance of use. Services that a carrier does not include in the personal health plan must be sold in a separate supplemental coverage, with a separate contract, separate premium, and separate copayment schedule. No supplemental coverage may be sold except as a supplement to the personal health plan or as a supplement to an employer's self-insured plan.

(d) The health care commissioner is permitted to establish tiers for the premiums in accord with the following, and carriers are permitted to give separate levels of how far down the list the carrier could go for that premium:

(i) Single person;

(ii) Family, by size.

(e) Carriers who participate in the personal health plan may offer coverages supplemental to the personal health plan or any other lawful coverages as they choose, subject only to the health care commissioner's regulatory authority under chapter 43.-- RCW (sections 101 through 148 of this act). State or local government self-insured plans shall offer to their employees and dependents the personal health plan and supplemental coverages on the same terms as insurance companies.

(f) Limited service plans as defined in section 137 of this act have no obligation to participate in the personal health care plan.

NEW SECTION. **Sec. 206.** PERSONAL HEALTH PLAN--OTHERWISE UNCOVERED PERSONS. (1) The following persons who do not have health care coverage through their workplace or otherwise may acquire coverage under the personal health program subject to the following conditions:

(a) Persons with family incomes under one hundred percent of the federal poverty level with premiums paid by the state, but with copayment requirements established by the health care commissioner to deter unnecessary utilization;

(b) Persons with family income levels over one hundred percent, but under two hundred fifty percent of the federal poverty level with premiums to be paid by covered persons on a sliding scale keyed to income to be determined by the health care commissioner, but with copayment requirements established to help fund the care provided and deter unnecessary utilization;

(c) Persons with family income above two hundred fifty percent of the federal poverty level with premiums paid by covered persons and with copayment requirements established to help fund the care provided and deter unnecessary utilization.

(2) Carrier eligibility to do business in the state shall be conditioned by the health care commissioner on accepting a fair allocation of state-sponsored personal health plan patients. The health care commissioner shall create standards addressing the criteria health care service plans may use to turn away personal health plan business on the basis of a carrier having accepted its fair share of such persons. The rules shall also endeavor to avoid adverse selection to particular kinds of carriers due to their popularity among the public and ensure that all carriers, in one way or another, cover approximately the same percentage of the personal health plan market that it has in the nonpersonal health plan market.

(3) Persons eligible for medicaid or other federal programs shall participate in the personal health plan if the federal government permits them to do so. If the federal government permits, employer self-insured employee benefit programs shall be treated like insurance programs for purposes of this chapter. With the written approval of the governor, the health care commissioner shall make application for necessary waivers from federal law to implement this subsection.

NEW SECTION. **Sec. 207.** PRACTITIONER DISCLOSURE REQUIREMENTS AND FACILITY PRIVILEGES--LEGISLATIVE FINDINGS. The legislature finds:

(1) Health care is a personal and intimate relationship between patients and providers of health care services. There are contending points of view as to appropriate therapeutic approaches, medically safe sites for care, and appropriate training of health care practitioners.

(2) This section and sections 208 through 211 of this act seek to ensure the patient's freedom of choice, the freedom of various practitioners to compete for patients, and the freedom of practitioners from being unfairly exposed to liability due to intervening in care that was managed by another type of practitioner.

(3) The purpose of this chapter is the regulation of competition by the state in this area through mandating that more information be made available in the market place to create real therapeutic choices for patients, and place some, but not all, of the responsibility for those choices on the patient.

NEW SECTION. **Sec. 208.** PRACTITIONER DISCLOSURE REQUIREMENTS AND FACILITY PRIVILEGES--PRACTITIONER-PATIENT RELATIONSHIP. (1) All practitioner-patient relationships, except those that both originate in an emergency and do not extend beyond the emergency, shall be under a written care agreement containing a written disclosure statement signed by both the practitioner and the patient containing the following:

(a) The formal training of the practitioner, including type and length, as well as posttraining experience;

(b) Specify a planned site for the entire course of care with the practitioner's certificate of suitability of the patient for such a site or with an indication that it is against the practitioner's advice;

(c) Indicate with whom the practitioner has a voluntary written call and back-up relationship and health care facility relationship, including admitting privileges, if any.

(2) The secretary of health, by rule, shall adopt forms or guidelines for forms and requirements to notify patients of changes in a practitioner's information that are to be used by all health care practitioners regulated under state law.

(3) A health care practitioner regulated under state law who violates this section is guilty of unprofessional conduct for purposes of chapter 18.130 RCW.

(4) Practitioners who must render care to patients with whom they have no care agreement, or no back-up relationship with the patient's practitioner and are not members of such practitioner's hospital staff, shall have a malpractice action brought against them arising out of the care adjudicated by a new standard of care imposing liability, only where there is intentional or reckless disregard of the standard of care in the community proven by clear and convincing evidence. The secretary of health may exempt from this subsection unforeseeable health care rendered to persons in different geographic localities from their place of residence.

NEW SECTION. **Sec. 209.** PRACTITIONER DISCLOSURE REQUIREMENTS AND FACILITY PRIVILEGES--PRACTITIONER-FACILITY RELATIONSHIP. (1) No hospital or other care facility in the state of Washington must extend admitting privileges to any type of practitioner.

(2) Hospitals shall not force practitioners of different licensure into the same hospital staffs without the consent of the practitioners. However, the medical staff shall contain practitioners licensed under chapters 18.71, 18.57, and 18.32 RCW, but shall not contain other practitioners except on terms and conditions as the medical staff by a two-thirds vote accepts.

(3) Subject to subsection (2) of this section, hospitals may create as many staffs as they choose.

(4) No hospital may require practitioners of another licensure staff to comment on the application, credentials, or conduct of practitioners outside of their staff.

(5) A hospital may require physicians to provide emergency care to patients of practitioners not on the medical staff, but the care will be judged in malpractice actions under the standard contained in section 208 of this act.

NEW SECTION. **Sec. 210.** PRACTITIONER DISCLOSURE REQUIREMENTS AND FACILITY PRIVILEGES--PRACTITIONER-PATIENT-INSURANCE COMPANY RELATIONSHIP. No public health care payer plan or health care service plan subject to the jurisdiction of the state of Washington is required to pay practitioners for services it regards as unsafe due to:

(1) The nature of the services;

(2) The training of the practitioner providing the service; or

(3) The site of the service;

if this was disclosed in the health care coverage contract.

NEW SECTION. **Sec. 211.** SECRETARY OF HEALTH IMPLEMENTATION OF SECTIONS 207 THROUGH 210 OF THIS ACT BY RULE. The secretary of health may implement sections 207 through 210 of this act by rule in accordance with chapter 34.05 RCW.

NEW SECTION. **Sec. 212.** SECRETARY OF HEALTH TO STUDY SUPPLY OF PRIMARY CARE PRACTITIONERS. The secretary of health shall conduct a study with the University of Washington medical school to identify practical steps the state of Washington can take to encourage the location of more primary care physicians in the state, particularly in traditionally underserved urban and rural areas.

NEW SECTION. **Sec. 213.** LONG-TERM CARE. The health care commissioner shall present a proposal to the legislature by December 15, 1993, to establish a financing mechanism and a proposed startup date, no later than January 1, 1996, for covering long-term care. Proposed benefit packages, changes to long-term care facility regulation, and the role of the personal health care plan and supplemental health care coverages should also be addressed in the proposal.

NEW SECTION. **Sec. 214.** REVENUE. (1) There is created in the state treasury the Washington state health care access account. Moneys deposited in the account under this section may be spent only on activities contained in sections 201 through 213 of this act.

(2) There shall be a tax on all alcoholic beverages sold subject to the jurisdiction of the state of Washington of twenty percent of the retail sales price including all other taxes. The tax shall be collected as a sales tax.

(3) There shall be a tax on all tobacco products sold subject to the jurisdiction of the state of Washington of fifty percent of the retail sales price including all other taxes. The tax shall be collected as a sales tax.

(4) There shall be a sales tax on all services provided subject to the jurisdiction of the state of Washington of one percent.

PART III - COST CONTAINMENT

NEW SECTION. **Sec. 301.** LEGISLATIVE FINDINGS. The legislature finds that the cost of health care:

(1) Is a serious barrier to providing services to those who need them;

(2) Deprives other sectors of the economy of needed resources;

(3) Is caused by a number of different features of both the health care industry and the state regulatory apparatus; and can be reduced effectively only by carefully addressing both of these issues.

NEW SECTION. **Sec. 302.** COOPERATIVE PURCHASING AND SELLING. (1) Greater flexibility is needed as to how groups of people may purchase health care coverage and how providers organize to provide cost-effective health care services. The express authorization of both buyers of health care coverage and sellers of health care services to form cooperatives is necessary to encourage additional innovation in these two important areas.

(2) It is declared to be the policy of the state that the health care commissioner will actively supervise the competitive practices of group purchasing organizations established under section 303 of this act and independent practice associations established under section 304 of this act in order to achieve the displacement of the federal antitrust laws to the maximum extent permitted under the Parker doctrine.

NEW SECTION. **Sec. 303.** COOPERATIVE PURCHASING OF HEALTH CARE INSURANCE. (1) The legislature finds that many businesses could achieve substantial savings in the premiums they pay for health care insurance for their employees if they were able to aggregate their buying power in reasonable and responsible ways. ERISA allows limited regulation of such activities containing employers and employees subject to its terms, and this chapter seeks to exercise the jurisdiction allowed. In order to allow public and church-employer groups the same benefits as private employers, they are included.

The legislature further finds that there is a danger that the undue aggregation of buying power by such organizations could be harmful to the competitive nature of a health care insurance marketplace and therefore has authorized, on a limited basis, consumer protection act suits under chapter 19.86 RCW.

(2) Definitions. For purposes of this section, the following words shall have the following meanings:

(a) "Commissioner" means the health care commissioner of the state of Washington.

(b) "Employee" and "employer" have the same meaning as under ERISA.

(c) "ERISA" means the Employee Retirement Income Security Act of 1974 as amended.

(d) "Group health care coverage" means group health care coverage regulated under chapter . . ., Laws of 1993 (this act) and may include other group insurance coverages when purchased in addition to group health care coverage.

(e) "Members" means all those who are covered by a group health care coverage arrangement or those for whom such coverage is arranged as defined in the organizational documents of the group purchasing organization.

(f) "Multiple employer purchasing organization" means a fully insured multiple employer welfare arrangement as defined in ERISA except that it includes nonfederal employers and employees not covered by ERISA because of section 4 of ERISA.

(g) "Other group purchasing organization" means any other fully insured group purchasing arrangement irrespective of who the sponsoring group is or whether it was formed for purposes of purchasing insurance.

(h) "Group purchasing organization" means both or either a multiple employer purchasing organization or another group purchasing organization.

(3) Creation of group purchasing organizations.

(a) A group of public or private employers may join together for purposes of organizing a multiple employer purchasing organization.

(b) Other group of residents may form another group purchasing organization for purposes of purchasing health care coverage for themselves and their dependents.

(4) Regulation.

(a) No entity may function as a group purchasing organization without first obtaining a certificate of authority from the commissioner. Subject to this chapter, such certificate of authority shall be subject to the procedural provisions of chapter 34.05 RCW and sections 120 through 148 of this act as to application, issuance, duration, renewal, refusal, suspension, revocation, or reauthorization.

(b) A group purchasing organization shall be issued a certificate of authority sixty days after submitting an application containing the following:

(i) A copy of the basic organizational document and bylaws of the organization with a list of officers, board of directors, or other governing body;

(ii) A list of the members or specific method of selecting members;

(iii) The identity of all persons or entities, if any, who will receive, hold, or transmit premiums for group health care coverage;

(iv) The method of collecting and setting the level of contributions from members that the group purchasing organization will maintain in order to ensure the timely payment of all premiums for the group health care coverage it purchases; and

(v) Such other information directly related to the provisions of this subsection (4)(b) and clearly necessary to carry out the provisions of this section as the commissioner shall require by rule.

(5)(a) The commissioner may adopt rules implementing this section. The commissioner may require, by rule, notification of changes by the group of information provided in its application. Unless the commissioner disapproves the change within thirty days, the change shall be deemed approved.

(b) The rules shall be maximally flexible and minimally intrusive so as to encourage the formation and functioning of group purchasing organizations and facilitate their complying with this chapter with a minimum of expense and effort.

(6)(a) Nothing authorized by the commissioner may be deemed a violation of chapter 19.86 RCW or Title 48 RCW.

(b) The commissioner, on the advice of the attorney general, may, after a hearing under chapter 34.05 RCW, convened on his or her own initiative or pursuant to public complaint, order a group purchasing organization to reduce its market share in a relevant geographic market if the commissioner finds by clear and convincing evidence that the purchasing power of a group purchasing organization constitutes a violation of RCW 19.86.040. The commissioner shall use the same standards in evaluating group purchasing associations in this regard as independent practice associations under section 304 of this act.

(c) Violations of this chapter that injure insureds or sponsors may be redressed in the same manner as violations of RCW 19.86.020 but do not constitute violations of chapter 19.86 RCW.

(7) Every group purchasing organization shall annually file with the commissioner, within one hundred twenty days of the closing of the calendar year, a statement verified by at least two of the principal officers of the group purchasing organization containing the following:

(a) A financial statement on a form adopted by the commissioner by rule, setting forth information relating to that part of its finances regulated by this section; and

(b) The numbers of persons for whom it jointly purchases health care by zip code.

(8) Failing to comply with a provision of this section is a ground for having a certificate of authority suspended or revoked. The revocation proceedings shall be governed by chapter 34.05 RCW.

(9) The commissioner may order the rehabilitation and liquidation of a group purchasing organization as if it were a domestic insurer under chapter 48.31 RCW, but only for violations of the standards contained in subsection (4)(b)(ii) of this section.

(10)(a) The commissioner may by rule establish an application fee for group purchasing organizations that will offset the reasonable costs of reviewing such applications.

(b) The commissioner may by rule establish an annual registration fee, in addition to the application fee, that will reasonably offset the reasonable costs of regulating such entities.

(c) Such fees shall be reviewable in the superior court of the county in which the group purchasing organization is domiciled for reasonableness, the burden of establishing such reasonableness being on the commissioner.

(d) Failing to pay such fees is a ground for refusing, suspending, or revoking a certificate of authority.

(e) The commissioner may by rule establish rules of competitive conduct that are designed solely to encourage a more competitive health care marketplace. Violations may be pursued by the commissioner through cease and desist orders reviewable under chapter 34.05 RCW. Violations of cease and desist orders that are made final constitute a misdemeanor.

NEW SECTION. **Sec. 304.** COOPERATIVE SELLING OF HEALTH CARE. (1) The legislature finds that the prompt and prolific growth of managed care systems will require that providers be able to put together innovative configurations of service providers. There is now some

uncertainty about how that can be done both under federal and state law. Clarity in the law affecting this important area is required in order to induce providers to form such groups.

(2) Definitions. For purposes of this section, the following words shall have the following meanings:

(a) "Commissioner" means the health care commissioner of the state of Washington.

(b) "Provider" means an institution or program that provides health care services subject to regulation by the state.

(c) "Practitioner" means an individual or group of individuals who provide health care services subject to regulation by the state.

(d) "Members" means practitioners and providers who join together to form an independent practice association to sell health care services.

(e) "Independent practice association" means an association of practitioners or providers who join together to sell jointly their services.

(3) Creation of independent practice associations.

A group of providers may join together for purposes of organizing an independent practice association.

(4)(a) Nothing authorized in this chapter may be deemed a violation of chapter 19.86, 18.100, or 18.130 RCW, however, nothing in this chapter shall be deemed to authorize the corporate practice of professions prohibited by the corporate practice of medicine doctrine.

(b) The commissioner may, after a hearing under chapter 34.05 RCW convened on his or her own initiative or pursuant to public complaint, order an independent practice association to reduce its market share in a relevant geographic market when the commissioner finds by clear and convincing evidence that the purchasing power of a group purchasing organization constitutes a violation of RCW 19.86.040. The commissioner shall use the same standards in evaluating independent practice associations in this regard as group purchasing organizations under section 303 of this act.

(c) Violations of this chapter that injure insureds or sponsors may be redressed in the same manner as violations of RCW 19.86.020 but do not constitute violations of chapter 19.86 RCW.

(d) Every independent practice association shall annually file with the commissioner, within one hundred twenty days of the closing of the calendar year, a statement verified by at least two of the principal

officers of the independent practice association containing the following:

(i) A list of contracts with buyers of health care services that are in effect on that date with an indication of the dollar volume of each contract during the previous year.

(ii) The numbers and specialty descriptions or provider types of members for whom it jointly sells health care by zip code.

(e) The commissioner may by rule establish rules of competitive conduct that are designed solely to encourage a more competitive health care marketplace. Violations may be pursued by the commissioner through cease and desist orders reviewable under chapter 34.05 RCW. Violations of cease and desist orders that are made final shall constitute a misdemeanor.

NEW SECTION. **Sec. 305.** AGGREGATING THE BUYING POWER OF THE STATE OF WASHINGTON. (1) The legislature finds that:

(a) The state may decide it can achieve cost savings and other efficiencies by consolidating its purchasing power for the medical care services it buys under state programs.

(b) The consolidation of this purchasing power may give the state substantial market power in the nonfederal health care marketplace. The legislature recognizes that there are at least two risks to the public associated with that purchasing power:

(i) If the price set is too low, providers will shift their losses to private payers causing private insurance rates to increase beyond that caused by the expenses of their insureds.

(ii) If providers are unable to shift the increases to the private sector, the health care delivery system will shrink, causing access problems and resulting in the disappearance of necessary services in many areas, particularly traditionally underserved areas.

(c) In order to balance the benefits and dangers of the state consolidating its purchasing power, it is necessary to permit the health care providers who deal with the state to negotiate jointly with the state, subject to the substantial safeguards contained in this chapter.

(d) Competition should be displaced to the extent required in this chapter and the process established should be actively supervised by the state as described herein. It seeks to displace the operation of

the federal antitrust laws to this joint negotiation with the state only, to the maximum extent allowable under Parker doctrine.

(2) Definitions. For the purposes of this section, the following words shall have the following meanings:

(a) "Administrator" means the administrator of the health care authority of the state of Washington.

(b) "Attorney general" means the attorney general of the state of Washington.

(c) "Health care provider" means a person or entity providing health care services who is providing health care services, but does not include a provider who bills through another provider or is an employee of another provider.

(d) "Health care service plan" means a nonpublic entity providing health care coverage subject to the jurisdiction of the state of Washington.

(e) "Provider representative" means a person or entity appointed by the governor to represent the provider regarding the terms and conditions under which it will provide health care services to the state of Washington.

(f) "State-arranged health care" means health care arranged or purchased for patients under the auspices of a program funded or administered, in whole or part, by the state of Washington. State-arranged health care does not include state programs in which the health care is provided by state employees or state-owned health care entities.

(3) Consolidation of state purchasing.

(a) If the state of Washington, in any material way, consolidates or takes steps to consolidate its purchasing power for more than one state-arranged health care program, then provider representatives shall be appointed by the governor for each major practitioner or facility category in a manner provided by rule and consistent with subsection (4) of this section.

(b) Six months before the date a contract or program is scheduled to provide state-arranged health care or three months before such program begins the bidding process for a state-arranged health care program, whichever is greater, the administrator shall arrange to have appear, in the Washington state register, a notice whether it intends to consolidate its purchasing power as provided in (a) of this subsection.

(c) A health care provider may seek a declaratory judgment in the superior court of Thurston county that the state has materially consolidated or taken steps to consolidate its purchasing power for more than one program of state-arranged health care. If the court finds that such a consolidation has taken place or that steps have been taken to effect such a consolidation, it may order the administrator to announce such fact in the Washington state register. The notice shall remain in effect until such time as the court, upon petition of the administrator of the health care authority, finds that the consolidation no longer exists. A health care provider may join as a party to an action brought under this subsection.

(4) Providers representatives.

(a) The governor shall designate as provider representatives an entity that is broadly representative of, and therefore agreeable to, the provider group in the state. The governor may appoint more than one provider representative in situations where multiple representation is indicated by the provider group's organization and history. All provider representative appointments may be reviewed in superior court using an arbitrary and capricious standard. Provider representatives may be removed by the governor for neglect of duty or violation of this chapter, but not for the substance of its conduct permitted by subsection (5) of this section.

(b) Provider representatives may establish compensation arrangements with the health care providers they represent that are reasonable.

(c) Provider representatives are not liable to the providers they represent except for intentional misconduct involving a clear breach of their fiduciary duties or fraud proved by clear and convincing evidence.

(5) Negotiation process.

(a) In the event of consolidation of purchasing power by the state, the health care authority administrator shall hold hearings and engage in meaningful negotiations with provider representatives about the terms and conditions of providing state-arranged health care. Nothing in this section may be construed to obligate the administrator to accede to the requests of provider representatives regarding the terms and conditions of providing state-arranged health care. Negotiations are to be conducted by the administrator only for those state-arranged health care programs whose purchasing was consolidated.

(b) Negotiations under this section shall be treated as collective bargaining negotiations for purposes of RCW 42.30.140.

(c) In the event a provider representative, in his or her sole judgment, concludes that the terms and conditions set by the state for obtaining state-arranged health care will result in:

(i) Cost-shifting to private payers to recoup losses caused by the setting of terms and conditions substantially varying from customary rates without offsetting economic advantages; or

(ii) Substantial diminution in the capacity of the health care provider to provide services to public or private patients,

such provider representatives may advise the health care providers it represents to refrain from providing state-arranged health care after the provider representative has filed with the administrator a written report containing its finding along with the written recommendations that it will send to the health care providers it represents.

(d) The administrator may rebut in writing the notice sent to represented health care providers, but the administrator may not vary the terms and conditions that the provider representative based his or her findings on.

(e) If the administrator wishes to change the terms and conditions he or she proposes for state-arranged health care from those the provider representative based its findings on, the administrator shall first engage in the negotiation process described in (a) of this subsection and allow provider representatives to respond to them and issue a new recommendation to the health care providers it represents in the manner provided in (c) of this subsection.

(6) Privileges and immunities.

(a) No making of a recommendation or the content of the recommendation of a provider representative made under subsection (5) of this section may be reviewable in or by a court or other body.

(b) No health care provider may be liable in damages or be subject to other action or penalty for following or not following the recommendation.

(c) Provider representatives may not agree among themselves as to what recommendation to make under subsection (5) of this section to the health care providers they represent. Nothing in this section shall prevent provider representatives from discussing among themselves the terms and conditions of proposals for state-arranged health care.

(d) No inferences of illegality may be drawn from actions or conduct permitted by this chapter.

(e) Nothing in this chapter may be deemed to affect the laws applying to the arranging of health care services with private sector purchasers.

(7) State supervision of process.

(a) The attorney general of the state of Washington may issue cease and desist orders to restrain any otherwise illegal collaborative anticompetitive action or conduct that is not permitted by this chapter. A superior court may review such a cease and desist order de novo under chapter 34.05 RCW upon the petition of a health care provider or provider representative named in the order. The court may award reasonable attorneys' fees to the substantially prevailing party. This remedy is in addition to other remedies available at law.

(b) The attorney general may by rule set the guidelines under which he or she will issue cease and desist orders. The rules are reviewable in a superior court in the state of Washington as if they were rules under chapter 34.05 RCW.

(c) The attorney general shall issue advisory opinions upon the request of provider representatives as to whether proposed actions would be the subject of a cease and desist order or other legal remedy sought by the attorney general. The opinions are reviewable under chapter 34.05 RCW in a superior court in the state of Washington as declaratory rulings.

NEW SECTION. **Sec. 306.** ANTICOMPETITIVE REGULATION OF HEALTH PROFESSIONS. (1) The legislature finds that professionally controlled boards are necessary to bring professional expertise to complex professional regulatory questions. However, the legislature also finds that these boards occasionally yield to the requests of their professional associations and individual practitioners to reach anticompetitive results which increases the costs of health care, frustrate consumer sovereignty, and distort the health care marketplace.

(2) The health care commissioner, with the concurrence of the secretary of health, is allowed to revise, through the rule-making process, a rule, standard, or guideline of a health care profession's regulatory board created under Title 18 RCW, upon making findings after

a public hearing held in accordance with the rule-making provisions of chapter 34.05 RCW:

(a) That the public health and safety justification for a board's rule, standard, or guideline is outweighed by the anticompetitive effects it will have on the health care marketplace;

(b) That the public health and safety justification for a board's rule, standard, or guideline can be substantially achieved in a manner that is less disruptive of a competitive health care marketplace; or

(c) That a board's rule, standard, or guideline is in violation of the legislative intent of the statute upon which it is based and substantially distorts a competitive health care marketplace.

NEW SECTION. **Sec. 307.** INTERSTATE MOBILITY OF HEALTH CARE PRACTITIONERS. The secretary of health shall have exclusive rule-making authority over the ability of practitioners licensed in other jurisdictions to be licensed in the state of Washington. The secretary shall permit to the maximum extent consistent with the public health and safety practitioners with good records from other jurisdictions to become licensed in the state of Washington if they could have met substantially the same entrance standards as practitioners in the state of Washington at the time they completed their professional training.

NEW SECTION. **Sec. 308.** PROFESSIONAL SCOPE OF PRACTICE. (1) The legislature finds that:

(a) The setting of the scopes of practice of health care professions subject to its jurisdiction is time consuming and often beyond its expertise;

(b) Professionally controlled boards have strong incentives to expand the scope of practice of their practitioner beyond what is permitted by statute, and that oversight of that process is virtually nonexistent;

(c) The public health and safety implications as well as the health care cost consequences of practitioner scopes of practice can be serious;

(d) This process could more intelligently and with greater attention to the complex scientific and economic consequence of such decisions be done by an administrative body.

(2) The legislature creates the health care professions practice board to be composed of the following state officials or their departmental designees:

(a) The director of the department of labor and industries;

(b) The secretary of health;

(c) The administrator of the state health care authority;

(d) The vice-president of medical affairs of the University of Washington; and

(e) The secretary of the department of social and health services.

(3) The health care professions practice board shall meet at the call of the chair who shall be appointed from among the members from time to time by the governor.

(4) On its own initiative or upon the petition of an interested party, the health care professions practice board may add to or take away functions of a profession's scope of practice under such terms and conditions as it deems prudent. However, the health care professions practice board may not reduce the scope of practice of any profession beyond what is found in statute as of the effective date of this section.

(5) Decisions of the health care professions practice board may be altered by the legislature by a sixty percent vote of each house and concurrence by the governor.

(6) The health care professions practice board, upon the request of any interested person, may convene an adjudicative hearing under chapter 34.05 RCW to determine whether any decision of any professional regulatory authority under Title 18 RCW regarding the scope of practice of a profession is consistent with any statute or the rules of the health care professions practice board. It may reverse, vacate, revoke, nullify, or modify any such decision. No review by the board shall serve to impose sanctions upon a health care professional unless that review occurs within ninety days of the decision being reviewed.

(7) All rules, standards, guidelines, or judgments of any kind relating to a profession's scope of practice of any health care professional authority under Title 18 RCW, whether adopted before or after the effective date of this section, are subject to the review of the health care professions practice board.

(8) In reaching decisions under this section, the health care professions practice board shall function de novo, that is, it shall give no deference to the decision of the board below, but may give

deference to the judgments of the board below in clinical and scientific areas only.

(9) Judicial review of all decisions of the health care professions practice board shall be in accord with chapter 34.05 RCW.

(10) The members of the health care professions practice board shall serve without pay, but shall be reimbursed for their costs in traveling to meetings in accord with state law.

(11) Funding for the health care professions practice board shall be by appropriation from the health professions account.

NEW SECTION. **Sec. 309.** ENHANCING COMPETITION IN HEALTH CARE FACILITY LICENSURE. The secretary of health is hereby directed to establish, by rule, new categories of health care facilities that contain components of health care facilities subject to regulation by the state of Washington to achieve the following goals:

(1) The start-up costs of health care facilities are reduced in order to encourage new entrants into the marketplace;

(2) That patient movement among different types of facilities are facilitated;

(3) That difference in type or level of severity of care delivered by health care facilities can be blended under one roof with greater regulatory ease; or

(4) That care can be segmented so that unrelated services need not be offered in a single health care facility because of regulatory reasons.

Such rules shall permit maximal flexibility in the provider community in creating new facilities to provide services to the public consistent requirements on clear public health and safety needs.

NEW SECTION. **Sec. 310.** PRACTITIONER SELF-REFERRAL. (1) The legislature finds that health care practitioners subject to the regulation of the state should make referral decisions on the basis of the interests of the patient.

(2) Definitions. For the purposes of this section, the following words shall have the following meanings:

(a) "Practitioner" means a health care practitioner regulated by the state of Washington.

(b) "Facility" means a health care facility regulated by the state of Washington.

(c) "Refer" means a recommendation of any kind to a patient that the patient receive health care or goods of any kind from an identified source other than:

(i) The referring practitioner or a group practice of which the referring practitioner is an employee; or

(ii) A practitioner or group of practitioners over which the referring practitioner has no meaningful supervision.

(3) No practitioner shall refer a patient for care unless any financial interest the practitioner has in the entity to whom the patient is referred is disclosed in writing:

(a) To the patient with the clear advice that the patient may go to the provider of his or her choice;

(b) To the patient's health service plan or other health care payer subject to the jurisdiction of the state upon timely written request of the service plan or payer;

(c) To the health care commissioner pursuant to a rule enacted by the commissioner.

(4) Knowing and willful violation of this section shall be a gross misdemeanor and construed to be unprofessional conduct for purposes of chapter 18.130 RCW.

NEW SECTION. **Sec. 311.** HOSPITALS TO INFORM PRACTITIONERS OF CHARGES. The secretary of health shall adopt rules under chapter 34.05 RCW requiring hospitals to advise their practitioners with admitting privileges of their charges for goods and services at least annually.

NEW SECTION. **Sec. 312.** PROVIDER ELIGIBILITY TO PARTICIPATE IN PLANS. All health care insurance plans, including self-insured plans, subject to the jurisdiction of the state of Washington may establish terms and conditions to be met by providers wishing to enter into an agreement with the insurer to provide services to the plan's enrollees. An insurer may not deny a provider the right to enter into such an agreement if the provider is willing and able to meet the terms and conditions established in that agreement. Plans may terminate providers for substantial cause in accordance with the agreement's terms. Providers terminated for cause under any agreement need not be accepted by a plan into its other or subsequent agreements.

NEW SECTION. **Sec. 313.** REGULATION OF UTILIZATION REVIEW EFFORTS. (1) No company subject to the jurisdiction of the state of Washington may provide utilization review services to any person, insurance or self-insured plan, or other entity without complying with this section. For purposes of this section, utilization review services include, but are not limited to, services whose purpose is to ascertain the necessity or appropriateness of medical or other health care services delivered or proposed to be delivered to patients enrolled in a health care plan for purposes of determining whether payment for such services should be made, providers acted appropriately or cost-effectively, or other similar purpose.

(2) The health care commissioner shall adopt rules ensuring that utilization review services are licensed by the health care commissioner. The health care commissioner by rule shall establish such licensing application process and standards.

(3) The application process may require the applicant to submit information that the health care commissioner reasonably requires in order to determine that the applicant meets licensing standards. The health care commissioner shall approve or disapprove complete applications within ninety days of submission or the application shall be deemed approved. Appeals from disapproval shall be governed by chapter 34.05 RCW. Suspensions or revocations of licensure shall also be governed by chapter 34.05 RCW.

(4) The standards for licensure shall be:

(a) That the health care service plan have appropriately qualified personnel;

(b) Appropriate standards of review that are justified by reliable scientific and medical knowledge;

(c) Safeguards against arbitrary decisions that result in denials of claims or deprivation of benefits promised in the underlying plan documents;

(d) Prompt notification of decisions to the plan, provider, and patient within two days or sooner as appropriate to the care and condition of the patient being reviewed;

(e) Notifications of decisions are to be in writing with explanations of the reasoning and basis for the decision, all such decisions shall be accompanied by a written explanation of the appeal procedure contained in the plan;

(f) That the appeal shall be decided by a physician or other provider licensed to provide the service without supervision who is appropriately certified in the specialty or subspecialty of care involved;

(g) That appeals conducted by the utilization review service shall be decided promptly and reasonably given the type of care being reviewed and the condition of the patient; and

(h) Such other standards that are clearly related to ensuring that accurate and fair decisions are made that are consistent with the underlying plan documents.

(5) The health care commissioner shall by rule levy an application fee and annual administrative assessment to cover the reasonable costs of processing the applications and regulating such services.

(6) The health care commissioner may levy fines against or suspend or revoke the licenses of services violating standards of performance adopted by rule. Such fines and penalties shall be proportional to the harm caused consumers, providers, or plans for whom the services were provided. Such proceedings are to be governed by chapter 34.05 RCW.

(7) The legislature directs the health care commissioner to allow maximum room for innovation in utilization review and to keep the administrative burdens on such services to a minimum. Courts or others reviewing rules adopted or licensing decisions made by the health care commissioner shall ensure that this legislative objective is achieved.

NEW SECTION. **Sec. 314.** LABOR AND INDUSTRIES HEALTH CARE TO BE PROVIDED PURSUANT TO MANAGED CARE. (1) All health care provided pursuant to Title 51 RCW shall be provided under managed care arrangements as defined in section 205 of this act. The director of the department of labor and industries in consultation with the health care commissioner and the secretary of health shall adopt rules to achieve that result before April 1, 1994, to the maximum extent consistent with state law.

(2) By September 30, 1994, the director of the department of labor and industries shall submit a report to both houses of the legislature identifying statutory changes necessary to fully implement the delivery of all care covered by Title 51 RCW through managed care as defined in section 205 of this act.

NEW SECTION. **Sec. 315.** LABOR AND INDUSTRIES DISABILITY RATING. (1) No treating practitioner shall be involved with decisions as to disability rating.

(2) The medical director shall create panels of three physicians in specialties relevant to the injury or condition of covered persons who shall make all decisions regarding disability rating and when to terminate treatment. Such physicians shall serve no more than six in a twelve-month period. Their compensation for this service shall be fixed by the department director by rule.

NEW SECTION. **Sec. 316.** HOSPITAL DISCOUNTS TO BE SUPPORTED BY COST CONSIDERATIONS. (1) The health care commissioner shall issue cease and desist orders against hospitals who enter into contracts with nonfederal payers under which they provide services at below marginal costs. Appeals from such orders shall be governed by the contested hearing provisions of chapter 34.05 RCW.

(2) The health care commissioner may adopt rules enforcing this section, including providing for the reporting of all contracts with such payers signed by hospitals. The health care commissioner may also prohibit service plans regulated by sections 120 through 148 of this act and any other public or private payers subject to the jurisdiction of the state of Washington soliciting hospital rates that do not cover the marginal costs of the services provided.

NEW SECTION. **Sec. 317.** STUDY OF COORDINATION OF BENEFITS ISSUES. The health care commissioner shall study the issue of coordination of benefits as it relates to relieving covered persons of the obligation of copayments and the possible result in unnecessary utilization caused thereby. The health care commissioner may study other aspects of coordination of benefits. The health care commissioner shall report to the governor and both houses of the legislature with recommendations for legislation, if any, by September 1, 1994.

NEW SECTION. **Sec. 318.** (1) The legislature recognizes that a broadly based system of health promotion and disease and injury prevention should be directed at entire populations or communities rather than to a succession of individuals.

(2) The secretary of the department of health shall prepare a recommendation to the legislature that would encourage and fund a

broadly based system of community health protection, community health promotion, and education and communicable disease prevention and control. The secretary shall report to the legislature by December 31, 1993.

PART IV - LIABILITY REFORM

Sec. 401. RCW 7.70.070 and 1975-'76 2nd ex.s. c 56 s 12 are each amended to read as follows:

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

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

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

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

((~~(4)~~)) (d) The amount involved and the results obtained;

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

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

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

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

(2) Subsection (1) of this section does not apply to contingent attorneys' fees calculated under section 402 of this act.

(3) In an action under this chapter, the court shall award reasonable attorneys' fees to a prevailing party after a voluntary or involuntary order of dismissal, order on summary judgment, final judgment after trial, or other final order terminating the action as to the prevailing party. In no event may the award of attorneys' fees to a prevailing party exceed ten thousand dollars. The award of attorneys' fees shall be in addition to any award for the prevailing party's costs. This subsection does not apply to any prevailing party

for whom attorneys' fees are calculated pursuant to section 402 of this act.

NEW SECTION. **Sec. 402.** CONTINGENT ATTORNEY FEES LIMITATIONS. (1) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 403.** NONECONOMIC DAMAGES--JOINT AND SEVERAL LIABILITY--LEGISLATIVE INTENT. 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 chapter for the purpose of reducing costs associated with the civil justice system.

NEW SECTION. **Sec. 404.** JOINT AND SEVERAL LIABILITY RESTRICTIONS. (1) For the purposes of this section, the term "economic damages" means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, 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 injuries, including the claimant or person suffering personal injury, 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 that 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 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 economic damages.

(3) If a defendant is jointly and severally liable under one of the exceptions listed in subsection (2)(a) or (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.

NEW SECTION. **Sec. 405.** CERTIFICATE OF MERIT REQUIRED. (1) The claimant's attorney shall file the certificate specified in subsection (2) of this section within thirty days of filing or service, whichever occurs later, for any action for damages arising out of injuries resulting from health care by a health care provider, as defined in RCW 7.70.020.

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

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

(b) That the attorney has consulted with at least one qualified expert who holds a license, certificate, or registration issued by this state or another state in the same profession as that of the defendant, who practices in the same specialty or subspecialty as the defendant, and whom the attorney reasonably believes is knowledgeable in the relevant issues involved in the particular action;

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

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

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

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

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

(5) Violation of this section shall be grounds for either dismissal of the case or sanctions against the attorney, which may include an order to pay to the defendant or defendants the amount of reasonable expense incurred including a reasonable attorneys' fee, or both, as the court deems appropriate.

NEW SECTION. **Sec. 406.** EXPERT TESTIMONY. In determining whether a proposed expert is qualified to present expert testimony at trial, by deposition, or by affidavit, in a malpractice proceeding against a health care practitioner, the court shall consider the following factors:

(1) If the proposed expert is a physician, whether the proposed expert is board-certified in the medical specialty at issue in the proceeding, or has completed the training required for board certification in the medical specialty at issue in the proceeding;

(2) If the proposed expert is an independent health care practitioner for which specialty certification or its equivalent is available, whether that expert has been certified or its equivalent in the type of practice or procedure at issue in the proceeding, or has completed the training required for such certification or its equivalent;

(3) Whether the proposed expert was engaged in the active practice of his or her discipline at the time the alleged negligence occurred; and

(4) Any other factors deemed necessary or appropriate by the court.

NEW SECTION. **Sec. 407.** MANDATORY MEDIATION. If an action filed under this chapter is not concluded within one year after the action was filed, the court shall order the dispute to be mediated through an informal, nonbinding mediation proceeding, unless the court finds good cause not to order mediation. The parties may select any mutually agreed-upon mediator or mediation organization or, if the parties cannot agree, the court shall appoint a mediator from among a list compiled by the court. The mediation shall continue until the action is resolved or until the mediator makes a finding that mediation will not be successful in resolving the action. Each party shall pay an equal share of the costs of the mediation proceeding. The provisions of RCW 5.60.070, pertaining to the privileged and confidential nature of any communication made or materials submitted as part of the mediation proceeding, apply to all mediation proceedings undertaken pursuant to this section.

PART V - MISCELLANEOUS

NEW SECTION. **Sec. 501.** RECODIFICATION. RCW 70.170.010, 70.170.020, 70.170.030, 70.170.040, 70.170.050, 70.170.100, and 70.170.110 as amended by this act are recodified. These sections and sections 101 through 110, 116, and 119 through 148 of this act shall constitute a new chapter in Title 43 RCW.

NEW SECTION. **Sec. 502.** REPEALERS. The following acts or parts of acts are each repealed:

(1) RCW 19.68.010 and 1973 1st ex.s. c 26 s 1 & 1965 ex.s. c 58 s 1;

(2) RCW 19.68.020 and 1965 ex.s. c 58 s 2 & 1949 c 204 s 2;

(3) RCW 19.68.030 and 1965 ex.s. c 58 s 3;

(4) RCW 19.68.040 and 1949 c 204 s 4;

(5) RCW 48.20.002 and 1987 c 185 s 25 & 1951 c 229 s 1;

(6) RCW 48.20.012 and 1951 c 229 s 2 & 1947 c 79 s .20.02;

(7) RCW 48.20.013 and 1983 1st ex.s. c 32 s 9 & 1967 c 150 s 26;

(8) RCW 48.20.015 and 1975 1st ex.s. c 266 s 9;

(9) RCW 48.20.022 and 1951 c 229 s 3;

(10) RCW 48.20.032 and 1951 c 229 s 4 & 1947 c 79 s .20.03;

(11) RCW 48.20.042 and 1951 c 229 s 5;

(12) RCW 48.20.050 and 1983 1st ex.s. c 32 s 16;

(13) RCW 48.20.052 and 1983 1st ex.s. c 32 s 17, 1975 1st ex.s. c 266 s 12, 1973 1st ex.s. c 152 s 4, 1969 ex.s. c 241 s 12, & 1951 c 229 s 6;

(14) RCW 48.20.062 and 1951 c 229 s 7;

(15) RCW 48.20.072 and 1951 c 229 s 8 & 1947 c 79 s .20.07;

(16) RCW 48.20.082 and 1951 c 229 s 9;

(17) RCW 48.20.092 and 1951 c 229 s 10 & 1947 c 79 s .20.10;

(18) RCW 48.20.102 and 1951 c 229 s 11;

(19) RCW 48.20.112 and 1951 c 229 s 12;

(20) RCW 48.20.122 and 1951 c 229 s 13;

(21) RCW 48.20.132 and 1951 c 229 s 14;

(22) RCW 48.20.142 and 1951 c 229 s 15;

(23) RCW 48.20.152 and 1951 c 229 s 16;

(24) RCW 48.20.162 and 1951 c 229 s 17;

(25) RCW 48.20.172 and 1951 c 229 s 18;

(26) RCW 48.20.192 and 1951 c 229 s 20;

(27) RCW 48.20.202 and 1987 c 185 s 26 & 1951 c 229 s 21;

(28) RCW 48.20.212 and 1987 c 185 s 27 & 1951 c 229 s 22;

(29) RCW 48.20.222 and 1987 c 185 s 28 & 1951 c 229 s 23;
(30) RCW 48.20.232 and 1951 c 229 s 24;
(31) RCW 48.20.242 and 1951 c 229 s 25;
(32) RCW 48.20.252 and 1951 c 229 s 26;
(33) RCW 48.20.262 and 1951 c 229 s 27;
(34) RCW 48.20.272 and 1951 c 229 s 28;
(35) RCW 48.20.282 and 1951 c 229 s 29;
(36) RCW 48.20.292 and 1951 c 229 s 30;
(37) RCW 48.20.302 and 1951 c 229 s 31;
(38) RCW 48.20.312 and 1951 c 229 s 32;
(39) RCW 48.20.322 and 1951 c 229 s 33;
(40) RCW 48.20.340 and 1961 c 194 s 5 & 1947 c 79 s .20.34;
(41) RCW 48.20.350 and 1947 c 79 s .20.35;
(42) RCW 48.20.360 and 1947 c 79 s .20.36;
(43) RCW 48.20.380 and 1947 c 79 s .20.38;
(44) RCW 48.20.390 and 1963 c 87 s 1;
(45) RCW 48.20.393 and 1989 c 338 s 1;
(46) RCW 48.20.395 and 1985 c 54 s 5 & 1983 c 113 s 1;
(47) RCW 48.20.397 and 1985 c 54 s 1;
(48) RCW 48.20.410 and 1965 c 149 s 2;
(49) RCW 48.20.411 and 1973 1st ex.s. c 188 s 3;
(50) RCW 48.20.412 and 1971 ex.s. c 13 s 1;
(51) RCW 48.20.414 and 1971 ex.s. c 197 s 1;
(52) RCW 48.20.416 and 1974 ex.s. c 42 s 1;
(53) RCW 48.20.420 and 1985 c 264 s 10 & 1969 ex.s. c 128 s 3;
(54) RCW 48.20.430 and 1983 1st ex.s. c 32 s 18 & 1974 ex.s. c 139 s 1;
(55) RCW 48.20.450 and 1985 c 264 s 11 & 1975 1st ex.s. c 266 s 16;
(56) RCW 48.20.460 and 1981 c 339 s 19 & 1975 1st ex.s. c 266 s 17;
(57) RCW 48.20.470 and 1985 c 264 s 12 & 1975 1st ex.s. c 266 s 18;
(58) RCW 48.20.480 and 1975 1st ex.s. c 266 s 19;
(59) RCW 48.20.490 and 1980 c 10 s 1;
(60) RCW 48.20.500 and 1986 c 140 s 2;
(61) RCW 48.20.510 and 1987 c 37 s 1;
(62) RCW 48.20.520 and 1988 c 173 s 1;
(63) RCW 48.20.530 and 1991 c 87 s 7;
(64) RCW 48.21.010 and 1992 c 226 s 2, 1949 c 190 s 27, & 1947 c 79 s .21.01;
(65) RCW 48.21.015 and 1992 c 226 s 3;

(66) RCW 48.21.020 and 1947 c 79 s .21.02;
(67) RCW 48.21.030 and 1947 c 79 s .21.03;
(68) RCW 48.21.040 and 1959 c 225 s 7 & 1947 c 79 s .21.04;
(69) RCW 48.21.045 and 1990 c 187 s 2;
(70) RCW 48.21.050 and 1947 c 79 s .21.05;
(71) RCW 48.21.060 and 1947 c 79 s .21.06;
(72) RCW 48.21.070 and 1947 c 79 s .21.07;
(73) RCW 48.21.075 and 1975 1st ex.s. c 117 s 1;
(74) RCW 48.21.080 and 1961 c 194 s 6 & 1947 c 79 s .21.08;
(75) RCW 48.21.090 and 1947 c 79 s .21.09;
(76) RCW 48.21.100 and 1947 c 79 s .21.10;
(77) RCW 48.21.110 and 1955 c 303 s 17 & 1947 c 79 s .21.11;
(78) RCW 48.21.120 and 1947 c 79 s .21.12;
(79) RCW 48.21.130 and 1963 c 87 s 2;
(80) RCW 48.21.140 and 1965 c 149 s 3;
(81) RCW 48.21.141 and 1973 1st ex.s. c 188 s 4;
(82) RCW 48.21.142 and 1971 ex.s. c 13 s 2;
(83) RCW 48.21.144 and 1971 ex.s. c 197 s 2;
(84) RCW 48.21.146 and 1974 ex.s. c 42 s 2;
(85) RCW 48.21.150 and 1977 ex.s. c 80 s 32 & 1969 ex.s. c 128 s 4;
(86) RCW 48.21.155 and 1983 1st ex.s. c 32 s 20 & 1974 ex.s. c 139 s 2;
(87) RCW 48.21.160 and 1987 c 458 s 13 & 1974 ex.s. c 119 s 1;
(88) RCW 48.21.180 and 1990 1st ex.s. c 3 s 7, 1987 c 458 s 14, & 1974 ex.s. c 119 s 3;
(89) RCW 48.21.190 and 1975 1st ex.s. c 266 s 10 & 1974 ex.s. c 119 s 5;
(90) RCW 48.21.195 and 1987 c 458 s 15;
(91) RCW 48.21.197 and 1987 c 458 s 21;
(92) RCW 48.21.200 and 1983 c 202 s 16, 1983 c 106 s 24, & 1975 1st ex.s. c 266 s 20;
(93) RCW 48.21.220 and 1988 c 245 s 31, 1984 c 22 s 1, & 1983 c 249 s 1;
(94) RCW 48.21.225 and 1989 c 338 s 2;
(95) RCW 48.21.230 and 1985 c 54 s 6 & 1983 c 113 s 2;
(96) RCW 48.21.235 and 1985 c 54 s 2;
(97) RCW 48.21.240 and 1987 c 283 s 3, 1986 c 184 s 2, & 1983 c 35 s 1;
(98) RCW 48.21.244 and 1988 c 276 s 6;

(99) RCW 48.21.250 and 1984 c 190 s 2;
(100) RCW 48.21.260 and 1984 c 190 s 3;
(101) RCW 48.21.270 and 1984 c 190 s 4;
(102) RCW 48.21.280 and 1986 c 140 s 3;
(103) RCW 48.21.290 and 1987 c 37 s 2;
(104) RCW 48.21.300 and 1988 c 173 s 2;
(105) RCW 48.21.310 and 1989 c 345 s 2;
(106) RCW 48.21.320 and 1989 c 331 s 2;
(107) RCW 48.21.330 and 1991 c 87 s 8;
(108) RCW 48.41.010 and 1987 c 431 s 1;
(109) RCW 48.41.020 and 1987 c 431 s 2;
(110) RCW 48.41.030 and 1989 c 121 s 1 & 1987 c 431 s 3;
(111) RCW 48.41.040 and 1989 c 121 s 2 & 1987 c 431 s 4;
(112) RCW 48.41.050 and 1987 c 431 s 5;
(113) RCW 48.41.060 and 1989 c 121 s 3 & 1987 c 431 s 6;
(114) RCW 48.41.070 and 1989 c 121 s 4 & 1987 c 431 s 7;
(115) RCW 48.41.080 and 1989 c 121 s 5 & 1987 c 431 s 8;
(116) RCW 48.41.090 and 1989 c 121 s 6 & 1987 c 431 s 9;
(117) RCW 48.41.100 and 1989 c 121 s 7 & 1987 c 431 s 10;
(118) RCW 48.41.110 and 1987 c 431 s 11;
(119) RCW 48.41.120 and 1989 c 121 s 8 & 1987 c 431 s 12;
(120) RCW 48.41.130 and 1987 c 431 s 13;
(121) RCW 48.41.140 and 1987 c 431 s 14;
(122) RCW 48.41.150 and 1989 c 121 s 9 & 1987 c 431 s 15;
(123) RCW 48.41.160 and 1987 c 431 s 16;
(124) RCW 48.41.170 and 1987 c 431 s 17;
(125) RCW 48.41.180 and 1987 c 431 s 18;
(126) RCW 48.41.190 and 1989 c 121 s 10 & 1987 c 431 s 19;
(127) RCW 48.41.200 and 1987 c 431 s 20;
(128) RCW 48.41.210 and 1987 c 431 s 21;
(129) RCW 48.41.900 and 1987 c 431 s 22;
(130) RCW 48.41.910 and 1987 c 431 s 25;
(131) RCW 48.44.010 and 1990 c 120 s 1 & 1986 c 223 s 1;
(132) RCW 48.44.011 and 1983 c 202 s 1 & 1969 c 115 s 7;
(133) RCW 48.44.015 and 1983 c 202 s 2 & 1969 c 115 s 6;
(134) RCW 48.44.020 and 1990 c 120 s 5, 1986 c 223 s 2, 1985 c 283 s 1, 1983 c 286 s 4, 1973 1st ex.s. c 65 s 1, 1969 c 115 s 1, 1961 c 197 s 2, & 1947 c 268 s 2;
(135) RCW 48.44.023 and 1990 c 187 s 3;

(136) RCW 48.44.026 and 1990 c 120 s 6, 1989 c 122 s 1, 1984 c 283 s 1, & 1982 c 168 s 1;

(137) RCW 48.44.030 and 1990 c 120 s 7, 1986 c 223 s 3, 1981 c 339 s 22, 1969 c 115 s 2, 1961 c 197 s 3, & 1947 c 268 s 3;

(138) RCW 48.44.033 and 1990 c 120 s 2;

(139) RCW 48.44.035 and 1990 c 120 s 3;

(140) RCW 48.44.037 and 1990 c 120 s 4;

(141) RCW 48.44.040 and 1947 c 268 s 4;

(142) RCW 48.44.050 and 1947 c 268 s 5;

(143) RCW 48.44.055 and 1990 c 120 s 11;

(144) RCW 48.44.057 and 1990 c 120 s 8;

(145) RCW 48.44.060 and 1947 c 268 s 6;

(146) RCW 48.44.070 and 1990 c 120 s 9, 1965 c 87 s 2, & 1961 c 197 s 4;

(147) RCW 48.44.080 and 1990 c 120 s 10, 1986 c 223 s 4, 1965 c 87 s 3, & 1961 c 197 s 5;

(148) RCW 48.44.090 and 1961 c 197 s 6;

(149) RCW 48.44.095 and 1983 c 202 s 3 & 1969 c 115 s 5;

(150) RCW 48.44.100 and 1961 c 197 s 7;

(151) RCW 48.44.110 and 1961 c 197 s 8;

(152) RCW 48.44.120 and 1961 c 197 s 9;

(153) RCW 48.44.130 and 1961 c 197 s 10;

(154) RCW 48.44.140 and 1961 c 197 s 11;

(155) RCW 48.44.145 and 1986 c 296 s 8, 1983 c 63 s 1, & 1969 c 115 s 12;

(156) RCW 48.44.150 and 1961 c 197 s 12;

(157) RCW 48.44.160 and 1988 c 248 s 19, 1973 1st ex.s. c 65 s 2, 1969 c 115 s 3, & 1961 c 197 s 13;

(158) RCW 48.44.164 and 1969 c 115 s 10;

(159) RCW 48.44.166 and 1983 c 202 s 4 & 1969 c 115 s 11;

(160) RCW 48.44.170 and 1961 c 197 s 14;

(161) RCW 48.44.180 and 1961 c 197 s 15;

(162) RCW 48.44.200 and 1977 ex.s. c 80 s 33 & 1969 ex.s. c 128 s 1;

(163) RCW 48.44.210 and 1977 ex.s. c 80 s 34 & 1969 ex.s. c 128 s 2;

(164) RCW 48.44.212 and 1984 c 4 s 1, 1983 c 202 s 5, & 1974 ex.s. c 139 s 3;

(165) RCW 48.44.220 and 1983 c 154 s 4, 1979 c 127 s 1, & 1969 c 115 s 4;

(166) RCW 48.44.225 and 1983 c 154 s 5;

(167) RCW 48.44.230 and 1983 1st ex.s. c 32 s 11 & 1973 1st ex.s. c 65 s 4;

(168) RCW 48.44.240 and 1990 1st ex.s. c 3 s 12, 1987 c 458 s 16, 1975 1st ex.s. c 266 s 14, & 1974 ex.s. c 119 s 4;

(169) RCW 48.44.245 and 1987 c 458 s 17;

(170) RCW 48.44.250 and 1982 c 149 s 1 & 1975 1st ex.s. c 117 s 3;

(171) RCW 48.44.260 and 1979 c 133 s 3;

(172) RCW 48.44.270 and 1979 c 133 s 4;

(173) RCW 48.44.290 and 1986 c 223 s 6 & 1981 c 175 s 1;

(174) RCW 48.44.299 and 1983 c 154 s 1;

(175) RCW 48.44.300 and 1986 c 223 s 7 & 1983 c 154 s 2;

(176) RCW 48.44.309 and 1983 c 286 s 1;

(177) RCW 48.44.310 and 1986 c 223 s 8 & 1983 c 286 s 2;

(178) RCW 48.44.320 and 1989 1st ex.s. c 9 s 222, 1988 c 245 s 33, 1984 c 22 s 3, & 1983 c 249 s 3;

(179) RCW 48.44.325 and 1989 c 338 s 3;

(180) RCW 48.44.330 and 1985 c 54 s 7 & 1983 c 113 s 3;

(181) RCW 48.44.335 and 1985 c 54 s 3;

(182) RCW 48.44.340 and 1987 c 283 s 4, 1986 c 184 s 3, & 1983 c 35 s 2;

(183) RCW 48.44.344 and 1988 c 276 s 7;

(184) RCW 48.44.350 and 1986 c 223 s 9 & 1983 c 202 s 6;

(185) RCW 48.44.360 and 1984 c 190 s 5;

(186) RCW 48.44.370 and 1984 c 190 s 6;

(187) RCW 48.44.380 and 1984 c 190 s 7;

(188) RCW 48.44.390 and 1986 c 223 s 10;

(189) RCW 48.44.400 and 1986 c 223 s 11;

(190) RCW 48.44.410 and 1986 c 223 s 12;

(191) RCW 48.44.420 and 1986 c 140 s 4;

(192) RCW 48.44.430 and 1987 c 37 s 3;

(193) RCW 48.44.440 and 1988 c 173 s 3;

(194) RCW 48.44.450 and 1989 c 345 s 1;

(195) RCW 48.44.460 and 1989 c 331 s 3;

(196) RCW 48.44.470 and 1991 c 87 s 9;

(197) RCW 48.45.005 and 1990 c 271 s 20;

(198) RCW 48.45.010 and 1990 c 271 s 22;

(199) RCW 48.45.020 and 1990 c 271 s 23;
(200) RCW 48.45.030 and 1990 c 271 s 24;
(201) RCW 48.46.010 and 1975 1st ex.s. c 290 s 2;
(202) RCW 48.46.020 and 1990 c 119 s 1, 1983 c 106 s 1, 1982 c 151 s 1, & 1975 1st ex. c 290 s 3;
(203) RCW 48.46.023 and 1983 c 202 s 8;
(204) RCW 48.46.027 and 1983 c 202 s 9;
(205) RCW 48.46.030 and 1990 c 119 s 2, 1985 c 320 s 1, 1983 c 106 s 2, & 1975 1st ex.s. c 290 s 4;
(206) RCW 48.46.040 and 1990 c 119 s 3, 1989 1st ex.s. c 9 s 223, 1983 c 106 s 3, & 1975 1st ex.s. c 290 s 5;
(207) RCW 48.46.060 and 1989 c 10 s 10;
(208) RCW 48.46.066 and 1990 c 187 s 4;
(209) RCW 48.46.070 and 1985 c 320 s 3, 1983 c 106 s 5, & 1975 1st ex.s. c 290 s 8;
(210) RCW 48.46.080 and 1983 c 202 s 10, 1983 c 106 s 6, & 1975 1st ex.s. c 290 s 9;
(211) RCW 48.46.090 and 1975 1st ex.s. c 290 s 10;
(212) RCW 48.46.100 and 1975 1st ex.s. c 290 s 11;
(213) RCW 48.46.110 and 1983 c 202 s 11 & 1975 1st ex.s. c 290 s 12;
(214) RCW 48.46.120 and 1987 c 83 s 1, 1986 c 296 s 9, 1985 c 7 s 115, 1983 c 63 s 2, & 1975 1st ex.s. c 290 s 13;
(215) RCW 48.46.130 and 1975 1st ex.s. c 290 s 14;
(216) RCW 48.46.135 and 1983 c 202 s 15;
(217) RCW 48.46.140 and 1975 1st ex.s. c 290 s 15;
(218) RCW 48.46.150 and 1975 1st ex.s. c 290 s 16;
(219) RCW 48.46.160 and 1975 1st ex.s. c 290 s 17;
(220) RCW 48.46.170 and 1983 c 106 s 7 & 1975 1st ex.s. c 290 s 18;
(221) RCW 48.46.180 and 1975 1st ex.s. c 290 s 19;
(222) RCW 48.46.200 and 1975 1st ex.s. c 290 s 21;
(223) RCW 48.46.210 and 1975 1st ex.s. c 290 s 22;
(224) RCW 48.46.220 and 1975 1st ex.s. c 290 s 23;
(225) RCW 48.46.225 and 1990 c 119 s 4;
(226) RCW 48.46.235 and 1990 c 119 s 5;
(227) RCW 48.46.240 and 1990 c 119 s 6, 1985 c 320 s 4, & 1982 c 151 s 3;
(228) RCW 48.46.243 and 1990 c 119 s 7;
(229) RCW 48.46.245 and 1990 c 119 s 8;

(230) RCW 48.46.247 and 1990 c 119 s 9;
(231) RCW 48.46.250 and 1984 c 4 s 2 & 1983 c 202 s 12;
(232) RCW 48.46.260 and 1983 c 202 s 13;
(233) RCW 48.46.270 and 1985 c 320 s 5 & 1983 c 202 s 14;
(234) RCW 48.46.275 and 1989 c 338 s 4;
(235) RCW 48.46.280 and 1985 c 54 s 8 & 1983 c 113 s 4;
(236) RCW 48.46.285 and 1985 c 54 s 4;
(237) RCW 48.46.290 and 1987 c 283 s 5, 1986 c 184 s 4, & 1983 c 35 s 3;
(238) RCW 48.46.300 and 1983 c 106 s 8;
(239) RCW 48.46.310 and 1983 c 106 s 9;
(240) RCW 48.46.320 and 1985 c 320 s 6 & 1983 c 106 s 10;
(241) RCW 48.46.340 and 1983 c 106 s 12;
(242) RCW 48.46.350 and 1990 1st ex.s. c 3 s 14, 1987 c 458 s 18, & 1983 c 106 s 13;
(243) RCW 48.46.355 and 1987 c 458 s 19;
(244) RCW 48.46.360 and 1985 c 7 s 116 & 1983 c 106 s 14;
(245) RCW 48.46.370 and 1983 c 106 s 15;
(246) RCW 48.46.375 and 1988 c 276 s 8;
(247) RCW 48.46.380 and 1983 c 106 s 16;
(248) RCW 48.46.390 and 1983 c 106 s 17;
(249) RCW 48.46.400 and 1983 c 106 s 18;
(250) RCW 48.46.410 and 1983 c 106 s 19;
(251) RCW 48.46.420 and 1990 c 119 s 10 & 1983 c 106 s 20;
(252) RCW 48.46.430 and 1983 c 106 s 21;
(253) RCW 48.46.440 and 1984 c 190 s 8;
(254) RCW 48.46.450 and 1984 c 190 s 9;
(255) RCW 48.46.460 and 1984 c 190 s 10;
(256) RCW 48.46.470 and 1985 c 320 s 7;
(257) RCW 48.46.480 and 1985 c 320 s 8;
(258) RCW 48.46.490 and 1986 c 140 s 5;
(259) RCW 48.46.500 and 1987 c 37 s 4;
(260) RCW 48.46.510 and 1988 c 173 s 4;
(261) RCW 48.46.520 and 1989 c 345 s 3;
(262) RCW 48.46.530 and 1989 c 331 s 4;
(263) RCW 48.46.540 and 1991 c 87 s 10;
(264) RCW 48.46.900 and 1975 1st ex.s. c 290 s 24;
(265) RCW 48.46.905 and 1975 1st ex.s. c 290 s 25;
(266) RCW 48.46.910 and 1975 1st ex.s. c 290 s 26;

(267) RCW 48.46.920 and 1975 1st ex.s. c 290 s 27;

(268) RCW 70.38.015 and 1989 1st ex.s. c 9 s 601, 1983 c 235 s 1, 1980 c 139 s 1, & 1979 ex.s. c 161 s 1;

(269) RCW 70.38.025 and 1991 c 158 s 1, 1989 1st ex.s. c 9 s 602, 1988 c 20 s 1, 1983 1st ex.s. c 41 s 43, 1983 c 235 s 2, 1982 c 119 s 1, 1980 c 139 s 2, & 1979 ex.s. c 161 s 2;

(270) RCW 70.38.095 and 1975 ex.s. c 161 s 9;

(271) RCW 70.38.105 and 1992 c 27 s 1, 1991 sp.s. c 8 s 4, 1989 1st ex.s. c 9 s 603, 1984 c 288 s 21, 1983 c 235 s 7, 1982 c 119 s 2, 1980 c 139 s 7, & 1979 ex.s. c 161 s 10;

(272) RCW 70.38.111 and 1992 c 27 s 2, 1991 c 158 s 2, 1989 1st ex.s. c 9 s 604, 1982 c 119 s 3, & 1980 c 139 s 9;

(273) RCW 70.38.115 and 1989 1st ex.s. c 9 s 605, 1989 c 175 s 126, 1984 c 288 s 22, 1983 c 235 s 8, 1980 c 139 s 8, & 1979 ex.s. c 161 s 11;

(274) RCW 70.38.125 and 1989 1st ex.s. c 9 s 606, 1983 c 235 s 9, 1980 c 139 s 10, & 1979 ex.s. c 161 s 12;

(275) RCW 70.38.135 and 1989 1st ex.s. c 9 s 607, 1983 c 235 s 10, & 1979 ex.s. c 161 s 13;

(276) RCW 70.38.155 and 1979 ex.s. c 161 s 15;

(277) RCW 70.38.156 and 1980 c 139 s 11;

(278) RCW 70.38.157 and 1983 c 235 s 11;

(279) RCW 70.38.158 and 1989 1st ex.s. c 9 s 608;

(280) RCW 70.38.220 and 1991 c 271 s 1;

(281) RCW 70.38.905 and 1983 c 235 s 12 & 1979 ex.s. c 161 s 16;

(282) RCW 70.38.910 and 1983 c 235 s 13 & 1979 ex.s. c 161 s 17;

(283) RCW 70.38.911 and 1980 c 139 s 12;

(284) RCW 70.38.914 and 1983 c 235 s 14;

(285) RCW 70.38.915 and 1979 ex.s. c 161 s 19;

(286) RCW 70.38.916 and 1980 c 139 s 14;

(287) RCW 70.38.918 and 1989 1st ex.s. c 9 s 609;

(288) RCW 70.38.919 and 1989 1st ex.s. c 9 s 610;

(289) RCW 70.38.920 and 1979 ex.s. c 161 s 22;

(290) RCW 70.43.010 and 1986 c 205 s 1;

(291) RCW 70.43.020 and 1986 c 205 s 2;

(292) RCW 70.43.030 and 1986 c 205 s 3;

(293) RCW 70.170.060 and 1989 1st ex.s. c 9 s 506;

(294) RCW 70.170.070 and 1989 1st ex.s. c 9 s 507;

(295) RCW 70.170.080 and 1991 sp.s. c 13 s 71 & 1989 1st ex.s. c 9 s 508;

(296) RCW 70.170.090 and 1989 1st ex.s. c 9 s 509;

(297) RCW 18.06.190 and 1991 c 3 s 18 & 1985 c 326 s 519;

(298) RCW 18.22.082 and 1990 c 147 s 10;

(299) RCW 18.25.040 and 1991 c 320 s 8, 1991 c 3 s 39, 1985 c 7 s 15, 1975 1st ex.s. c 30 s 20, 1971 ex.s. c 227 s 6, & 1919 c 5 s 14;

(300) RCW 18.29.045 and 1991 c 3 s 47 & 1989 c 202 s 29;

(301) RCW 18.32.215 and 1989 c 202 s 30;

(302) RCW 18.34.115 and 1991 c 332 s 33;

(303) RCW 18.35.085 and 1991 c 332 s 31;

(304) RCW 18.36A.120 and 1991 c 3 s 97 & 1987 c 447 s 12;

(305) RCW 18.50.065 and 1991 c 332 s 32;

(306) RCW 18.52.130 and 1992 c 53 s 9, 1991 c 3 s 121, 1985 c 7 s 50, 1975 1st ex.s. c 30 s 55, & 1970 ex.s. c 57 s 13;

(307) RCW 18.53.035 and 1991 c 332 s 30;

(308) RCW 18.55.105 and 1991 c 180 s 12;

(309) RCW 18.57.130 and 1991 c 160 s 10, 1991 c 3 s 151, 1985 c 7 s 56, 1979 c 117 s 15, 1975 1st ex.s. c 30 s 59, 1921 c 82 s 1, & 1919 c 4 s 17;

(310) RCW 18.59.070 and 1984 c 9 s 8;

(311) RCW 18.71.090 and 1985 c 322 s 5;

(312) RCW 18.74.060 and 1991 c 3 s 179, 1985 c 7 s 64, 1983 c 116 s 10, 1975 1st ex.s. c 30 s 66, 1961 c 64 s 5, & 1949 c 239 s 6;

(313) RCW 18.78.072 and 1988 c 211 s 3;

(314) RCW 18.83.170 and 1991 c 3 s 202, 1984 c 279 s 92, 1975 1st ex.s. c 30 s 76, 1965 c 70 s 17, & 1955 c 305 s 17;

(315) RCW 18.88.150 and 1989 c 114 s 6, 1988 c 211 s 5, 1973 c 133 s 14, 1961 c 288 s 9, & 1949 c 202 s 15;

(316) RCW 18.108.095 and 1987 c 443 s 12;

(317) RCW 18.138.050 and 1991 c 3 s 282 & 1988 c 277 s 6;

(318) RCW 51.48.280 and 1986 c 200 s 6; and

(319) RCW 74.09.240 and 1979 ex.s. c 152 s 5.

Sec. 503. RCW 43.70.050 and 1989 1st ex.s. c 9 s 107 are each amended to read as follows:

(1) The powers and duties of the department under this section are transferred to and shall be performed by the office of the health care commissioner.

(2) The legislature intends that the department, board, and council promote and assess the quality, cost, and accessibility of health care throughout the state as their roles are specified in ((~~this act~~)) chapter 9, Laws of 1989 1st ex.s., in accordance with the provisions of this chapter. In furtherance of this goal, the ((~~secretary~~)) health care commissioner shall create an ongoing program of data collection, storage, assessability, and review. The legislature does not intend that the department conduct or contract for the conduct of basic research activity. The ((~~secretary~~)) health care commissioner may request appropriations for studies according to this section from the legislature, the federal government, or private sources.

((~~(2)~~)) (3) All state agencies which collect or have access to population-based, health-related data are directed to allow the ((~~secretary~~)) health care commissioner access to such data. This includes, but is not limited to, data on needed health services, facilities, and personnel; future health issues; emerging bioethical issues; health promotion; recommendations from state and national organizations and associations; and programmatic and statutory changes needed to address emerging health needs. Private entities, such as insurance companies, health maintenance organizations, and private purchasers are also encouraged to give the secretary access to such data in their possession. The ((~~secretary's~~)) commissioner's access to and use of all data shall be in accordance with state and federal confidentiality laws and ethical guidelines. Such data in any form where the patient or provider of health care can be identified shall not be disclosed, subject to disclosure according to chapter 42.17 RCW, discoverable or admissible in judicial or administrative proceedings. Such data can be used in proceedings in which the use of the data is clearly relevant and necessary and both the ((~~department~~)) office of the health care commissioner and the patient or provider are parties.

((~~(3)~~)) (4) The ((~~department~~)) office of the health care commissioner shall serve as the clearinghouse for information concerning innovations in the delivery of health care services, the enhancement of competition in the health care marketplace, and federal and state information affecting health care costs.

((~~(4)~~)) (5) The ((~~secretary~~)) health care commissioner shall review any data collected, pursuant to this chapter, to:

(a) Identify high-priority health issues that require study or evaluation. Such issues may include, but are not limited to:

(i) Identification of variations of health practice which indicate a lack of consensus of appropriateness;

(ii) Evaluation of outcomes of health care interventions to assess their benefit to the people of the state;

(iii) Evaluation of specific population groups to identify needed changes in health practices and services;

(iv) Evaluation of the risks and benefits of various incentives aimed at individuals and providers for both preventing illnesses and improving health services;

(v) Identification and evaluation of bioethical issues affecting the people of the state; and

(vi) Other such objectives as may be appropriate;

(b) Further identify a list of high-priority health study issues for consideration by the board or council, within their authority, for inclusion in the state health report required by RCW 43.20.050. The list shall specify the objectives of each study, a study timeline, the specific improvements in the health status of the citizens expected as a result of the study, and the estimated cost of the study; and

(c) Provide background for the state health report required by RCW 43.20.050.

((~~(5)~~)) (6) Any data, research, or findings may also be made available to the general public, including health professions, health associations, the governor, professional boards and regulatory agencies and any person or group who has allowed the secretary access to data.

((~~(6)~~)) (7) The ((~~secretary~~)) health care commissioner may charge a fee to persons requesting copies of any data, research, or findings. The fee shall be no more than necessary to cover the cost to the ((~~department~~)) office of the health care commissioner of providing the copy.

Sec. 504. RCW 43.70.060 and 1989 1st ex.s. c 9 s 108 are each amended to read as follows:

(1) The powers and duties of the department under this section are transferred to and shall be performed by the office of the health care commissioner.

(2) It is the intent of the legislature to promote appropriate use of health care resources to maximize access to adequate health care services. The legislature understands that the rapidly increasing costs of health care are limiting access to care. To promote health

care cost-effectiveness, the ((~~department~~)) office of the health care commissioner shall:

((~~(1)~~)) (a) Implement the certificate of need program;

((~~(2)~~)) (b) Monitor and evaluate health care costs;

((~~(3)~~)) (c) Evaluate health services and the utilization of services for outcome and effectiveness; and

((~~(4)~~)) (d) Recommend strategies to encourage adequate and cost-effective services and discourage ineffective services.

Sec. 505. RCW 43.70.070 and 1989 1st ex.s. c 9 s 109 are each amended to read as follows:

(1) The powers and duties of the department under this section are transferred to and shall be performed by the office of the health care commissioner.

(2) The ((~~department~~)) office of the health care commissioner shall evaluate and analyze readily available data and information to determine the outcome and effectiveness of health services, utilization of services, and payment methods. This section should not be construed as allowing the ((~~department~~)) office of the health care commissioner access to proprietary information.

(1) The ((~~department~~)) office of the health care commissioner shall make its evaluations available to the board and the council for use in preparation of the state health report required by RCW 43.20.050, and to consumers, purchasers, and providers of health care.

(2) The ((~~department~~)) office of the health care commissioner, with advice from the council shall use the information to:

(a) Develop guidelines which may be used by consumers, purchasers, and providers of health care to encourage necessary and cost-effective services; and

(b) Make recommendations to the governor on how state government and private purchasers may be prudent purchasers of cost-effective, adequate health services.

Sec. 506. RCW 18.19.160 and 1991 c 3 s 31 are each amended to read as follows:

((~~(1) Upon receiving a written application, evidence of qualification and the required fee, the department shall issue a certificate for certification without examination to an applicant who is currently credentialed under the laws of another jurisdiction, if~~

~~the requirements of the other jurisdiction are substantially equal to the requirements of this chapter.~~

~~(2)~~)) A person certified under this chapter who is or desires to be temporarily retired from practice in this state shall send written notice to the secretary. Upon receipt of the notice, the person shall be placed upon the nonpracticing list. While on the list, the person is not required to pay the renewal fees and shall not engage in any such practice. In order to resume practice, application for renewal shall be made in the ordinary course with the renewal fee for the current period. Persons in a nonpracticing status for a period exceeding five years shall provide evidence of current knowledge or skill, by examination, as the secretary may require.

Sec. 507. RCW 18.64.080 and 1989 1st ex.s. c 9 ss 403, 420 and 1989 c 352 s 3 are each reenacted and amended to read as follows:

(1) The department may license as a pharmacist any person who has filed an application therefor, subscribed by the person under oath or affirmation, containing such information as the board may by regulation require, and who--

(a) Is at least eighteen years of age;

(b) Has satisfied the board that he or she is of good moral and professional character, that he or she will carry out the duties and responsibilities required of a pharmacist, and that he or she is not unfit or unable to practice pharmacy by reason of the extent or manner of his or her proven use of alcoholic beverages, drugs, or controlled substances, or by reason of a proven physical or mental disability;

(c) Holds a baccalaureate degree in pharmacy or a doctor of pharmacy degree granted by a school or college of pharmacy which is accredited by the board of pharmacy;

(d) Has completed or has otherwise met the internship requirements as set forth in board rules;

(e) Has satisfactorily passed the necessary examinations approved by the board and administered by the department.

(2) The department shall, at least once in every calendar year, offer an examination to all applicants for a pharmacist license who have completed their educational and internship requirements pursuant to rules promulgated by the board. The examination shall be determined by the board. In case of failure at a first examination, the applicant shall have within three years the privilege of a second and third

examination. In case of failure in a third examination, the applicant shall not be eligible for further examination until he or she has satisfactorily completed additional preparation as directed and approved by the board. The applicant must pay the examination fee determined by the secretary for each examination taken. Upon passing the required examinations and complying with all the rules and regulations of the board and the provisions of this chapter, the department shall grant the applicant a license as a pharmacist and issue to him or her a certificate qualifying him or her to enter into the practice of pharmacy.

(3) Any person enrolled as a student of pharmacy in an accredited college may file with the department an application for registration as a pharmacy intern in which application he or she shall be required to furnish such information as the board may, by regulation, prescribe and, simultaneously with the filing of said application, shall pay to the department a fee to be determined by the secretary. All certificates issued to pharmacy interns shall be valid for a period to be determined by the board, but in no instance shall the certificate be valid if the individual is no longer making timely progress toward graduation, provided however, the board may issue an intern certificate to a person to complete an internship to be eligible for initial licensure or for the reinstatement of a previously licensed pharmacist.

(4) To assure adequate practical instruction, pharmacy internship experience as required under this chapter shall be obtained after registration as a pharmacy intern by practice in any licensed pharmacy or other program meeting the requirements promulgated by regulation of the board, and shall include such instruction in the practice of pharmacy as the board by regulation shall prescribe.

(5) ((~~The department may, without examination other than one in the laws relating to the practice of pharmacy, license as a pharmacist any person who, at the time of filing application therefor, is currently licensed as a pharmacist in any other state, territory, or possession of the United States. The person shall produce evidence satisfactory to the department of having had the required secondary and professional education and training and who was licensed as a pharmacist by examination in another state prior to June 13, 1963, shall be required to satisfy only the requirements which existed in this state at the time he or she became licensed in such other state, and that the state in which the person is licensed shall under similar~~

~~conditions grant reciprocal licenses as pharmacist without examination to pharmacists duly licensed by examination in this state. Every application under this subsection shall be accompanied by a fee determined by the department.~~

~~(6)~~)) The department shall provide for, regulate, and require all persons licensed as pharmacists to renew their license periodically, and shall prescribe the form of such license and information required to be submitted by all applicants.

NEW SECTION. **Sec. 508.** CODIFICATION. (1) Sections 201 through 306, 308 through 313, 316, and 317 of this act shall constitute a new chapter in Title 70 RCW.

(2) Sections 314 and 315 of this act are each added to Title 51 RCW.

(3) Sections 402 through 407 of this act are each added to chapter 7.70 RCW.

(4) Section 307 of this act is added to chapter 43.70 RCW.

NEW SECTION. **Sec. 509.** (1) Sections 101 through 111 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect immediately.

(2) Sections 112 through 148 of this act shall take effect September 1, 1993.

(3) Sections 201 through 407 of this act shall take effect January 1, 1994.

NEW SECTION. **Sec. 510.** 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. 511.** CAPTIONS NOT LAW. Captions and part headings as used in this act constitute no part of the law.

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