S-0191.6

SENATE BILL 5165

State of Washington 53rd Legislature 1993 Regular Session

By Senators West and Anderson

Read first time 01/15/93. Referred to Committee on Health & Human Services.

AN ACT Relating to health care; amending RCW 48.14.020, 48.14.022, 48.21.010, 48.21.050, 48.30.300, 48.44.220, 48.46.370, 7.70.070, 7.06.060, 70.170.010, 70.170.020, 70.170.030, 70.170.040, 70.170.050, 70.170.070, 70.170.100, 70.170.110, 43.20.050, 43.70.050, 70.47.010, 70.47.020, 70.47.030, 70.47.060, 70.47.080, 70.47.120, 43.131.355, 43.131.356, 19.68.010, 82.24.020, 82.26.020, and 43.84.092; adding a new section to chapter 43.70 RCW; adding new sections to chapter 7.06 RCW; adding new sections to chapter 70.170 RCW; adding new sections to chapter 74.09 RCW; adding a new section to chapter 18.130 RCW; adding a new section to chapter 48.20 RCW; adding a new section to chapter 48.21 RCW; adding a new section to chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; adding a new section to chapter 48.84 RCW; adding a new section to chapter 41.05 RCW; adding a new section to Title 51 RCW; adding a new section to chapter 70.47 RCW; adding new chapters to Title 48 RCW; adding new chapters to Title 70 RCW; creating new sections; repealing RCW 70.170.080; making appropriations; providing an effective date; and declaring an emergency.

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

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PART I - MANAGED COMPETITION IN THE EMPLOYER AND INDIVIDUAL INSURANCE MARKET

NEW SECTION. **Sec. 101.** LEGISLATIVE INTENT. The legislature finds that there is a lack of affordable health insurance coverage for small businesses and individuals in the state. In 1990, employees of small businesses and their dependents represented over forty percent of the total uninsured in the state. Average spending for health insurance premiums grew at almost fourteen percent per annum during the 1980's and continues to grow. This continued rate of cost increase will make it more difficult for small firms to afford the cost of insurance for their employees. Uninsured individuals have limited or no access to the health care system and many suffer poor health status as a result.

The legislature further finds current insurance rating and other practices make obtaining insurance difficult and expensive for small firms if these businesses have employees with health problems. Small businesses and individuals also lack the purchasing power that larger firms enjoy and often do not have sufficient economic leverage to obtain insurance at reasonable prices. In addition, due to economies of scale, the administrative costs of providing health insurance to small employer groups has been shown to be proportionately higher than for large employer groups. Restructuring the health insurance market will enable individuals and small businesses to better organize as effective purchasers by having more economic leverage through joint purchasing. This will increase their market clout and help these groups obtain affordable health insurance. Providing purchasers and consumers with information about the cost and quality of health care services will enable them to become more prudent purchasers.

The legislature declares that restructuring the small group insurance market, introducing effective price competition, creating proper incentives for fair insurance practices, and pooling small businesses and individuals through cooperative purchasing arrangements are effective means for making health insurance more available and affordable for small businesses and individuals.

NEW SECTION. **Sec. 102.** DEFINITIONS. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries, or other individual acceptable to the commissioner, that a partnership is in compliance with the provisions of this chapter, based upon that examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the partnership in establishing premium rates for applicable health benefit plans.

(2) "Carrier" means an entity that provides health insurance benefit plans in Washington state as an insurance company, health services contractor, or health maintenance organization and is regulated by the state of Washington under chapter 48.20, 48.21, 48.44, or 48.46 RCW.

(3) "Commissioner" means the insurance commissioner as defined in RCW 48.02.010.

(4) "Cooperative region" or "region" means one of the health insurance purchasing cooperative regions established under this chapter.

(5) "Dependent" means the enrollee’s lawful spouse; unmarried natural child, adopted child or child legally placed for adoption, or stepchild under the age of eighteen; legally designated minor ward; unmarried child who is a full-time student under the age of twenty-three years who is financially dependent upon an enrollee; or unmarried child of any age who is medically certified as disabled and claimed as an exemption on the federal income tax form of the eligible individual who is an employee.

(6) "Eligible individual" means (a) an individual person who resides in a cooperative region, or (b) an active employee, proprietor, partner, or corporate officer of the employer who resides in a cooperative region, is paid on a regular, periodic basis through the employer’s payroll system, regularly works on a full-time basis and has a normal work week of twenty or more hours, and is expected to continue in this employment capacity.

(7) "Enrollee" means an eligible individual who receives the uniform health benefit from an integrated health care partnership.

(8) "Employer" or "business" means a person, firm, corporation, or partnership as defined under Title 25 RCW, that was actively engaged in

business, on at least fifty percent of its working days during the preceding calendar quarter.

(9) "Established geographic service area" means a geographical area as approved by the commissioner within which the carrier is authorized to provide coverage.

(10) "Financially impaired" means a partnership that, after the effective date of this section, is not insolvent but is:

(a) Deemed by the commissioner to be potentially unable to fulfill its contractual obligations; or

(b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(11) "Health benefit plan" means a hospital or medical policy or certificate, health care service contract, health maintenance organization subscriber contract, or plan provided by another benefit arrangement subject to this chapter. The term does not include accident only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

(12) "Health insurance purchasing cooperative" or "cooperative" means a Washington-based nonprofit entity that serves as a purchasing agent for employers and individuals and offers to employers and individuals uniform benefit plans.

(13) "Integrated health care partnership" or "partnership" means a carrier and health care providers that deliver as part of a managed care system the full array of health services in the uniform health benefit plan to enrollees on a prepaid capitated basis, compete on price, services, and quality to provide the uniform benefit plan through one or more cooperatives, and meet other requirements established under this chapter.

(14) "Preexisting condition" means a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment immediately preceding the effective date of enrollment or a condition for which medical advice, diagnosis, care, or treatment was recommended or received immediately preceding the effective date of enrollment.

(15) "Premium" means all moneys paid by an employer and enrollees to a cooperative as a condition for receiving the uniform benefit plan from a partnership providing coverage through the cooperative. The

premium may include other fees charged by the cooperative to administer the uniform health benefit plan.

(16) "Purchaser" means a business or individual who purchases the uniform benefit plan through a cooperative.

(17) "Qualifying previous coverage" and "qualifying existing coverage" means benefits or coverage provided by medicare, medicaid, the state's basic health plan, or by a carrier or self-insurer that provides benefits similar to or exceeding benefits provided under a uniform health benefit plan provided that such coverage has been in effect for the individual in question for a period of at least six months.

(18) "Regional cooperative coordinating council" or "council" means the regional cooperative coordinating councils as established under this chapter.

(19) "Small employer" means a person, firm, corporation, partnership, or association actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than one hundred eligible individuals who are employees, the majority of whom were employed within Washington state.

(20) "Uniform benefit plan" or "uniform benefit" means the minimum health insurance coverage defined by a council that may be obtained through the cooperatives.

NEW SECTION. **Sec. 103.** APPLICABILITY AND SCOPE. (1) This chapter shall apply to all cooperatives and partnerships that provide a uniform health benefit plan to employees and individuals in Washington state.

(2) Unless otherwise provided for in this chapter, all carriers regulated in the state of Washington under chapter 48.20, 48.21, 48.44, or 48.46 RCW that provide health benefit plans to small employers or individuals in the state must operate as partnerships and offer the uniform benefit plans in accordance with the provisions of this chapter.

(3) After July 1, 1995, the council may require carriers to offer uniform benefit plans under this chapter to any employer regardless of the employer's number of employees.

(4) Nothing in this chapter shall prevent a carrier from offering, or an individual or employer from obtaining, health benefit plans that are not offered through a cooperative.

(5) Nothing in this chapter shall prevent a carrier from offering, or an individual or employer from obtaining, supplemental benefit plans that include services not covered in the uniform benefit plan.

NEW SECTION. **Sec. 104.** HEALTH INSURANCE PURCHASING COOPERATIVE REGIONS. There are created in the state of Washington two health insurance purchasing cooperative regions. The eastern Washington health insurance purchasing cooperative region covers all areas east of the crest of the Cascade mountain range. The western Washington health insurance purchasing cooperative region covers all areas west of the crest of the Cascade mountain range.

NEW SECTION. **Sec. 105.** STATE-WIDE HEALTH CARE OPERATING STANDARDS--INSURANCE COMMISSIONER'S DUTIES. (1) The commissioner is responsible for establishing operating standards for the purchasers, cooperatives, and partnerships who purchase, offer, or provide the uniform benefit plan. The standards shall have the goal of assuring that effective and cost-efficient competition occurs between cooperatives and between partnerships to enable purchasers to obtain the uniform benefit plan based on the best price, service, value, quality, and highest rate of consumer satisfaction.

(2) The commissioner, in consultation with representatives of groups who will obtain, offer, or receive services from the uniform benefit plan, shall develop uniform operating standards concerning the following:

(a) Portability of uniform benefit coverage across the cooperative regions;

(b) Content and form of the cooperative operating plans;

(c) Rules for participation by employers, employees, individuals, and dependents in a uniform benefit plan;

(d) Enrollee point of service cost-sharing;

(e) Restricting balance billing by partnerships for uniform benefit services;

(f) Rules allowing a partnership to offer the uniform benefit plan through a cooperative in an area served by the partnership if the partnership meets the requirements of this chapter;

(g) Rules concerning age, sex, and geographic adjustments to premiums for the uniform benefit plans that the councils may authorize be paid by cooperatives to partnerships;

(h) Rules for distributing seed grant funding made available for the purpose of establishing cooperatives authorized by this chapter.

NEW SECTION. **Sec. 106.** REGIONAL COOPERATIVE COORDINATING COUNCIL--INITIAL FORMATION--AUTHORITY. (1) After the state-wide cooperative operating standards have been developed by the commissioner and made public, any Washington-based nonprofit entity or entities may seek to organize a health insurance purchasing cooperative in one or both of the cooperative regions of the state. The nonprofit entities shall have governing boards representing individuals and groups who will purchase and receive health care services through the cooperative. The nonprofit entity or entities shall submit evidence to the commissioner's satisfaction that it has the potential administrative capability and integrated health care partnership network to provide at least two uniform benefit plans and serve at least seventy-five thousand enrollees within the cooperative region it seeks to participate. If at least two nonprofit entities have demonstrated a potential capability to serve as a cooperative, the commissioner shall authorize them to organize a regional cooperative coordinating council. The council shall meet within sixty days of the authorization to commence its duties under this chapter.

(2) Notwithstanding the authority granted to nonprofit entities in subsection (1) of this section to form a regional cooperative coordinating council, a subsequent grant of authority for a nonprofit entity to offer the uniform benefit plan as a cooperative requires that the entity meet the provisions of this chapter.

NEW SECTION. **Sec. 107.** REGIONAL COOPERATIVE COORDINATING COUNCILS. Annually, after the initial formation of the council under section 106 of this act, the cooperatives in the region shall appoint a new council membership. The membership of the council shall be composed of one representative from each of the health insurance purchasing cooperatives. The representative shall be designated by the cooperative. The council's duties shall include:

(1) Developing and periodically revising a uniform health benefit plan to be offered by partnerships through cooperatives in the cooperative region. It shall include basic health care services, including physician services, inpatient and outpatient hospital services, pharmaceuticals, and other services that may be necessary for

basic health care that enrollees shall be entitled to receive in return for premium payments. Uniform health benefit services shall emphasize proven preventive and primary health care and shall include all services necessary for prenatal, postnatal, and well-child care;

(2) Establishing protocols, based on operating standards established by the commissioner, for assuring portability of benefits between the cooperative regions;

(3) Developing, in consultation with the council under chapter 70.170 RCW a uniform outcome-based accountability and reporting system to allow employers and enrollees to compare the quality and value of health care delivered by the partnerships;

(4) Developing rules permitting employers and individuals to select among any of the cooperatives in the cooperative region;

(5) Developing a schedule of adjustments that may be made in premium rates paid by cooperatives to partnerships for sex, age, and geographic factors of the enrollee population;

(6) Assessing the need and, if deemed necessary, implement methods to assure fair distribution of high medical risk enrollees among cooperatives and partnerships in the region or fair financial compensation for partnerships and cooperatives that have a disproportionate high number of high medical risk enrollees. These methods may include, but are not limited to, the purchase of reinsurance or the actuarial adjustment of premiums paid to reflect differences in the medical risk of enrollees;

(7) Developing, if deemed appropriated, and no earlier than July 1, 1995, rules for allowing employers with more than one hundred employees to obtain uniform benefit plans from cooperatives under provisions established in this chapter. The rules shall assure the orderly inclusion of such employers into the cooperatives;

(8) Distributing grant seed funding made available for establishing cooperatives in accordance with rules developed by the commissioner.

NEW SECTION. **Sec. 108.** COOPERATIVE OPERATING PLANS. As a requirement for operating as a health care purchasing cooperative, a cooperative operating plan must be filed by each cooperative with the commissioner, and annually updated, by the dates and in the manner prescribed by the commissioner. The commissioner shall review the cooperative operating plans within sixty days of receipt for compliance

with the provisions of this chapter. The operating plans shall include:

(1) The integrated health care partnership bids obtained from integrated health care partnerships seeking to provide the uniform benefit plan through the cooperative;

(2) Sample contract agreements that the cooperative will make with the integrated health care partnerships;

(3) Copies of the enrollee handbook, which shall compare the uniform benefit plans available through the cooperative in a uniform and easy to understand manner to permit enrollees to make meaningful comparisons of the plan options and their costs;

(4) An administrative plan documenting how the cooperative will serve as a purchasing agent of the uniform benefit for at least seventy-five thousand eligible enrollees in the region. It shall provide evidence that demonstrates the ability to:

(a) Contract with employer groups and individuals to provide health benefit plans; and

(b) Contract with multiple partnerships to provide benefits to multiple employer groups and individuals;

(5) The premium schedule showing the premium each of the integrated health care partnerships will charge to provide the uniform benefit to enrollees;

(6) The cooperative administrative fee to be collected from enrollees;

(7) Procedures and policies to be followed to assure:

(a) Uniform benefit plans will be made widely available within the region;

(b) Uniform benefit plans will be made available by partnerships to eligible individuals in the partnerships' established geographic service areas;

(c) The cooperative will pursue activities to assure optimal price competition for the uniform benefit plans within the region;

(d) The cooperative and its participating partnerships will not engage in practices that will result in intentional avoidance of enrollees based on high medical risk;

(e) Effective enrollee grievance procedures are in place; and

(f) Partnerships that will be contracted with meet the requirements established in this chapter;

(8) Proposed contracts to be made with employers who voluntarily seek health benefits through the cooperative that require the employer to:

(a) Prohibit employers from enrolling only those employees and dependents with a health condition or a poor health status;

(b) Offer each employee all the uniform benefit plans available to the employer through the cooperative;

(c) Enroll at least ninety percent of the employer's employees except those who have coverage through a spouse or dependent;

(d) Participate in an annual open enrollment for all employees at a time designated by the council to permit employee selection among the available uniform health benefit plans;

(e) Pay on behalf of each eligible employee between fifty and ninety percent of the lowest priced premium among the uniform benefit plans available and make appropriate deductions from employee wages for excess premium amounts for enrollees who select more expensive uniform benefit plans;

(f) Pay on behalf of each eligible employee's covered dependents between fifty and ninety percent of the lowest priced premium among the uniform benefit plans available and make appropriate deductions from employee wages for excess premium amounts for enrollees who select more expensive uniform benefit plans;

(g) Obtain uniform benefit plans exclusively through one cooperative for the period between open enrollments;

(h) Follow employee cost-sharing rules developed by the commissioner;

(i) Maintain continuous enrollment in a uniform benefit plan and not drop coverage because an employee or employees no longer have health conditions requiring health services that would be reimbursed through a uniform benefit plan; and

(j) Make timely notification to the cooperative of changes in enrollment and be responsible for payment of benefits to employees caused by unreasonable employer delays in notification;

(9) Proposed contracts with individuals who voluntarily elect to purchase the uniform benefit plan through the cooperative that:

(a) Follow participation rules established by the commissioner;

(b) Require the individual to maintain continuous enrollment in a uniform benefit plan and not drop coverage because the individual no

longer has health conditions requiring health services that would be reimbursed through a uniform benefit plan; and

(c) Require the cooperative to conduct an annual open enrollment for individual enrollees at a time designated by the council to permit selection among the available uniform health benefit plans;

(10) Affirmation that the cooperative does not have a financial or managerial interest in the partnerships from which the cooperative has accepted bids.

NEW SECTION. **Sec. 109.** INTEGRATED HEALTH CARE PARTNERSHIPS--CARRIERS REQUIRED TO SECURE. (1) All carriers regulated by the state under chapter 48.20, 48.44, 48.21, or 48.46 RCW, and offering health benefit plans to individuals and small employers shall also offer uniform benefit plan coverage to employers and individuals as partnerships, except under the following conditions:

(a) Coverage is not required to be provided to a geographic area of the state other than the carrier's established geographic service area;

(b) Coverage is not required to be offered to eligible individuals in the carrier's established geographic service area when the carrier demonstrates to the satisfaction of the commissioner that it will not have the capacity within that area in its network of providers to deliver service adequately to the members of such groups because of the carrier's obligations to existing group contract holders and enrollees; or

(c) Coverage is not required to be offered to eligible individuals if the commissioner finds that the acceptance of an application or applications would place the carrier in a financially impaired condition, provided that the carrier may not offer a health benefit plan to additional employer groups or individuals except as approved by the commissioner.

(2) A partnership shall offer a uniform health benefit plan through a cooperative under the conditions set forth in this chapter to any eligible individual that applies for such a plan, makes the required premium payments, and satisfies the other requirements of participation established under this chapter.

NEW SECTION. **Sec. 110.** GENERAL PARTNERSHIP REQUIREMENTS--INSURANCE REFORM--BIDS. All partnerships shall comply with the provisions in this section when offering the uniform benefit plan. An

integrated health partnership offering the uniform benefit plan shall annually submit a bid to an eligible cooperative at a time to be determined by the council and in a form to be determined by the commissioner. The bid shall document the following:

(1) The partnership is a regulated carrier in the state of Washington under chapter 48.20, 48.21, 48.44, or 48.46 RCW.

(2) The partnership shall meet operating standards and other requirements established under this chapter and comply with requirements established for carriers under this chapter as well as any applicable requirements established under chapter 48.20, 48.21, 48.44, or 48.46 RCW that do not conflict with the provisions of this chapter.

(3) The partnership shall offer the full array of services in the uniform health benefit plan to all eligible individuals and dependents in the partnership's geographic service area.

(4) The partnership shall include a list of health care providers that will provide the uniform benefit plan and shall inform the cooperative of changes in providers in a timely manner.

(5) The partnership shall not deny, exclude, or limit benefits for a covered individual for expenses incurred more than six months following the effective date of the eligible individual's coverage due to a preexisting condition. In addition, a partnership shall waive the preexisting condition exclusion if the eligible individual was covered by qualifying previous coverage, provided that the qualifying previous coverage did not terminate more than sixty days prior to the effective date of the new coverage.

(6) The partnership shall not modify, decrease, exclude, or restrict benefits through riders, conditions, restrictions, endorsements, or otherwise, on the basis of sex, age, or health status or health condition of the eligible individual.

(7) The partnership shall not modify, decrease, or restrict coverage through riders, conditions, restrictions, endorsements, or otherwise, on the basis of category of business trade, employment skill, or vocation or profession of the eligible individual.

(8) The partnership will assume the financial risk of providing the uniform health benefit to all enrolled individuals subject to any risk-sharing arrangements that may be authorized under this chapter.

(9) The partnership shall determine annual premium rates based on the experience of the regional cooperative pool as a community.

(10) The partnership shall not deny coverage to an enrollee during the contract enrollment period provided that premium payments are made and other conditions of participation are met in accordance with this chapter.

(11) The partnership shall provide health care services using cost-effective managed health care delivery systems.

(12) The partnership shall participate in an open enrollment period each year at a time established by the council.

(13) The partnership shall establish and maintain effective quality assurance processes complying with standards developed by the quality center established under section 601 of this act.

(14) The partnership shall comply with uniform claims processing requirements required in sections 1001 through 1011 of this act.

(15) The partnership shall offer financial and other incentives to encourage providers to offer high quality, cost-effective health care services.

(16) The partnership shall participate in a council-adopted uniform outcome-based accountability and reporting system to allow employers and individuals to compare the price and best value of the integrated health care partnerships.

(17) The partnership shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(18) The partnership shall include an actuarial certification indicating that the partnership is in compliance with this chapter and that the rating methods of the partnership are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the commissioner. A copy of the certification shall be retained by the partnership at its principal place of business.

NEW SECTION. **Sec. 111.** WAIVER OF STATE LAWS REQUIRING MANDATED HEALTH BENEFITS. Nothing in this chapter shall be construed to require a uniform health benefit plan established by a council to satisfy the applicable requirements of:

(1) RCW 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, and 48.20.520.

(2) RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 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, 48.21.300, 48.21.310, or 48.21.320;

(3) RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460;

(4) RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530.

NEW SECTION. **Sec. 112.** CODIFICATION DIRECTIONS. Sections 101 through 111 of this act shall constitute a new chapter in Title 48 RCW.

Sec. 113. RCW 48.14.020 and 1986 c 296 s 1 are each amended to read as follows:

(1) Subject to other provisions of this chapter, each health care service contractor under chapter 48.44 RCW and health maintenance organization under chapter 48.46 RCW and authorized insurer, except title insurers, shall on or before the first day of March of each year pay to the state treasurer through the commissioner's office a tax on premiums. Except as provided in subsection (2) of this section, such tax shall be in the amount of two percent of all premiums, excluding amounts returned to or the amount of reductions in premiums allowed to holders of industrial life policies for payment of premiums directly to an office of the insurer, collected or received by the insurer during the preceding calendar year other than ocean marine and foreign trade insurances, after deducting premiums paid to policyholders as returned premiums, upon risks or property resident, situated, or to be performed in this state. For the purposes of this section the consideration received by an insurer for the granting of an annuity shall not be deemed to be a premium.

(2) In the case of insurers which require the payment by their policyholders at the inception of their policies of the entire premium thereon in the form of premiums or premium deposits which are the same in amount, based on the character of the risks, regardless of the length of term for which such policies are written, such tax shall be

in the amount of two percent of the gross amount of such premiums and premium deposits upon policies on risks resident, located, or to be performed in this state, in force as of the thirty-first day of December next preceding, less the unused or unabsorbed portion of such premiums and premium deposits computed at the average rate thereof actually paid or credited to policyholders or applied in part payment of any renewal premiums or premium deposits on one-year policies expiring during such year.

(3) Each authorized insurer shall with respect to all ocean marine and foreign trade insurance contracts written within this state during the preceding calendar year, on or before the first day of March of each year pay to the state treasurer through the commissioner's office a tax of ninety-five one-hundredths of one percent on its gross underwriting profit. Such gross underwriting profit shall be ascertained by deducting from the net premiums (i.e., gross premiums less all return premiums and premiums for reinsurance) on such ocean marine and foreign trade insurance contracts the net losses paid (i.e., gross losses paid less salvage and recoveries on reinsurance ceded) during such calendar year under such contracts. In the case of insurers issuing participating contracts, such gross underwriting profit shall not include, for computation of the tax prescribed by this subsection, the amounts refunded, or paid as participation dividends, by such insurers to the holders of such contracts.

(4) The state does hereby preempt the field of imposing excise or privilege taxes upon insurers or their agents, other than title insurers, and no county, city, town or other municipal subdivision shall have the right to impose any such taxes upon such insurers or their agents.

(5) If an authorized insurer collects or receives any such premiums on account of policies in force in this state which were originally issued by another insurer and which other insurer is not authorized to transact insurance in this state on its own account, such collecting insurer shall be liable for and shall pay the tax on such premiums.

Sec. 114. RCW 48.14.022 and 1987 c 431 s 23 are each amended to read as follows:

(1) The taxes imposed in RCW 48.14.020 do not apply to premiums collected or received for policies of insurance issued under RCW 48.41.010 through 48.41.210.

(2) In computing tax due under RCW 48.14.020, there may be deducted from taxable premiums the amount of any assessment against the taxpayer under RCW 48.41.010 through 48.41.210. Any portion of the deduction allowed in this section which cannot be deducted in a tax year without reducing taxable premiums below zero may be carried forward and deducted in successive years until the deduction is exhausted.

(3) The taxes imposed in RCW 48.14.020 do not apply to premiums collected or received for the uniform benefit plans issued under chapter 48.-- RCW (sections 101 through 111 of this act) or for premiums collected or received for health benefit plans from employers with one hundred or more employees unless carriers are required to provide uniform benefit plans to such employers under section 103(3) of this act.

Sec. 115. RCW 48.21.010 and 1992 c 226 s 2 are each amended to read as follows:

Group disability insurance is that form of disability insurance, including stop loss insurance as defined in RCW 48.11.030, provided by a master policy issued to an employer, to a trustee appointed by an employer or employers, or to an association of employers formed for purposes other than obtaining such insurance, except as authorized in chapter 48.-- RCW (sections 101 through 111 of this act), covering, with or without their dependents, the employees, or specified categories of the employees, of such employers or their subsidiaries or affiliates, or issued to a labor union, or to an association of employees formed for purposes other than obtaining such insurance, covering, with or without their dependents, the members, or specified categories of the members, of the labor union or association, or issued pursuant to RCW 48.21.030. Group disability insurance shall also include such other groups as qualify for group life insurance under the provisions of this code.

Sec. 116. RCW 48.21.050 and 1947 c 79 s .21.05 are each amended to read as follows:

Except as provided for in chapter 48.-- RCW (sections 101 through 111 of this act) and chapter 48.-- RCW (sections 201 through 204 of this act), every policy of group or blanket disability insurance shall contain in substance the provisions as set forth in RCW 48.21.060 to 48.21.090, inclusive, or provisions which in the opinion of the

commissioner are more favorable to the individuals insured, or at least as favorable to such individuals and more favorable to the policyholder. No such policy of group or blanket disability insurance shall contain any provision relative to notice or proof of loss, or to the time for paying benefits, or to the time within which suit may be brought upon the policy, which in the opinion of the commissioner is less favorable to the individuals insured than would be permitted by the standard provisions required for individual disability insurance policies.

Sec. 117. RCW 48.30.300 and 1975-'76 2nd ex.s. c 119 s 7 are each amended to read as follows:

No person or entity engaged in the business of insurance in this state shall refuse to issue any contract of insurance or cancel or decline to renew such contract because of the sex or marital status, or the presence of any sensory, mental, or physical handicap of the insured or prospective insured. The amount of benefits payable, or any term, rate, condition, or type of coverage shall not be restricted, modified, excluded, increased or reduced on the basis of the sex or marital status, or be restricted, modified, excluded or reduced on the basis of the presence of any sensory, mental, or physical handicap of the insured or prospective insured. Except as provided for in chapter 48.-- RCW (sections 101 through 111 of this act) and chapter 48.-- RCW (sections 201 through 204 of this act), these provisions shall not prohibit fair discrimination on the basis of sex, or marital status, or the presence of any sensory, mental, or physical handicap when bona fide statistical differences in risk or exposure have been substantiated.

Sec. 118. RCW 48.44.220 and 1983 c 154 s 4 are each amended to read as follows:

No health care service contractor shall deny coverage to any person solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap. Except as provided for in chapter 48.-- RCW (sections 101 through 111 of this act) and chapter 48.-- RCW (sections 201 through 204 of this act), nothing in this section shall be construed as limiting a health care service contractor's authority to deny or otherwise limit coverage to a person when the person because of a medical condition does not meet the

essential eligibility requirements established by the health care service contractor for purposes of determining coverage for any person.

No health care service contractor shall refuse to provide reimbursement or indemnity to any person for covered health care services for reasons that the health care services were provided by a holder of a license under chapter 18.22 RCW.

Sec. 119. RCW 48.46.370 and 1983 c 106 s 15 are each amended to read as follows:

No health maintenance organization may deny coverage to a person solely on account of the presence of any sensory, mental, or physical handicap. Except as provided for in chapter 48.-- RCW (sections 101 through 111 of this act) and chapter 48.-- RCW (sections 201 through 204 of this act), nothing in this section may be construed as limiting a health maintenance organization's authority to deny or otherwise limit coverage to a person when the person because of a medical condition does not meet the essential eligibility requirements established by the health maintenance organization for purposes of determining coverage for any person.

PART II - SMALL BUSINESS AND INDIVIDUAL HEALTH CARE INSURANCE REFORM

NEW SECTION. **Sec. 201.** SHORT TITLE. This chapter shall be known and cited as the small employer and individual health coverage act.

NEW SECTION. **Sec. 202.** DEFINITIONS. As used in this chapter:

(1) "Carrier" means an entity that provides a health insurance benefit plan to small employers and individuals in Washington state as an insurance company, health services contractor, or health maintenance organization and that is regulated by the state of Washington under chapter 48.20, 48.21, 48.44, or 48.46 RCW.

(2) "Enrollee" means an eligible individual who receives a health benefit plan from a carrier.

(3) "Eligible individual" means (a) an individual person not associated with an employer, or (b) an active employee, proprietor, partner, or corporate officer of a small employer group who is paid on a regular, periodic basis through the group's payroll system, regularly works on a full-time basis and has a normal work week of twenty or more hours, and is expected to continue in this employment capacity.

(4) "Health benefit plan" means a hospital or medical policy or certificate, health care service contract, health maintenance organization subscriber contract, or plan provided by another benefit arrangement subject to this chapter. The term does not include accident only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

(5) "Preexisting condition" means a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment immediately preceding the effective date of coverage or a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage or a pregnancy existing on the effective date of coverage.

(6) "Rating period" means the twelve-month period for which premium rates established by a carrier are presumed to be in effect.

(7) "Small employer" means a person, firm, corporation, partnership, or association actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than one hundred employees, the majority of whom were employed within Washington state.

NEW SECTION. **Sec. 203.** SCOPE AND APPLICABILITY. Except for health benefit plans offered under chapter 48.-- RCW (sections 101 through 111 of this act), the provisions of this chapter shall apply to all health insurance benefits offered to individuals and small businesses in Washington state by state regulated insurance companies under chapter 48.20 or 48.21 RCW, health services contractors under chapter 48.44 RCW, or health maintenance organizations under chapter 48.46 RCW.

NEW SECTION. **Sec. 204.** GENERAL REQUIRED PRACTICES BY CARRIERS IN THE SMALL EMPLOYER AND INDIVIDUAL HEALTH BENEFITS PLAN MARKET. Carriers subject to the provisions of this chapter:

(1) Shall not deny, exclude, or limit benefits for a covered individual for losses incurred following the effective date of the eligible individual's coverage due to a preexisting condition;

(2) Shall not modify, decrease, exclude, or restrict benefits through riders, conditions, restrictions, endorsements, or otherwise, on the basis of sex, age, or health status or health condition of the eligible individual;

(3) Shall not modify, decrease, or restrict coverage through riders, conditions, restrictions, endorsements, or otherwise, on the basis of category of business trade, employment skill, or vocation or profession of the eligible individual;

(4) Shall assume the full financial risk of providing the health benefits plan to all enrollees;

(5) Shall determine and adjust annual premium rates on a community basis for all lines of businesses involving health benefit plans. The carriers shall use the entire state as the community pool to determine premium rates;

(6) Shall not refuse to renew coverage except for nonpayment of premiums;

(7) Shall require as a condition for offering coverage that small employers:

(a) Enroll at least eighty percent of individuals in the small employer's group;

(b) Pay no more than ninety percent of premiums on behalf of employees enrolled in the health benefits plan;

(c) Pay no more than fifty percent of premiums on behalf of employees' covered dependents enrolled in the health benefits plan; and

(d) Require point of service cost-sharing as established by the insurance commissioner under chapter 48.-- RCW (sections 101 through 111 of this act);

(8) Shall only adjust premium rates during a rating period based upon the average of actual or expected variation in claims costs or actual or expected variation in the health status of the community pool.

NEW SECTION. **Sec. 205.** CODIFICATION DIRECTIONS. Sections 201 through 204 of this act shall constitute a new chapter in Title 48 RCW.

PART III - THE GOOD HEALTH TRUST ACCOUNT

NEW SECTION. **Sec. 301.** A new section is added to chapter 43.70 RCW to read as follows:

GOOD HEALTH TRUST ACCOUNT. The good health trust account is created in the state treasury. Moneys in the account shall be spent only after appropriation and only for health-related activities authorized by chapter . . ., Laws of 1993 (this act). Expenditures from the account shall be used for purposes of chapter . . ., Laws of 1993 (this act). A ten percent account reserve shall be accumulated and maintained annually. The reserve expenditures may be expended when the director of the office of financial management determines that consumption of cigarettes has declined and the declining tax revenues from cigarette consumption threatens programs supported by this trust account. Any interest accruing from money in the trust account shall be deposited in the trust account.

PART IV - MALPRACTICE REFORM

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

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

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

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

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

(4) The amount involved and the results obtained;

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

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

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

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

NEW SECTION. **Sec. 402.** CONTINGENT ATTORNEYS' FEES LIMITED. (1) As used in this section:

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

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

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

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

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

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

(3) The fees allowed in subsection (2) of this section are computed on the net sum of the recovery after deducting from the recovery the properly chargeable disbursements. In computing the fee, the costs as taxed by the court are part of the amount of the money judgment. In the case of a recovery payable in installments, the fee is computed using the present value of the future payments.

(4) A contingency fee agreement made by an attorney with a client must be in writing and must be executed at the time the client retains

the attorney for the claim or action that is the basis for the contingency fee agreement. An attorney who fails to comply with this subsection is barred from recovering a fee in excess of the lowest fee available under subsection (2) of this section, but the other provisions of the contingency fee agreement remain enforceable.

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

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

NEW SECTION. **Sec. 403.** 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 that may arise from *Sofie*, defendants in health care malpractice 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 section 404 of this act 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 health care malpractice actions involving fault of more than one entity, the trier of fact shall determine the percentage of the total fault that is attributable to every entity that 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 which represents that party's proportionate share of the claimant's total damages. The liability of each defendant shall be several only and shall not be joint except:

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

(b) If the trier of fact determines that the claimant or party suffering bodily injury 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 person regulated by a disciplinary authority in the state of Washington to practice a health care profession under RCW 18.130.040 or by the state board of pharmacy under chapter 18.64 RCW.

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 406.** APPLICATION. Section 405 of this act applies to all actions for damages arising out of injuries resulting from health care filed on or after September 1, 1993.

NEW SECTION. **Sec. 407.** PAYMENT OF ATTORNEYS' FEES. (1) Notwithstanding any other provisions of law, in any action for damages for injuries resulting from health care there shall be taxed and allowed to the prevailing party as a part of the costs of the action a reasonable amount to be fixed by the court as attorneys' fees.

(2)(a) The plaintiff shall be deemed the prevailing party within the meaning of subsection (1) of this section when the recovery, exclusive of costs, is greater than the amount offered in settlement by the plaintiff, as set forth in subsection (3) of this section.

(b) The defendant shall be deemed the prevailing party within the meaning of subsection (1) of this section when the recovery, exclusive of costs, is less than the amount offered in settlement by the defendant, as set forth in subsection (3) of this section.

(3) Offers of settlement shall be served on the adverse party in the manner prescribed by applicable court rules at least ten days prior to trial. Offers of settlement shall not be served until thirty days after the completion of the service and filing of the summons and complaint. Offers of settlement shall not be filed or communicated to the trier of fact until after judgment, at which time a copy of the last offer of settlement shall be filed for the purposes of determining attorneys' fees as set forth in subsection (1) of this section.

NEW SECTION. **Sec. 408.** REQUIRED NOTICE PRIOR TO FILING OF LAWSUITS. (1) At least thirty days before filing suit, a claimant shall transmit written notice to the intended defendant of the specific claims involved including the amount of actual damages and expenses. The notice must be transmitted to an address reasonably calculated to provide actual notice to the party. Failure to provide the notice shall result in dismissal without prejudice of the lawsuit.

(2) Any applicable statute of limitations that would expire during the period of notice shall expire on the thirtieth day from the date written notice was transmitted to the defendant.

NEW SECTION. **Sec. 409.** MANDATORY ARBITRATION OF HEALTH CARE MALPRACTICE. Notwithstanding the provisions of RCW 7.06.010 and 7.06.020 all actions, regardless of the amount in claim, for injuries resulting from health care are subject to mandatory arbitration.

Sec. 410. RCW 7.06.060 and 1979 c 103 s 6 are each amended to read as follows:

The supreme court may by rule provide for costs and reasonable ((~~attorney's~~)) attorneys' fees that may be assessed against a party appealing from the award who fails to improve his or her position on the trial de novo, except that in all actions for injuries resulting from health care, costs and attorneys' fees shall be assessed against a party appealing from the award who fails to improve his or her position on the trial de novo.

NEW SECTION. **Sec. 411.** CODIFICATION DIRECTIONS. Sections 402 through 409 of this act are each added to chapter 7.06 RCW.

PART V - HEALTH DATA

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

(1) The legislature finds and declares that there is a need for health care information that helps the general public understand health care issues and how they can be better consumers and that is useful to purchasers, payers, and providers in making health care choices, determining and monitoring the quality of health care services, and ((~~negotiating payments~~)) making health care purchasing decisions. It is the purpose and intent of this chapter to establish a hospital 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.

(5) The intent of the information collection activities authorized under this chapter is to ensure that:

(a) A comprehensive data system that meets the objectives of this section be developed in the most efficient, accurate, and unbiased manner possible;

(b) All public and private providers and purchasers of health care services regularly supply the types of relevant data necessary to ensure a complete, comprehensive, and accurate data system;

(c) The data system shall not by design or operation result in any provider or purchaser of health care being placed at a competitive advantage over any other provider or purchaser of health care;

(d) Providers, health care purchasers, consumers, public agencies, and others have equal access to the system's data; and

(e) Providers, health care purchasers, consumers, public agencies, and others have access to useful information developed from the system's data that enables them to make the comparative decisions necessary to fulfill the health care purchasing, provider selection, and quality assurance objectives set forth in this section.

Sec. 502. 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" means the health ((~~care access and cost control~~)) services data and quality assurance council created by this chapter.

(2) "Department" means department of health.

(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" means secretary of health.

(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.

(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.

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

(8) "Health care" means all care, goods, technologies, or services provided to persons by providers of care intended to ascertain, improve, or maintain the health of such persons. It specifically includes the care, goods, technologies, or services of health care practitioners, programs, facilities, or other health care entities regulated by Title 18 RCW or this title.

(9) "Providers" means all health care practitioners, programs, facilities, or other health care entities regulated pursuant to Title 18 RCW or this title.

(10) "Health care payers" includes all state health care payment programs; all disability insurers, health care service contractors, and health maintenance organizations subject to the jurisdiction of the insurance commissioner pursuant to Title 48 RCW; and all employers who provide health care benefits to employees through self-insurance.

(11) "Reporters" means providers and health care payers.

NEW SECTION. **Sec. 503.** A new section is added to chapter 70.170 RCW to read as follows:

WRITTEN OPERATING AGREEMENTS. The secretary and the council shall enter into written operating agreements on administrative procedures. The intent of these agreements is to provide a process for the department to consult the council on administrative matters and to ensure that the administration and staff functions effectively enable the council to fulfill its statutory responsibilities. The agreements shall include, but not be limited to, the following provisions:

(1) Administrative activities supporting the council's policies, goals, and objectives;

(2) Development and review of the agency budget as it relates to the council; and

(3) Council-related personnel issues.

The agreements shall be reviewed and revised in like manner if appropriate at the beginning of each fiscal year, and at other times upon written request by the secretary or the council.

Sec. 504. 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~~)) services data and quality assurance council within the department of health consisting of the following: The director of the department of labor and industries; the administrator of the health care authority; the secretary of social and health services; the administrator of the basic health plan; a person representing the governor on matters of health policy; the secretary of health; and ((~~one member from the public-at-large to be selected by the governor who shall represent individual consumers of health care~~)) seven public members. Public members shall be appointed by the governor with consent of the senate. In selecting public members, the governor shall assure that the council collectively has the technical expertise in health care data systems design, data collection, and other technical areas relevant to the design and operation of a health care data system and also reflects the perspectives of the users and reporters of data. In its confirmation of gubernatorial nomination, the senate should verify the technical qualifications of appointments. Public members shall serve four-year terms and the governor shall designate four of the initial appointees to serve two-year terms in order to provide staggered terms. Thereafter, public members shall serve four-year terms. All persons appointed to fill vacancies shall be appointed in the same manner as the persons they are replacing. The public members shall not have any fiduciary obligation to any health care facility or any financial interest in the provision of health care services. Members employed by the state shall serve without pay and participation in the council's work shall be deemed performance of their employment. The public members shall be compensated in accordance with RCW 43.03.240 and shall be reimbursed for related travel expenses in accordance with RCW 43.03.050 and 43.03.060.

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

(3) ((~~Four~~)) Seven members shall constitute a quorum, but ((~~a vacancy on the council shall not impair its power to act~~)) at least

four of that number shall be public members. No action of the council shall be effective unless four members concur therein.

Sec. 505. RCW 70.170.040 and 1989 1st ex.s. c 9 s 504 are each amended to read as follows:

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

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

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

((~~(4) The department may undertake, with advice from the council 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 shall report its findings and recommendations to the governor and the appropriate committees of the legislature not later than July 1, 1991.~~))

Sec. 506. RCW 70.170.050 and 1989 1st ex.s. c 9 s 505 are each amended to read as follows:

The ((~~department~~)) council shall have the authority to respond to requests ((~~of others~~)) for data, special studies, or analysis. The department may require ((~~such sponsors to pay~~)) payment of 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~~)) section 508 of this act.

Sec. 507. RCW 70.170.070 and 1989 1st ex.s. c 9 s 507 are each amended to read as follows:

(1) Every person who shall violate or knowingly aid and abet the violation of RCW 70.170.060 (5) or (6), ((~~70.170.080~~)) section 508 of this act, or 70.170.100, or any valid orders or rules adopted pursuant to these sections, or who fails to perform any act which it is herein made his or her duty to perform, shall be guilty of a misdemeanor. Following official notice to the accused by the department of the existence of an alleged violation, each day of noncompliance upon which a violation occurs shall constitute a separate violation. Any person violating the provisions of this chapter may be enjoined from continuing such violation. The department has authority to levy civil penalties not exceeding one thousand dollars for violations of this chapter and determined pursuant to this section.

(2) Every person who shall violate or knowingly aid and abet the violation of RCW 70.170.060 (1) or (2), or any valid orders or rules adopted pursuant to such section, or who fails to perform any act which it is herein made his or her duty to perform, shall be subject to the following criminal and civil penalties:

(a) For any initial violations: The violating person shall be guilty of a misdemeanor, and the department may impose a civil penalty not to exceed one thousand dollars as determined pursuant to this section.

(b) For a subsequent violation of RCW 70.170.060 (1) or (2) within five years following a conviction: The violating person shall be guilty of a misdemeanor, and the department may impose a penalty not to exceed three thousand dollars as determined pursuant to this section.

(c) For a subsequent violation with intent to violate RCW 70.170.060 (1) or (2) within five years following a conviction: The criminal and civil penalties enumerated in (a) of this subsection; plus up to a three-year prohibition against the issuance of tax exempt bonds under the authority of the Washington health care facilities authority; and up to a three-year prohibition from applying for and receiving a certificate of need.

(d) For a violation of RCW 70.170.060 (1) or (2) within five years of a conviction under (c) of this subsection: The criminal and civil penalties and prohibition enumerated in (a) and (b) of this subsection; plus up to a one-year prohibition from participation in the state medical assistance or medical care services authorized under chapter 74.09 RCW.

(3) The provisions of chapter 34.05 RCW shall apply to all noncriminal actions undertaken by the department of health, the department of social and health services, and the Washington health care facilities authority pursuant to ((~~this act~~)) chapter 9, Laws of 1989 1st ex. sess.

NEW SECTION. **Sec. 508.** A new section is added to chapter 70.170 RCW to read as follows:

The department shall fund the creation and maintenance of the data base and studies provided for in RCW 70.170.100 and 70.170.110 from a surcharge levied on the data acquired in whatever manner it deems to be efficient and fair by rule. No such assessment shall 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. The department may accept gifts, donations, grants, and other funds received by the department. All moneys collected under this section shall be deposited by the state treasurer in the health care data collection account, which is hereby 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. The department 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.

Any amounts raised by the collection of assessments provided for in this section that are not required to meet appropriations in the budget act for the current fiscal year shall be available to the department in succeeding years.

Sec. 509. RCW 70.170.100 and 1990 c 269 s 12 are each amended to read as follows:

(1) The ((~~department~~)) council is responsible for the development((~~,~~)) and implementation((~~, and custody~~)) of a state-wide ((~~hospital~~)) health care data system. The department shall be responsible for custody of the state-wide health care data system. As part of the design stage for development of the system, the ((~~department~~)) council shall undertake a needs assessment of the types of, and format for, hospital data needed by consumers, purchasers, ((~~payers, hospitals,~~)) health care payers, providers, and state government as consistent with the intent of this chapter. The ((~~department~~)) council shall identify a set of ((~~hospital~~)) health care data elements and report specifications which satisfy these needs. The department with advice from the council shall ((~~review the design of the data system and may direct the department to~~)) contract with a private vendor ((~~for assistance in the design of the data system~~)) in the state of Washington for data collection work to be performed under this section. The data elements, specifications, and other ((~~design~~)) distinguishing features of this data system shall be made available for public review and comment and shall be published, with comments, as the ((~~department's first~~)) council's data plan by ((~~January 1, 1990~~)) July 1, 1993.

(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~~)) council shall identify ((~~hospital~~)) health care data elements relating to ((~~both hospital~~

~~finances~~)) health care costs, the quality of health care services, and ((~~the~~)) use of ((~~services by patients~~)) health care by consumers. Data elements ((~~relating to hospital finances~~)) shall be reported ((~~by hospitals~~)) as the council directs by reporters in conformance with a uniform ((~~system of~~)) reporting ((~~as specified by the department and shall~~)) system established by the council, which shall be adopted by reporters. In the case of hospitals this includes data elements identifying each hospital's revenues, expenses, contractual allowances, charity care, bad debt, other income, total units of inpatient and outpatient services, and other financial information reasonably necessary to fulfill the purposes of 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~~)). The council shall permit reporting by electronic transmission or hard copy as is practical and economical to reporters.

((~~(4)~~)) (3) The state-wide ((~~hospital~~)) health care data system shall be uniform in its identification of reporting requirements for ((~~hospitals~~)) reporters across the state to the extent that such uniformity is ((~~necessary~~)) useful to fulfill the purposes of 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 pertinent distinguishing factors~~)) that involve pertinent distinguishing features as determined by the council by rule. So far as ((~~possible~~)) is practical, the data system shall be coordinated with any requirements of the trauma care data registry as authorized in RCW 70.168.090, the federal department of health and human services in its administration of the medicare program, and the state in its role of gathering public health statistics or any other payer program of consequence, so as to minimize any unduly burdensome reporting requirements imposed on ((~~hospitals~~)) reporters.

((~~(5)~~)) (4) In identifying financial reporting requirements under the state-wide ((~~hospital~~)) health care data system, the ((~~department~~)) council may require both annual reports and condensed quarterly reports from reporters, 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.

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

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

~~(8)~~)) (5) The ((~~hospital~~)) health care data collected ((~~and maintained~~)) by the ((~~department~~)) council shall be available for retrieval from the department 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 or studies shall be funded by a fee schedule developed by the department ((~~which~~)) that reflects the direct cost of retrieving the data or study in the requested form.

(6) All persons subject to this chapter shall in the acquisition of data comply with council requirements as established by rule. The council shall report December 1 of even-numbered years to the senate and house of representatives policy committees on health care on the status of the data system, the level of participation by payer and provider groups, and recommended statutory changes necessary to meet the objectives established in this chapter.

Sec. 510. 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~~)) with advice from the council may contract with a private ((~~entity to provide, hospital analyses and reports~~)) vendor in the state of Washington to provide any studies or reports it chooses to conduct 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. These reports shall~~)) The department may perform such studies or reports consistent with the purposes of this chapter. These reports may include:

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

(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;

(4) Any other reports the council deems useful to assist the public in understanding the prudent and cost-effective use of the health care delivery system; and

(5) An outcome-based accountability and reporting system to be used by the integrated health care partnerships under chapter 48.-- RCW (sections 101 through 111 of this act) to assist the partnerships, health care purchasers, and consumers evaluate the effectiveness and cost-efficiencies of health services delivered through the partnerships. The council will consult with the partnerships, health care purchasing cooperatives, health care purchasers, consumers, the quality center established under chapter 48.-- RCW (sections 101 through 111 of this act), and others in the design of this system.

NEW SECTION. **Sec. 511.** RCW 70.170.080 and 1991 sp.s. c 13 s 71 & 1989 1st ex.s. c 9 s 508 are each repealed.

PART VI - HEALTH CARE QUALITY CENTER--BOOTH GARDNER AWARD FOR EXCELLENCE IN HEALTH CARE

NEW SECTION. **Sec. 601.** HEALTH CARE QUALITY CENTER ESTABLISHED. (1) It is the intent of the legislature to improve the quality of health care services delivered in the state. The collection and dissemination of information to health care providers, purchasers, and consumers about quality and best value is essential to assure high quality health care is delivered. Information about the highest quality practice of health care also provides direction and serves as an incentive for health care providers to deliver best quality care possible. The legislature further declares that the establishment of the health care quality center will be instrumental in implementing legislative intent.

(2) The state health care quality center is established within the University of Washington. The center shall form an advisory council whose membership shall include:

(a) Representation from the disciplinary and licensing authorities for the health professions under Title 18 RCW;

(b) Representation from health care providers, including health care facilities;

(c) Representation from health care purchasing cooperatives established under chapter 48.-- RCW (sections 101 through 111 of this act);

(d) Representation from integrated health care partnerships established under chapter 48.-- RCW (sections 101 through 111 of this act);

(e) Representation from consumers of health care services;

(f) Representation from the health services data and quality assurance council established under chapter 70.170 RCW.

(3) The center established under this section shall:

(a) Collect timely information and data on practices that promote high quality health care;

(b) Establish guidelines for best observed practice by health care providers;

(c) Consult with integrated health care partnerships and health care insurance cooperatives established under chapter 48.-- RCW (sections 101 through 111 of this act) and other health care providers to adopt best observed practice guidelines;

(d) Assess and evaluate new medical technologies and procedures and make recommendations on how new cost-effective technologies can be developed to improve the quality of health care services;

(e) Make recommendations to the governor and the legislature on improving the quality of health care services delivered in the state;

(f) Consult with the health services data and quality assurance council established under chapter 70.170 RCW in creation of the outcome-based accountability and reporting system required under that chapter.

NEW SECTION. **Sec. 602.** BOOTH GARDNER AWARD FOR EXCELLENCE IN HEALTH CARE. There is hereby created the Booth Gardner Award for Excellence in Health Care. The governor shall annually identify and honor health care providers practicing in the state of Washington who exhibit exceptional quality and value in the practice of his or her health care profession. The selection shall be based upon actual delivery of health care services by such person or health care facility and shall include such factors as consumer satisfaction, creative and innovative delivery practices, cost-efficient practices, and other factors the governor deems appropriate.

NEW SECTION. **Sec. 603.** CODIFICATION DIRECTIONS. Sections 601 and 602 of this act shall constitute a new chapter in Title 70 RCW.

PART VII - PUBLIC HEALTH INITIATIVES

NEW SECTION. **Sec. 701.** LEGISLATIVE INTENT. The legislature finds that the good health of the citizens in the state through the reduction of mortality and morbidity and the promotion of good health should be the prime objective of state health-related activities. The legislature further finds that the availability of population-based health services such as health promotion, community health protection, personal clinical preventative services, and services related to the access to these health services is essential for meeting this state policy objective. The availability of these population-based services

is contingent upon the existence of an ongoing and functioning capacity to assess health status, develop public policy to promote and maintain good health, and assure the provision of services through adequate administrative and service capabilities that engage in appropriate and effective health interventions.

The legislature further finds that the responsibility to provide population-based services involves many individuals and organizations in the private and public sector and at different levels of government. The intent of the legislature is that, when feasible and practical, existing providers of population-based health services shall be involved in the planning and continued delivery of such services.

The legislature declares that state public policy on health interest is best served by assuring the availability of basic population-based health services throughout the state including the administrative structure and capacity to provide and maintain such services.

NEW SECTION. **Sec. 702.** STATE-WIDE POPULATION-BASED ESSENTIAL HEALTH SERVICES PLAN--CONTENT AND EVALUATION. By December 1, 1993, the department of health, in consultation with the state board of health, the departments of agriculture and ecology, and local health jurisdictions, shall prepare a state population-based health services plan. The purpose of the plan is to identify the core functions and services necessary to assure the presence of a state-wide population-based health care system capable of providing essential population-based health care services.

(1) The state population-based health services plan shall identify existing and new activities necessary to maintain the state-wide population-based health services system. The plan shall specifically describe how the following core function and service elements will be assured:

(a) An ongoing capability to assess the health status and health-related conditions and trends in the state through the utilization of data collection and analysis from public and private sources, including the state health report as required under RCW 43.20.050;

(b) An ongoing capability to develop public policy objectives for health based on the assessment to identify state population-based essential health needs, set state-wide priorities among identified health needs, establish goals and measurable outcome-based objectives

to address priority needs, and develop policy implementation strategies that include the identification of necessary resources to meet priority needs; and

(c) An ongoing capability to provide services to address the identified population-based essential health needs, or the identification of other public or private entities responsible for the provision of such services. In addition to the services specified in subsection (2) of this section, it shall also include the capacity of the state and local health jurisdictions to respond to critical situations and emergencies that jeopardize public health.

(2) The plan shall identify specific activities necessary to assure the provision of the following population-based essential health services:

(a) Services related to health promotion that may include, but not be limited to, the areas of physical activity and fitness, nutrition, community education in substance abuse avoidance, and parenting;

(b) Services related to community health protection that may include, but not be limited to, injury control, safe water, food, housing and waste management, air quality, and facility and professional licensure; and

(c) Services related to personal disease prevention that may include, but not be limited to, immunizations, screenings, communicable disease control, and chronic disease management.

(3) The department of health shall assure the active participation of entities interested in the development of population-based health services policy objectives.

(4) The department of health shall periodically evaluate the progress made toward meeting the essential population-based health care needs of the state. This evaluation shall be based upon the use of outcome measures and targets.

NEW SECTION. **Sec. 703.** LOCAL POPULATION-BASED HEALTH SERVICES PLANS--CONTENT AND EVALUATION. (1) By July 1, 1994, each local health officer shall prepare a local health department population-based health services plan in accordance with the provisions of this section. The plan shall be approved by the secretary of the department of health in accordance with this chapter. The purpose of the plan is to identify the core services and functions necessary to assure the presence of a local population-based health care system capable of providing

essential population-based health care services in the local health jurisdiction. The plan shall identify how it will meet the policy objectives and service requirements specified in the state-wide plan under this chapter. Approval of the plan is required for the receipt of funding as provided for under this chapter.

(2) The local population-based health services plan shall identify existing and new activities necessary to maintain the jurisdiction's population-based health services system. It shall specifically describe how the following core function and service elements will be assured:

(a) The ongoing capability to assess the health status and health-related conditions and trends in the local health jurisdiction through the utilization of data collection and analysis from public and private sources;

(b) The ongoing capability to develop public policy objectives for health based on the assessment to identify population-based essential health needs, set priorities among identified health needs, establish goals and measurable outcome-based objectives to address priority needs, and develop policy implementation strategies that include the identification of necessary resources to meet priority needs; and

(c) The ongoing capability to provide services to address the identified population-based essential health needs, or the identification of other public or private entities responsible for the provision of such services. In addition to the services specified in subsection (3) of this section, it also includes the capacity of the local health jurisdiction to respond to critical situations and emergencies that jeopardize public health.

(3) The plan shall identify activities necessary to assure the provision of the following population-based essential health services:

(a) Services related to health promotion that may include, but not be limited to, the areas of physical activity and fitness, nutrition, community education in substance abuse avoidance, and parenting;

(b) Services related to community health protection that may include, but not be limited to, community injury control, safe water, food, housing and waste management, air quality, and facility and professional licensure; and

(c) Services related to personal disease prevention that may include, but not be limited to, immunizations, screenings, communicable disease control, and chronic disease management.

(4) Two or more local health jurisdictions may, through agreement, jointly provide services specified in this section if such joint provision results in greater efficiencies and economies in the system or increases access to services. The joint agreements must be approved by the department.

(5) The local health jurisdictions shall periodically evaluate progress made toward meeting the essential population-based health care needs of the jurisdiction. The system of evaluation shall use outcome measures and targets to evaluate the system's progress.

(6) The local health jurisdiction shall identify funding sources in addition to any funds appropriated under this act to support the population-based health services system. Any funding provided for by chapter . . ., Laws of 1993 (this act) is not intended to supplant funding provided from other sources.

(7) The local health jurisdiction shall assure the active participation of entities interested in the development of population-based health services policy objectives.

NEW SECTION. **Sec. 704.** POPULATION-BASED ESSENTIAL HEALTH SERVICES PLAN--LOCAL PLAN APPROVAL--OTHER DEPARTMENT DUTIES. (1) The department of health shall review and approve local population-based health services plans submitted by local health jurisdictions. The secretary of the department of health shall specify the format and timeline for such submissions. In reviewing each local plan, the department of health shall determine whether:

(a) Proposed policies, services, and activities reasonably and adequately address identified health care needs, that adequate outcome measures will be used to indicate progress toward meeting identified needs, and that sufficient resources have been identified to operate the population-based health services system;

(b) The local health jurisdiction has specified activities necessary to provide for the services and functions identified in the state population-based health services plan;

(c) Multilocal health jurisdiction joint agreements should be pursued in order to address one or more elements of the local plan;

(d) Joint agreements for multijurisdictional activities proposed in the local plan are justified and should be approved; and

(e) Adequate local capabilities exist to evaluate and report to the department on progress in meeting the population-based health care needs of the local jurisdiction.

(2) The department of health shall expeditiously review and approve or recommend specific modifications to the local plans. Local health jurisdictions shall be given an opportunity to respond to recommendations for the modification of the plan. An appeal process shall be established by the department to review appeals of disputes.

(3) Within ninety days after the effective date of this act, the department of health shall devise a funding distribution formula for the purpose of allocating funds appropriated under this act to local health jurisdictions when local plans have been approved. The formula shall include projections of funding needs to provide for the local population-based health service needs of each local health jurisdiction. The formula shall take into consideration differences between the local health jurisdictions with respect to demographic features of the population, workload, and other such factors that affect the ability to provide the services and functions in the local plans. The department of health shall include means for determining the distribution of funding in those circumstances where multijurisdictional joint agreements have been approved. Funding appropriated under this act for essential population-based services shall be used solely for activities related to this chapter. Funding authorized under this act shall not supplant funding from other sources.

(4) The department of health shall prepare a local population-based health services plan for any local health department that fails or refuses to meet its responsibilities under this chapter. In such cases, the department of health may contract with such entities as is necessary to provide for services or functions of the local population-based health services system. It shall use such funds appropriated under this act and intended for local health jurisdictions for such purposes.

NEW SECTION. **Sec. 705.** CENTER FOR HEALTH PROMOTION ESTABLISHED. There is established within the department of health a center for health promotion and disease and injury prevention, the principal administrator of which shall report to the secretary. The center shall contain departmental functions that the secretary determines are most

directly related to the promotion of health and the prevention of disease and intentional and unintentional injuries, consistent with the organizational principles set forth in RCW 43.70.020.

(1) Included as part of the state-wide population-based health services plan, the center shall assist the department to:

(a) Identify the leading causes of death, disease, and injury to Washington citizens;

(b) Isolate the causes and risk factors for these illnesses and injuries, both intentional and unintentional;

(c) Identify geographic areas and population groups at risk for these illnesses and intentional and unintentional injuries;

(d) Identify strategies in the state-wide population-based essential health services plan that have been demonstrated to be effective in reducing these illnesses, intentional and unintentional injuries, causes, or risk factors.

(2) Biennially the center shall establish health promotion and disease and injury prevention state-wide objectives as part of the state-wide population-based essential health services plan. It shall consult with the local health jurisdictions and state board of health and shall consider such appropriate objectives as may be found in the state health report and United States public health service year 2000 objectives. Using data on Washington residents, the department shall adopt state-wide objectives in a manner that addresses at least the following national objectives to be achieved by the year 2000:

(a) Reduce cigarette smoking among people twenty years and over to no more than fifteen percent;

(b) Reduce cigarette smoking among people less than twenty years to no more than fifteen percent;

(c) Reduce breast cancer deaths to no more than 25.2 per one hundred thousand women;

(d) Reduce prevalence of cholesterol levels of two hundred forty milligrams per deciliter among people twenty and older to no more than twenty percent;

(e) Reduce deaths from cancer of the uterine cervix to no more than 1.5 per one hundred thousand women;

(f) Reduce serious nonfatal head injuries to no more than eighty-three per one hundred thousand people;

(g) Reduce drowning deaths to no more than 1.7 per one hundred thousand persons;

(h) Improve control of diabetes, as measured by a reduction in hospitalization to 6.9 per one thousand people with diabetes;

(i) Reverse the rising incidence of physical abuse of children under age eighteen to no more than ten per one thousand children;

(j) Reduce assault injuries among people age twelve and older to no more than 1650 per one hundred thousand people;

(k) Reduce alcohol-related motor vehicle crash deaths to 8.5 per one hundred thousand people;

(l) Reduce by fifty percent the use of alcohol, marijuana, and cocaine among young people ages twelve to seventeen years;

(m) Reduce annual average alcohol consumption by people age fourteen and older by twenty-three percent to two gallons of ethanol per year;

(n) Reduce by twenty-five percent the number of infants born to chemical abusing women; and

(o) Reduce the incidence of gonorrhea to two hundred twenty-five cases per one hundred thousand people.

(3) The center shall also:

(a) Act as a clearinghouse and consultive resource for local health departments, other public and private groups, and voluntary community associations that wish to implement these strategies; and

(b) Request and receive funds, gifts, grants, or appropriations from the legislature, the federal government, or private sources to pursue the department of health's duties under this section.

NEW SECTION. **Sec. 706.** STATE BOARD OF HEALTH--IMMUNIZATION SCHEDULE. (1) The state board of health shall adopt rules by September 1, 1993, that establish a schedule of appropriate immunizations against vaccine preventable infectious diseases for adults and children. The schedule shall include the type of immunization recommended and the appropriate age for receiving vaccines. The state board of health may modify by rule the recommended immunization schedule. In implementing this section the state board of health shall consider recommended immunization schedules developed by such entities as the American academy of pediatrics and the United States public health service.

(2) The state board of health shall make immunization schedules required by this section available to the secretary of the department of health and the general public no later than October 1, 1993.

NEW SECTION. **Sec. 707.** IMMUNIZATION INCENTIVE PROGRAM. (1) The department of health shall establish an immunization incentive program for the purpose of providing financial incentives to local health jurisdictions to improve immunization rates among children under four years of age. The program shall provide a twenty thousand dollar per year bonus to local health jurisdictions that meet the requirements of this section.

(2) The department of health, in consultation with each local health jurisdiction, shall establish the current rate of immunization compliance in each of the state's local health jurisdictions for children under four years of age. The rate shall be based upon the immunization schedules adopted by the state board of health under this chapter. This rate shall be known as the base rate.

(3) The department of health shall award each local health jurisdiction the sum of twenty thousand dollars for each year the local health jurisdiction increases the compliance rate by five percent. The jurisdiction shall receive an additional fifty thousand dollars for immunization compliance rates when ninety-eight percent of children under four years of age in the jurisdiction have complied with the state board of health recommended immunization schedule.

Sec. 708. RCW 43.20.050 and 1992 c 34 s 4 are each amended to read as follows:

(1) The state board of health shall provide a forum for the development of health policy in Washington state. It is authorized to recommend to the secretary means for obtaining appropriate citizen and professional involvement in all health policy formulation and other matters related to the powers and duties of the department. It is further empowered to hold hearings and explore ways to improve the health status of the citizenry.

(a) At least every five years, the state board shall convene regional forums to gather citizen input on health issues.

(b) Every two years, in ((~~coordination with~~)) advance of the development of the state biennial budget and in coordination with the development of the state and local population-based public health service system objectives as provided for in chapter 70.-- RCW (sections 701 through 707 of this act), the state board shall prepare the state health report that outlines the health priorities of the ensuing biennium and provides information for use in development of the

state biennial budget and state and local population-based public health service system objectives as provided under chapter 70.-- RCW (sections 701 and 707 of this act). The report shall:

(i) Consider the citizen input gathered at the health forums;

(ii) Be developed with the assistance of local health departments;

(iii) Be based on the best available information collected and reviewed according to RCW 43.70.050 and recommendations from the council;

(iv) Be developed with the input of state health care agencies. At least the following directors of state agencies shall provide timely recommendations to the state board on suggested health priorities for the ensuing biennium: The secretary of social and health services, the health care authority administrator, the insurance commissioner, the administrator of the basic health plan, the superintendent of public instruction, the director of labor and industries, the director of ecology, and the director of agriculture;

(v) Be used by state health care agency administrators in preparing proposed agency budgets and executive request legislation;

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

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

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

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

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

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

(iii) Public water system management and reporting requirements;

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

(v) Public water system operation and maintenance requirements;

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

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

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

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

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

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

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

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

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

dollars, upon first conviction, and not less than one hundred dollars upon second conviction.

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

Sec. 709. RCW 43.70.050 and 1989 1st ex.s. c 9 s 107 are each amended to read as follows:

(1) 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. sess. in accordance with the provisions of this chapter. In furtherance of this goal, the secretary shall create an ongoing program of data collection, storage, ((~~assessability~~)) accessibility, and review. The legislature does not intend that the department conduct or contract for the conduct of basic research activity. The secretary may request appropriations for studies according to this section from the legislature, the federal government, or private sources.

(2) All state agencies which collect or have access to population-based, health-related data are directed to allow the secretary 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 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 and the patient or provider are parties.

(3) The department 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) The secretary 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) Use such data, research, and findings in preparation of the state and local population-based health services plan as authorized under chapter 70.-- RCW (sections 701 through 707 of this act); and

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

(5) 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) The secretary 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 of providing the copy.

NEW SECTION. **Sec. 710.** CODIFICATION DIRECTIONS. Sections 701 through 707 of this act shall constitute a new chapter in Title 70 RCW.

PART VIII - BASIC HEALTH PLAN REAUTHORIZATION AND EXPANSION

Sec. 801. RCW 70.47.010 and 1987 1st ex.s. c 5 s 3 are each amended to read as follows:

(1) The legislature finds that:

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

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

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

(2) The purpose of this chapter is to provide or make available necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization of necessary health care services. To that end, this chapter establishes a program to be made available to those residents under sixty-five years of age not otherwise eligible for medicare with gross family income at or below ((~~two~~)) three hundred percent of the federal poverty guidelines, except as provided for in RCW 70.47.060(11)(b), who share in a portion of the cost or who pay the full cost of receiving basic health care services from a managed health care system.

(3) It is not the intent of this chapter to provide health care services for those persons who are presently covered through private employer-based health plans, nor to replace employer-based health plans. Further, it is the intent of the legislature to expand, wherever possible, the availability of private health care coverage and to discourage the decline of employer-based coverage.

(4) ((~~The program authorized under this chapter is strictly limited in respect to the total number of individuals who may be allowed to participate and the specific areas within the state where it may be established. All such restrictions or limitations shall remain in full~~

~~force and effect until quantifiable evidence based upon the actual operation of the program, including detailed cost benefit analysis, has been presented to the legislature and the legislature, by specific act at that time, may then modify such limitations~~)) (a) It is the purpose of this chapter to acknowledge the initial success of this program that has (i) assisted thousands of families in their search for affordable health care; (ii) demonstrated that low-income uninsured families are willing to pay for their own health care coverage to the extent of their ability to pay; and (iii) proved that local health care providers are willing to enter into a public/private partnership as they configure their own professional and business relationships into a managed care system.

(b) As a consequence, the legislature intends to make the program available to individuals in the state with incomes below three hundred percent of federal poverty guidelines, except as provided for in RCW 70.47.060(11)(b), who reside in communities where the plan is operational, and who collectively or individually wish to exercise the opportunity to purchase health care coverage through the program if it is done at no cost to the state. It is also the intent of the legislature to allow employers and other financial sponsors to financially assist such individuals in purchasing health care through the program.

Sec. 802. RCW 70.47.020 and 1987 1st ex.s. c 5 s 4 are each amended to read as follows:

As used in this chapter:

(1) "Washington basic health plan" or "plan" means the system of enrollment and payment on a prepaid capitated basis for basic health care services, administered by the plan administrator through participating managed health care systems, created by this chapter.

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

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

(4) "Enrollee" means an individual, or an individual plus the individual's spouse and/or dependent children, all under the age of sixty-five and not otherwise eligible for medicare, who resides in an area of the state served by a managed health care system participating in the plan, ((~~whose gross family income at the time of enrollment does not exceed twice the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services,~~)) who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan. Nonsubsidized enrollees shall be considered enrollees unless otherwise specified.

(5) "Nonsubsidized enrollee" means an enrollee who pays the full premium for participation in the plan and shall not be eligible for any subsidy from the plan.

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

((~~(6)~~)) (7) "Premium" means a periodic payment, based upon gross family income and determined under RCW 70.47.060(2), which an enrollee makes to the plan as consideration for enrollment in the plan.

((~~(7)~~)) (8) "Rate" means the per capita amount, negotiated by the administrator with and paid to a participating managed health care system, that is based upon the enrollment of enrollees in the plan and in that system.

Sec. 803. RCW 70.47.030 and 1992 c 232 s 907 are each amended to read as follows:

(1) The basic health plan trust account is hereby established in the state treasury. ((~~All~~)) Any nongeneral fund-state funds collected for this program shall be deposited in the basic health plan trust account and may be expended without further appropriation. Moneys in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of enrollees in the plan and payment of costs of administering the plan. After July 1, 1993, the administrator shall not expend or encumber for an ensuing fiscal period amounts exceeding ninety-five

percent of the amount anticipated to be spent for purchased services during the fiscal year.

(2) The basic health plan subscription account is created in the custody of the state treasurer. All receipts from amounts due under RCW 70.47.060 (11) and (12) shall be deposited into the account. Funds in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of enrollees in the plan and payment of costs of administrating the plan. The account is subject to allotment procedures under chapter 43.88 RCW, but no appropriation is required for expenditures.

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

Sec. 804. RCW 70.47.060 and 1992 c 232 s 908 are each amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, and other services that may be necessary for basic health care, which enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care and shall include all services necessary for prenatal, postnatal, and well-child care. However, for the period ending June 30, 1993, with respect to coverage for groups of subsidized enrollees, the administrator shall not contract for prenatal or postnatal services that are provided under the medical assistance program under chapter 74.09 RCW except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider, or except to provide any such services associated with pregnancies diagnosed by the managed care provider before July 1, 1992. The schedule of services shall also include a separate schedule of basic

health care services for children, eighteen years of age and younger, for those enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.42.080, and such other factors as the administrator deems appropriate.

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

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

(b) Premiums due from nonsubsidized enrollees, who are not otherwise eligible to be enrollees, shall be in an amount equal to the cost charged by the managed health care system provider to the state for the plan plus the administrative cost of providing the plan to those enrollees.

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

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

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

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

(c) Coinsurance rates that are established based on specific service and procedure costs and the enrollee’s ability to pay for the care. However, coinsurance rates for families with incomes below one hundred twenty percent of the federal poverty level shall be nominal.

No coinsurance shall be required for specific proven prevention programs, such as prenatal care. The coinsurance rate levels shall not have a measurable negative effect upon the enrollee's health status; and

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

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

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

(6)(a) To limit the payment of a subsidy to only of those enrollees, as defined in RCW 70.47.020, whose gross family income at the time of enrollment does not exceed twice the federal poverty level adjusted for family size and determined annually by the federal department of health and human services.

(b) Except as provided for in subsection (11)(b) of this section, to limit participation of nonsubsidized enrollees in the plan to those whose family incomes at the time of enrollment does not exceed three times the federal poverty level adjusted for family size and determined annually by the federal department of health and human services.

(7) To adopt a schedule for the orderly development of the delivery of services and availability of the plan to residents of the state, subject to the limitations contained in RCW 70.47.080.

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

representative of the portion of the state's population that lacks such coverage, and the need for geographic, demographic, and economic diversity.

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

~~(7)~~)) (8) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state.

((~~(8)~~)) (9) To receive periodic premiums from enrollees, deposit them in the basic health plan operating account, keep records of enrollee status, and authorize periodic payments to managed health care systems on the basis of the number of enrollees participating in the respective managed health care systems.

((~~(9)~~)) (10) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and at least annually thereafter, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. Except as provided for in subsection (11)(b) of this section, an enrollee who remains current in payment of the sliding-scale premium, as determined under subsection (2) of this section, and whose gross family income has risen above ((~~twice~~)) three times the federal poverty level, may continue enrollment unless and until the enrollee's gross family income has remained above ((~~twice~~)) three times the poverty level for ((~~six~~)) eighteen consecutive months, by making payment at the unsubsidized rate required for the managed health care system in which he or she may be enrolled plus the administrative cost of providing the plan to that enrollee. No subsidy may be paid with respect to any enrollee whose

current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to re-enroll in the plan.

((~~(10)~~)) (11)(a) To accept applications from small business owners on behalf of themselves and their employees, spouses, and dependent children who reside in an area served by the plan. The administrator may require all or the substantial majority of the eligible employees of such businesses to enroll in the plan and establish those procedures necessary to facilitate the orderly enrollment of groups in the plan and into a managed health care system. For the purposes of this subsection, an employee means an individual who regularly works for the employer for at least twenty hours per week. Such businesses shall have less than one hundred employees and enrollment shall be limited to those not otherwise eligible for medicare, whose gross family income at the time of enrollment does not exceed three times the federal poverty level as adjusted for family size and determined by the federal department of health and human services, who wish to enroll in the plan at no cost to the state and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. The administrator shall adjust the amount determined to be due on behalf of or from all such enrollees whenever the amount negotiated by the administrator with the participating managed health care system or systems is modified or the administrative cost of providing the plan to such enrollees changes. No enrollee of a small business group shall be eligible for any subsidy from the plan and at no time shall the administrator allow the credit of the state or funds from the trust account to be used or extended on their behalf.

(b) Notwithstanding income limitations provided for in (a) of this subsection, if seventy-five percent or more of employees in a small business at the time of enrollment have gross family incomes that do not exceed three times the federal poverty level as adjusted for family size and determined by the federal department of health and human services, all employees in the small business will be eligible for enrollment under this subsection. The plan shall annually require participating small businesses enrolled under this subsection (11)(b)

to provide evidence of gross family incomes of enrolled employees for purposes of determining continued eligibility of such employees under this subsection (11)(b). To minimize the burden and cost of complying with this reporting requirement, the plan shall accept documentation from the small business that provides such information as may be required by other state agencies. Should more than twenty-five percent of employees of an enrolled small business be found to have gross family incomes exceeding three times the federal poverty level, the plan shall notify the small business that those employees are no longer eligible for enrollment and shall disenroll these employees eighteen months after the notification. The remaining employees of such small businesses who have gross family incomes below three times the federal poverty level will continue to be eligible enrollees under (a) of this subsection.

(12) To accept applications from individuals residing in areas serviced by the plan, on behalf of themselves and their spouses and dependent children, under sixty-five years of age and not otherwise eligible for medicare, whose gross family income at the time of enrollment does not exceed three times the federal poverty level as adjusted for family size and determined by the federal department of health and human services, who wish to enroll in the plan at no cost to the state and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. Any such nonsubsidized enrollees must pay the amount negotiated by the administrator with the participating managed health care system and the administrative cost of providing the plan to such nonsubsidized enrollees and shall not be eligible for any subsidy from the plan.

(13) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the administrator shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant. In determining the rate to be paid to a contractor, the administrator shall strive to assure that the rate does

not result in adverse cost shifting to other private payers of health care.

((~~(11)~~)) (14) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed health care systems and to the administrator. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

((~~(12)~~)) (15) To monitor the access that state residents have to adequate and necessary health care services, determine the extent of any unmet needs for such services or lack of access that may exist from time to time, and make such reports and recommendations to the legislature as the administrator deems appropriate.

((~~(13)~~)) (16) To evaluate the effects this chapter has on private employer-based health care coverage and to take appropriate measures consistent with state and federal statutes that will discourage the reduction of such coverage in the state.

((~~(14)~~)) (17) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

((~~(15)~~)) (18) To provide, consistent with available resources, technical assistance for rural health activities that endeavor to develop needed health care services in rural parts of the state.

Sec. 805. RCW 70.47.080 and 1987 1st ex.s. c 5 s 10 are each amended to read as follows:

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

~~total enrollment of those eligible for subsidies to exceed thirty thousand.~~))

Thereafter, ((~~total~~)) the average monthly enrollment of those eligible for subsidies during any biennium shall not exceed the number established by the legislature in any act appropriating funds to the plan, and total subsidized enrollment shall not result in expenditures that exceed the total amount that has been made available by the legislature in any act appropriating funds to the plan.

((~~Before July 1, 1988, the administrator shall endeavor to secure participation contracts from managed health care systems in discrete geographic areas within at least five congressional districts of the state and in such manner as to allow residents of both urban and rural areas access to enrollment in the plan. The administrator shall make a special effort to secure agreements with health care providers in one such area that meets the requirements set forth in RCW 70.47.060(4).~~))

The administrator shall at all times closely monitor growth patterns of enrollment so as not to exceed that consistent with the orderly development of the plan as a whole, in any area of the state or in any participating managed health care system. The annual or biennial enrollment limitations derived from operation of the plan under this section do not apply to nonsubsidized enrollees as defined in RCW 70.47.020(5).

Sec. 806. RCW 70.47.120 and 1987 1st ex.s. c 5 s 14 are each amended to read as follows:

In addition to the powers and duties specified in RCW 70.47.040 and 70.47.060, the administrator has the power to enter into contracts for the following functions and services:

(1) With public or private agencies, to assist the administrator in her or his duties to design or revise the schedule of covered basic health care services, and/or to monitor or evaluate the performance of participating managed health care systems.

(2) With public or private agencies, to provide technical or professional assistance to health care providers, particularly public or private nonprofit organizations and providers serving rural areas, who show serious intent and apparent capability to participate in the plan as managed health care systems.

(3) With public or private agencies, including health care service contractors registered under RCW 48.44.015, and doing business in the

state, for marketing and administrative services in connection with participation of managed health care systems, enrollment of enrollees, billing and collection services to the administrator, and other administrative functions ordinarily performed by health care service contractors, other than insurance except that the administrator may purchase or arrange for the purchase of reinsurance, or self-insure for reinsurance, on behalf of its participating managed health care systems. Any activities of a health care service contractor pursuant to a contract with the administrator under this section shall be exempt from the provisions and requirements of Title 48 RCW.

Sec. 807. RCW 43.131.355 and 1987 1st ex.s. c 5 s 24 are each amended to read as follows:

The Washington basic health plan administrator and its powers and duties shall be terminated on June 30, ((~~1992~~)) 1997, as provided in RCW 43.131.356.

Sec. 808. RCW 43.131.356 and 1987 1st ex.s. c 5 s 25 are each amended to read as follows:

The following acts or parts of acts, as now existing or hereafter amended, are each repealed, effective June 30, ((~~1993~~)) 1998:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 809.** A new section is added to chapter 74.09 RCW to read as follows:

FEDERAL WAIVER FOR STATE MEDICAID PROGRAM. (1) The department shall negotiate with the United States congress and the federal department of health and human services to obtain a waiver of provisions of the medicaid statute, Title XIX of the federal social security act to permit medicaid eligible individuals to:

(a) Enroll in the state basic health plan and receive the benefits offered to basic health plan enrollees; and

(b) Participate financially in purchasing health care benefits through such means as premium sharing, copayments, and deductibles provided that such contributions will be implemented in a manner to encourage the appropriate use of effective medical care services and do not serve as a barrier to receiving necessary medical care services.

(2) The department shall report to the appropriate policy and fiscal standing committees of the senate and house of representatives by November 30, 1993, on the progress of such negotiations.

PART IX - PROVIDER FINANCIAL CONFLICT OF INTEREST STANDARDS

NEW SECTION. **Sec. 901.** LEGISLATIVE INTENT. The legislature finds that there is a growing practice of health care professionals having financial interest in laboratory and other services. The legislature further finds that such practices may result in overutilization of health care services and excessive costs to individuals, third-party payers, and the health care system.

The legislature declares that the notification of patients and third-party payers about these referral practices can make them more

aware of such practices and allow payers to track providers who through referrals overutilize services for financial reasons.

Sec. 902. RCW 19.68.010 and 1973 1st ex.s. c 26 s 1 are each amended to read as follows:

It shall be unlawful for any person, firm, corporation or association, whether organized as a cooperative, or for profit or nonprofit, to pay, or offer to pay or allow, directly or indirectly, to any person licensed by the state of Washington to engage in the practice of medicine and surgery, drugless treatment in any form, dentistry, or pharmacy and it shall be unlawful for such person to request, receive or allow, directly or indirectly, a rebate, refund, commission, unearned discount or profit by means of a credit or other valuable consideration in connection with the referral of patients to any person, firm, corporation or association, or in connection with the furnishings of medical, surgical or dental care, diagnosis, treatment or service, on the sale, rental, furnishing or supplying of clinical laboratory supplies or services of any kind, drugs, medication, or medical supplies, or any other goods, services or supplies prescribed for medical diagnosis, care or treatment: PROVIDED, That ownership of a financial interest in any firm, corporation or association which furnishes any kind of clinical laboratory or other services prescribed for medical, surgical, or dental diagnosis shall not be prohibited under this section where (1) the referring practitioner affirmatively discloses to the patient and to the payer of the patient's health care services in writing, the fact that such practitioner has a financial interest in such firm, corporation, or association; and (2) the referring practitioner provides the patient with a list of effective alternative facilities, informs the patient that he or she has the option to use one of the alternative facilities, and assures the patient that he or she will not be treated differently by the referring practitioner if the patient chooses one of the alternative facilities.

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

NEW SECTION. **Sec. 903.** A new section is added to chapter 18.130 RCW to read as follows:

CONFLICT OF INTEREST STANDARDS. The secretary, in consultation with the health care disciplinary authorities under RCW

18.130.040(2)(b), shall establish standards prohibiting or restricting provider investments and referrals that present a conflict of interest resulting from inappropriate financial gain for the provider or his or her immediate family. These standards are not intended to inhibit the efficient operation of managed health care systems. The secretary shall report to the health policy committees of the senate and house of representatives by June 30, 1994, on the development of the standards and any recommended statutory changes necessary to implement the standards.

PART X - UNIFORM ELECTRONIC CLAIMS PROCESSING

NEW SECTION. **Sec. 1001.** A new section is added to chapter 48.20 RCW to read as follows:

APPLICATION TO DISABILITY INSURANCE POLICIES. (1) After January 1, 1995, all disability insurance policies that provide coverage for hospital or medical expenses shall use for all billing purposes in electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1995, the forms developed under section 1010 of this act shall be used by providers of health care and carriers under this chapter.

NEW SECTION. **Sec. 1002.** A new section is added to chapter 48.21 RCW to read as follows:

APPLICATION TO GROUP DISABILITY INSURANCE POLICIES. (1) After January 1, 1995, all group disability insurance policies that provide coverage for hospital or medical expenses shall use for all billing purposes in electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1995, the forms developed under section 1010 of this act shall be used by providers of health care and carriers under this chapter.

NEW SECTION. **Sec. 1003.** A new section is added to chapter 48.44 RCW to read as follows:

APPLICATION TO HEALTH CARE INSURANCE CONTRACTS. (1) After January 1, 1995, all health care insurance contracts that provide coverage for hospital or medical expenses shall use for all billing purposes in electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1995, the forms developed under section 1010 of this act shall be used by providers of health care and carriers under this chapter.

NEW SECTION. **Sec. 1004.** A new section is added to chapter 48.46 RCW to read as follows:

APPLICATION TO HEALTH MAINTENANCE AGREEMENTS. (1) After January 1, 1995, all health maintenance agreements that provide coverage for hospital or medical expenses shall use for all billing purposes in electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1995, the forms developed under section 1010 of this act shall be used by providers of health care and carriers under this chapter.

NEW SECTION. **Sec. 1005.** A new section is added to chapter 48.84 RCW to read as follows:

APPLICATION TO LONG-TERM CARE PROVIDERS. (1) After January 1, 1995, all providers of long-term care that provide coverage for hospital or medical expenses shall use for all billing purposes in electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform bill (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1995, the forms developed under section 1010 of this act shall be used by providers of health care and carriers under this chapter.

NEW SECTION. **Sec. 1006.** A new section is added to chapter 41.05 RCW to read as follows:

APPLICATION TO STATE HEALTH CARE AUTHORITY. After July 1, 1995, the health care financing administration (HCFA) 1500 form, or its successor, and the uniform billing (UB) 82 form, or its successor, shall be used in electronic format for state-paid health care services provided through the health care authority. The forms developed under section 1010 of this act shall be used for billing purposes for pharmacists, dentists, eyeglasses, transportation, or vocational services.

NEW SECTION. **Sec. 1007.** A new section is added to chapter 74.09 RCW to read as follows:

APPLICATION TO THE MEDICAL ASSISTANCE PROGRAM. After July 1, 1995, the health care financing administration (HCFA) 1500 form, or its successor, and the uniform billing (UB) 82 form, or its successor, shall be used in electronic format for state-paid health care services provided by the department. The forms developed under section 1010 of this act shall be used for billing purposes for pharmacists, dentists, eyeglasses, transportation, or vocational services.

NEW SECTION. **Sec. 1008.** A new section is added to Title 51 RCW to read as follows:

APPLICATION TO LABOR AND INDUSTRIES. After July 1, 1995, the health care financing administration (HCFA) 1500 form, or its successor, and the uniform billing (UB) 82 form, or its successor, shall be used in electronic format for state-paid health care services provided under this title. The forms developed under section 1010 of this act shall be used for billing purposes for pharmacists, dentists, eyeglasses, transportation, or vocational services.

NEW SECTION. **Sec. 1009.** A new section is added to chapter 70.47 RCW to read as follows:

APPLICATION TO BASIC HEALTH PLAN. After July 1, 1995, the health care financing administration (HCFA) 1500 form, or its successor, and

the uniform billing (UB) 82 form, or its successor, shall be used in electronic format for state-paid health care services provided under the basic health plan. The forms developed under section 1010 of this act shall be used for billing purposes for pharmacists, dentists, eyeglasses, transportation, or vocational services.

NEW SECTION. **Sec. 1010.** A new section is added to chapter 70.170 RCW to read as follows:

JOINT AGENCY RULES. By January 1, 1994, the council shall develop and adopt by rule electronic format billing forms to be used for pharmacists, dentists, eyeglasses, transportation, and vocational services. These forms shall be made available to providers of health care coverage licensed under chapters 48.20, 48.21, 48.44, 48.46, and 48.84 RCW.

NEW SECTION. **Sec. 1011.** A new section is added to chapter 70.170 RCW to read as follows:

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

PART XI - APPROPRIATIONS

NEW SECTION. **Sec. 1101.** POPULATION-BASED HEALTH SERVICES FUNDING. The sum of forty-five million dollars, or as much thereof as may be necessary, is appropriated for the biennium ending June 30, 1995, from the good health trust account to the department of health for distribution to local health departments for the purposes of funding population-based health services as authorized in sections 701 through 707 of this act. The funding is to be disbursed by the department in accordance with the formula set forth in section 704 of this act and the provisions set forth in section 707 of this act.

NEW SECTION. **Sec. 1102.** FAMILY MEDICINE RESIDENCY FUNDING. The sum of one million eighty-one thousand eight hundred fifteen dollars, or as much thereof as is necessary, is appropriated for the biennium ending June 30, 1995, from the good health trust account to the University of Washington for the purposes of funding the state-wide

family medicine residency program authorized under chapter 70.112 RCW. The conditions set forth in RCW 70.112.060 regarding expenditures of state funding shall apply to this appropriation. The funds shall be used to train resident physicians in family practice who provide medical care to medically underserved or rural populations as defined by the department of health. The University of Washington shall make a good faith effort to expend the appropriation in a manner to maximize potential federal or nonstate matching funds. The amount appropriated in this section is in addition to that set forth in the 1993-1995 biennial appropriations act.

NEW SECTION. **Sec. 1103.** HEALTH PROFESSIONAL LOAN REPAYMENT AND SCHOLARSHIP PROGRAM FUNDING. The sum of five million dollars, or as much thereof as may be necessary, is appropriated for the biennium ending June 30, 1995, from the good health trust account to the health professional loan repayment and scholarship program fund to be disbursed by the higher education coordinating board for the purposes of funding the health professional loan repayment and scholarship program authorized under chapter 28B.115 RCW. This amount is in addition to that set forth in the 1993-1995 biennial appropriations act.

NEW SECTION. **Sec. 1104.** COMMUNITY HEALTH CLINICS FUNDING. The sum of two million dollars, or as much thereof as may be necessary, is appropriated for the biennium ending June 30, 1995, from the good health trust account to the department of health for the purposes of funding the expansion of primary health care services to new clients through community health clinics. This amount is in addition to that set forth in the 1993-1995 biennial appropriations act.

NEW SECTION. **Sec. 1105.** BASIC HEALTH PLAN FUNDING. The sum of one hundred twenty-seven million dollars, or as much thereof as may be necessary, is appropriated for the biennium ending June 30, 1995, from the good health trust account to the Washington basic health plan authorized under chapter 70.47 RCW for the purposes of enrolling no more than forty thousand additional members during the 1993-1995 biennium. This amount is in addition to that set forth in the 1993-1995 biennial appropriations act.

NEW SECTION. **Sec. 1106.** START-UP GRANTS FOR HEALTH INSURANCE PURCHASING COOPERATIVES. The sum of three million dollars, or as much thereof as may be necessary, is appropriated for the biennium ending June 30, 1995, from the good health trust account to the insurance commissioner for the purposes of establishing health insurance purchasing cooperatives and the regional cooperative coordinating councils under sections 101 through 111 of this act.

NEW SECTION. **Sec. 1107.** HEALTH QUALITY CENTER. The sum of two million dollars, or as much thereof as may be necessary, is appropriated for the biennium ending June 30, 1995, from the good health trust account to the University of Washington to fund the health care quality center in section 601 of this act.

NEW SECTION. **Sec. 1108.** CENTER FOR HEALTH PROMOTION. The sum of one million dollars, or as much thereof as may be necessary, is appropriated for the biennium ending June 30, 1995, from the good health trust account to the department of health for the purpose of establishing the center for health promotion under section 705 of this act.

PART XII - REVENUES

Sec. 1201. RCW 82.24.020 and 1989 c 271 s 504 are each amended to read as follows:

(1) There is levied and there shall be collected as hereinafter provided, a tax upon the sale, use, consumption, handling, possession or distribution of all cigarettes, in an amount equal to the rate of eleven and one-half mills per cigarette.

(2) Until July 1, 1995, an additional tax is imposed upon the sale, use, consumption, handling, possession, or distribution of all cigarettes, in an amount equal to the rate of one and one-half mills per cigarette. All revenues collected during any month from this additional tax shall be deposited in the drug enforcement and education account under RCW 69.50.520 by the twenty-fifth day of the following month.

(3) There is an additional tax imposed upon the sale, use, consumption, handling, possession, or distribution of all cigarettes, in an amount equal to five cents per cigarette. All revenues collected

from this additional tax shall be deposited in the good health trust account.

(4) Wholesalers and retailers subject to the payment of this tax may, if they wish, absorb one-half mill per cigarette of the tax and not pass it on to purchasers without being in violation of this section or any other act relating to the sale or taxation of cigarettes.

((~~(4)~~)) (5) For purposes of this chapter, "possession" shall mean both (a) physical possession by the purchaser and, (b) when cigarettes are being transported to or held for the purchaser or his designee by a person other than the purchaser, constructive possession by the purchaser or his designee, which constructive possession shall be deemed to occur at the location of the cigarettes being so transported or held.

Sec. 1202. RCW 82.26.020 and 1983 2nd ex.s. c 3 s 16 are each amended to read as follows:

(1) From and after June 1, 1971, there is levied and there shall be collected a tax upon the sale, use, consumption, handling, or distribution of all tobacco products in this state at the rate of forty-five percent of the wholesale sales price of such tobacco products. Such tax shall be imposed at the time the distributor (a) brings, or causes to be brought, into this state from without the state tobacco products for sale, (b) makes, manufactures, or fabricates tobacco products in this state for sale in this state, or (c) ships or transports tobacco products to retailers in this state, to be sold by those retailers.

(2) An additional tax is imposed equal to the rate specified in RCW 82.02.030 multiplied by the tax payable under subsection (1) of this section.

(3) An additional tax is imposed equal to 190.90 percent of the wholesale sales price of tobacco products.

(4) Revenues collected under subsection (3) of this section shall be deposited in the good health trust account.

PART XIII - MISCELLANEOUS

Sec. 1301. RCW 43.84.092 and 1992 c 235 s 4 are each amended to read as follows:

(1) All earnings of investments of surplus balances in the state treasury shall be deposited to the treasury income account, which account is hereby established in the state treasury.

(2) Monthly, the state treasurer shall distribute the earnings credited to the treasury income account. The state treasurer shall credit the general fund with all the earnings credited to the treasury income account except:

(a) The following accounts and funds shall receive their proportionate share of earnings based upon each account's and fund's average daily balance for the period: The capitol building construction account, the Cedar River channel construction and operation account, the Central Washington University capital projects account, the charitable, educational, penal and reformatory institutions account, the common school construction fund, the county criminal justice assistance account, the county sales and use tax equalization account, the data processing building construction account, the deferred compensation administrative account, the deferred compensation principal account, the department of retirement systems expense account, the Eastern Washington University capital projects account, the federal forest revolving account, the good health trust account, the industrial insurance premium refund account, the judges' retirement account, the judicial retirement administrative account, the judicial retirement principal account, the local leasehold excise tax account, the local sales and use tax account, the medical aid account, the municipal criminal justice assistance account, the municipal sales and use tax equalization account, the natural resources deposit account, the perpetual surveillance and maintenance account, the public employees' retirement system plan I account, the public employees' retirement system plan II account, the Puyallup tribal settlement account, the resource management cost account, the site closure account, the special wildlife account, the state employees' insurance account, the state employees' insurance reserve account, the state investment board expense account, the state investment board commingled trust fund accounts, the supplemental pension account, the teachers' retirement system plan I account, the teachers' retirement system plan II account, the University of Washington bond retirement fund, the University of Washington building account, the volunteer fire fighters' relief and pension principal account, the volunteer fire fighters' relief and pension administrative account, the Washington judicial

retirement system account, the Washington law enforcement officers' and fire fighters' system plan I retirement account, the Washington law enforcement officers' and fire fighters' system plan II retirement account, the Washington state patrol retirement account, the Washington State University building account, the Washington State University bond retirement fund, and the Western Washington University capital projects account. Earnings derived from investing balances of the agricultural permanent fund, the normal school permanent fund, the permanent common school fund, the scientific permanent fund, and the state university permanent fund shall be allocated to their respective beneficiary accounts. All earnings to be distributed under this subsection (2)(a) shall first be reduced by the allocation to the state treasurer's service fund pursuant to RCW 43.08.190.

(b) The following accounts and funds shall receive eighty percent of their proportionate share of earnings based upon each account's or fund's average daily balance for the period: The central Puget Sound public transportation account, the city hardship assistance account, the county arterial preservation account, the economic development account, the essential rail assistance account, the essential rail banking account, the ferry bond retirement fund, the grade crossing protective fund, the high capacity transportation account, the highway bond retirement fund, the highway construction stabilization account, the highway safety account, the motor vehicle fund, the motorcycle safety education account, the pilotage account, the public transportation systems account, the Puget Sound capital construction account, the Puget Sound ferry operations account, the recreational vehicle account, the rural arterial trust account, the special category C account, the state patrol highway account, the transfer relief account, the transportation capital facilities account, the transportation equipment fund, the transportation fund, the transportation improvement account, and the urban arterial trust account.

(3) In conformance with Article II, section 37 of the state Constitution, no treasury accounts or funds shall be allocated earnings without the specific affirmative directive of this section.

NEW SECTION. **Sec. 1302.** CAPTIONS AND HEADINGS NOT LAW. Captions, table of contents, and part headings as used in this act constitute no part of the law.

NEW SECTION. **Sec. 1303.** SEVERABILITY. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 1304.** EFFECTIVE DATE. This act is 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 July 1, 1993.

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