

Governor Gregoire Signs Legislation to Provide High Quality, Affordable Health Care to Washingtonians

For Immediate Release: May 2, 2007

SEATTLE - Governor Chris Gregoire today signed into law a measure she requested that, based on the recommendations of the Blue Ribbon Commission on Health Care Costs and Access, will help to provide high quality, affordable health care to Washingtonians.

“We have a responsibility to ensure that all Washingtonians have access to quality health care that fits within their budget, but the current system is not working for too many of our citizens,” said Governor Gregoire. “The recommendations of the Blue Ribbon Commission are the foundation for this bill and this is a significant step to increase access to high-quality care.”

Governor Gregoire’s bill includes over 20 initiatives, many recommended by the Blue Ribbon Commission on health care, that will address cost, quality and access to our health care system, including:

- Establishing the **Health Insurance Partnership** to assist small businesses with insurance;
- Creating health record banks to connect providers and patients with their health information when and where they need it;
- Expanding coverage to dependents up to age 25; and
- Changing how we reimburse for health care to pay for quality care and prevention, better manage chronic illnesses and establish a Quality Forum to evaluate trends in procedures across the state.

These efforts are designed to build on Governor Gregoire’s 5-point strategy to improve how health care is delivered and to target investments to health care that is proven to work.

“Access to quality health care is a national problem. Families and businesses across the country are struggling to afford the care they need for their family and employees,” said Governor Gregoire. “We cannot just keep throwing more money into a broken health care system – we actually need to fix that system. This means we need to pay for care that we know works, focus on prevention, better manage chronic illnesses, help patients get more involved in their health care and build a more efficient system. This bill does just that.”

Governor Gregoire last May announced the formation of the Blue Ribbon Commission to find ways to provide accessible, affordable, quality health care for all Washingtonians.

Co-chaired by Sen. Pat Thibaudeau, the bipartisan Commission released its final report in January.

The commission outlined several key goals including access to affordable health insurance for all Washington children by 2010 and all Washingtonians by 2012. The report provides 16 specific recommendations and action steps to build a high-quality health care system, provide affordable insurance options for our families, ensure the health of the next generation and promote prevention and healthy lifestyles.

Engrossed Second Substitute Senate Bill 5930, requested by Governor Gregoire and sponsored by Sen. Karen Keiser (D-Kent), passed the Senate with 31 votes and passed the House with 63 votes. The bill takes effect 90 days after adjournment of the Legislative session, except for select sections that become effective immediately.

CERTIFICATION OF ENROLLMENT

ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1569

Chapter 260, Laws of 2007

(partial veto)

60th Legislature
2007 Regular Session

HEALTH INSURANCE--IMPROVING COVERAGE

EFFECTIVE DATE: 07/22/07

Passed by the House April 16, 2007
Yeas 61 Nays 34

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate April 12, 2007
Yeas 28 Nays 20

BRAD OWEN

President of the Senate

Approved May 2, 2007, 10:38 a.m., with
the exception of sections 3 and 17
which are vetoed.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Richard Nafziger, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1569** as passed by the House of Representatives and the Senate on the dates hereon set forth.

RICHARD NAFZIGER

Chief Clerk

FILED

May 3, 2007

**Secretary of State
State of Washington**

ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1569

AS AMENDED BY THE SENATE

Passed Legislature - 2007 Regular Session

State of Washington 60th Legislature 2007 Regular Session

By House Committee on Appropriations (originally sponsored by Representatives Cody, Campbell, Morrell, Linville, Moeller, Green, Seaquist, Conway, Dickerson, Appleton, McIntire, McCoy, Kagi, Pedersen, Kenney, Lantz, Santos, Wood and Ormsby)

READ FIRST TIME 03/05/07.

1 AN ACT Relating to improving health insurance coverage by
2 establishing a health insurance partnership for the purchase of small
3 employer health insurance coverage, evaluating the inclusion of
4 additional health insurance markets in the health insurance
5 partnership, and studying the impact of health insurance mandates;
6 amending RCW 70.47A.010, 70.47A.020, 70.47A.030, 70.47A.040, 48.21.045,
7 48.44.023, 48.46.066, 70.47A.050, 70.47A.060, and 70.47A.080; adding
8 new sections to chapter 70.47A RCW; creating new sections; repealing
9 2006 c 255 s 10 (uncodified); providing an effective date; and
10 declaring an emergency.

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

12 **Sec. 1.** RCW 70.47A.010 and 2006 c 255 s 1 are each amended to read
13 as follows:

14 (1) The legislature finds that many small employers struggle with
15 the cost of providing employer-sponsored health insurance coverage to
16 their employees, while others are unable to offer employer-sponsored
17 health insurance due to its high cost. Low-wage workers also struggle
18 with the burden of paying their share of the costs of

1 employer-sponsored health insurance, while others turn down their
2 employer's offer of coverage due to its costs.

3 (2) The legislature intends, through establishment of a (~~small~~
4 ~~employer~~) health insurance partnership program, to remove economic
5 barriers to health insurance coverage for low-wage employees of small
6 employers by building on the private sector health benefit plan system
7 and encouraging employer and employee participation in
8 employer-sponsored health benefit plan coverage.

9 **Sec. 2.** RCW 70.47A.020 and 2006 c 255 s 2 are each amended to read
10 as follows:

11 The definitions in this section apply throughout this chapter
12 unless the context clearly requires otherwise.

13 (1) "Administrator" means the administrator of the Washington state
14 health care authority, established under chapter 41.05 RCW.

15 (2) "Board" means the health insurance partnership board
16 established in section 4 of this act.

17 (3) "Eligible (~~employee~~) partnership participant" means an
18 individual who:

19 (a) Is a resident of the state of Washington;

20 (b) Has family income (~~less than~~) that does not exceed two
21 hundred percent of the federal poverty level, as determined annually by
22 the federal department of health and human services; and

23 (c) Is employed by a participating small employer or is a former
24 employee of a participating small employer who chooses to continue
25 receiving coverage through the partnership following separation from
26 employment.

27 (~~(3)~~) (4) "Health benefit plan" has the same meaning as defined
28 in RCW 48.43.005 (~~or any plan provided by a self-funded multiple~~
29 ~~employer welfare arrangement as defined in RCW 48.125.010 or by another~~
30 ~~benefit arrangement defined in the federal employee retirement income~~
31 ~~security act of 1974, as amended)).~~

32 (~~(4) "Program"~~) (5) "Participating small employer" means a small
33 employer that employs at least one eligible partnership participant and
34 has entered into an agreement with the partnership for the partnership
35 to offer and administer the small employer's group health benefit plan,
36 as defined in federal law, Sec. 706 of ERISA (29 U.S.C. Sec. 1167), for
37 enrollees in the plan.

1 (6) "Partnership" means the (~~small employer~~) health insurance
2 partnership (~~program~~) established in RCW 70.47A.030.

3 (~~(5)~~) (7) "Partnership participant" means an employee of a
4 participating small employer, or a former employee of a participating
5 small employer who chooses to continue receiving coverage through the
6 partnership following separation from employment.

7 (8) "Small employer" has the same meaning as defined in RCW
8 48.43.005.

9 (~~(6)~~) (9) "Subsidy" or "premium subsidy" means payment or
10 reimbursement to an eligible (~~employee~~) partnership participant
11 toward the purchase of a health benefit plan, and may include a net
12 billing arrangement with insurance carriers or a prospective or
13 retrospective payment for health benefit plan premiums.

14 *Sec. 3. RCW 70.47A.030 and 2006 c 255 s 3 are each amended to read
15 as follows:

16 (1) To the extent funding is appropriated in the operating budget
17 for this purpose, the (~~small employer~~) health insurance partnership
18 (~~program~~) is established. The administrator shall be responsible for
19 the implementation and operation of the (~~small employer~~) health
20 insurance partnership (~~program~~), directly or by contract. The
21 administrator shall offer premium subsidies to eligible (~~employees~~)
22 partnership participants under RCW 70.47A.040.

23 (2) Consistent with policies adopted by the board under section 4
24 of this act, the administrator shall, directly or by contract:

25 (a) Establish and administer procedures for enrolling small
26 employers in the partnership, including publicizing the existence of
27 the partnership and disseminating information on enrollment, and
28 establishing rules related to minimum participation of employees in
29 small groups purchasing health insurance through the partnership.
30 Opportunities to publicize the program for outreach and education of
31 small employers on the value of insurance shall explore the use of
32 online employer guides. As a condition of participating in the
33 partnership, a small employer must agree to establish a cafeteria plan
34 under section 125 of the federal internal revenue code that will enable
35 employees to use pretax dollars to pay their share of their health
36 benefit plan premium. The partnership shall provide technical
37 assistance to small employers for this purpose;

1 (b) Establish and administer procedures for health benefit plan
2 enrollment by employees of small employers during open enrollment
3 periods and outside of open enrollment periods upon the occurrence of
4 any qualifying event specified in the federal health insurance
5 portability and accountability act of 1996 or applicable state law.
6 Neither the employer nor the partnership shall limit an employee's
7 choice of coverage from among all the health benefit plans offered;

8 (c) Establish and manage a system for the partnership to be
9 designated as the sponsor or administrator of a participating small
10 employer health benefit plan and to undertake the obligations required
11 of a plan administrator under federal law;

12 (d) Establish and manage a system of collecting and transmitting to
13 the applicable carriers all premium payments or contributions made by
14 or on behalf of partnership participants, including employer
15 contributions, automatic payroll deductions for partnership
16 participants, premium subsidy payments, and contributions from
17 philanthropies;

18 (e) Establish and manage a system for determining eligibility for
19 and making premium subsidy payments under this act;

20 (f) Establish a mechanism to apply a surcharge to all health
21 benefit plans, which shall be used only to pay for administrative and
22 operational expenses of the partnership. The surcharge must be applied
23 uniformly to all health benefit plans offered through the partnership
24 and must be included in the premium for each health benefit plan.
25 Surcharges may not be used to pay any premium assistance payments under
26 this chapter;

27 (g) Design a schedule of premium subsidies that is based upon gross
28 family income, giving appropriate consideration to family size and the
29 ages of all family members based on a benchmark health benefit plan
30 designated by the board. The amount of an eligible partnership
31 participant's premium subsidy shall be determined by applying a sliding
32 scale subsidy schedule with the percentage of premium similar to that
33 developed for subsidized basic health plan enrollees under RCW
34 70.47.060. The subsidy shall be applied to the employee's premium
35 obligation for his or her health benefit plan, so that employees
36 benefit financially from any employer contribution to the cost of their
37 coverage through the partnership. Employees shall not be eligible for
38 premium assistance if they have immediately transitioned from employer-

1 sponsored insurance, until they have fulfilled a six-month waiting
2 period. During that time, the employee may participate in the program
3 but not receive state-sponsored premium assistance.

4 (3) The administrator may enter into interdepartmental agreements
5 with the office of the insurance commissioner, the department of social
6 and health services, and any other state agencies necessary to
7 implement this chapter.

*Sec. 3 was vetoed. See message at end of chapter.

8 NEW SECTION. Sec. 4. A new section is added to chapter 70.47A RCW
9 to read as follows:

10 (1) The health insurance partnership board is hereby established.
11 The governor shall appoint a seven-member health insurance partnership
12 board by June 30, 2007. The board shall be composed of persons with
13 expertise in the health insurance market and benefit design, and be
14 chaired by the administrator.

15 (2) The governor shall appoint the initial members of the board to
16 staggered terms not to exceed four years. Initial appointments shall
17 be made on or before June 1, 2007. Members appointed thereafter shall
18 serve two-year terms. Members of the board shall be compensated in
19 accordance with RCW 43.03.250 and shall be reimbursed for their travel
20 expenses while on official business in accordance with RCW 43.03.050
21 and 43.03.060. The board shall prescribe rules for the conduct of its
22 business. Meetings of the board shall be at the call of the chair.

23 (3) The board may establish technical advisory committees or seek
24 the advice of technical experts when necessary to execute the powers
25 and duties included in this section.

26 (4) The board and employees of the board shall not be civilly or
27 criminally liable and shall not have any penalty or cause of action of
28 any nature arise against them for any action taken or not taken,
29 including any discretionary decision or failure to make a discretionary
30 decision, when the action or inaction is done in good faith and in the
31 performance of the powers and duties under this chapter. Nothing in
32 this section prohibits legal actions against the board to enforce the
33 board's statutory or contractual duties or obligations.

34 NEW SECTION. Sec. 5. A new section is added to chapter 70.47A RCW
35 to read as follows:

36 (1) The health insurance partnership board shall:

1 (a) Develop policies for enrollment of small employers in the
2 partnership, including minimum participation rules for small employer
3 groups. The small employer shall determine the criteria for
4 eligibility and enrollment in his or her plan and the terms and amounts
5 of the employer's contributions to that plan, consistent with any
6 minimum employer premium contribution level established by the board
7 under (d) of this subsection;

8 (b) Designate health benefit plans that are currently offered in
9 the small group market that will qualify for premium subsidy payments.
10 At least four health benefit plans shall be chosen, with multiple
11 deductible and point-of-service cost-sharing options. The health
12 benefit plans shall range from catastrophic to comprehensive coverage,
13 and one health benefit plan shall be a high deductible health plan.
14 Every effort shall be made to include health benefit plans that include
15 components to maximize the quality of care provided and result in
16 improved health outcomes, such as preventive care, wellness incentives,
17 chronic care management services, and provider network development and
18 payment policies related to quality of care;

19 (c) Approve a mid-range benefit plan from those selected to be used
20 as a benchmark plan for calculating premium subsidies;

21 (d) Determine whether there should be a minimum employer premium
22 contribution on behalf of employees, and if so, how much;

23 (e) Determine appropriate health benefit plan rating methodologies.
24 The methodologies shall be based on the small group adjusted community
25 rate as defined in Title 48 RCW. The board shall evaluate the impact
26 of applying the small group community rating with the partnership
27 principle of allowing each employee to choose their health benefit
28 plan, and consider options to reduce uncertainty for carriers and
29 provide for efficient risk management of high-cost enrollees through
30 risk adjustment, reinsurance, or other mechanisms;

31 (f) Conduct analyses and provide recommendations as requested by
32 the legislature and the governor, with the assistance of staff from the
33 health care authority and the office of the insurance commissioner.

34 (2) The board may authorize one or more limited health care service
35 plans for dental care services to be offered by limited health care
36 service contractors under RCW 48.44.035. However, such plan shall not
37 qualify for subsidy payments.

1 (3) In fulfilling the requirements of this section, the board shall
2 consult with small employers, the office of the insurance commissioner,
3 members in good standing of the American academy of actuaries, health
4 carriers, agents and brokers, and employees of small business.

5 **Sec. 6.** RCW 70.47A.040 and 2006 c 255 s 4 are each amended to read
6 as follows:

7 ~~((1))~~ Beginning ~~((July 1, 2007))~~ September 1, 2008, the
8 administrator shall accept applications from eligible ~~((employees))~~
9 partnership participants, on behalf of themselves, their spouses, and
10 their dependent children, to receive premium subsidies through the
11 ~~((small employer))~~ health insurance partnership ~~((program))~~.

12 ~~((2) Premium subsidy payments may be provided to eligible
13 employees if:~~

14 ~~(a) The eligible employee is employed by a small employer;~~

15 ~~(b) The actuarial value of the health benefit plan offered by the
16 small employer is at least equivalent to that of the basic health plan
17 benefit offered under chapter 70.47 RCW. The office of the insurance
18 commissioner under Title 48 RCW shall certify those small employer
19 health benefit plans that are at least actuarially equivalent to the
20 basic health plan benefit; and~~

21 ~~(c) The small employer will pay at least forty percent of the
22 monthly premium cost for health benefit plan coverage of the eligible
23 employee.~~

24 ~~(3) The amount of an eligible employee's premium subsidy shall be
25 determined by applying the sliding scale subsidy schedule developed for
26 subsidized basic health plan enrollees under RCW 70.47.060 to the
27 employee's premium obligation for his or her employer's health benefit
28 plan.~~

29 ~~(4) After an eligible individual has enrolled in the program, the
30 program shall issue subsidies in an amount determined pursuant to
31 subsection (3) of this section to either the eligible employee or to
32 the carrier designated by the eligible employee.~~

33 ~~(5) An eligible employee must agree to provide verification of
34 continued enrollment in his or her small employer's health benefit plan
35 on a semiannual basis or to notify the administrator whenever his or
36 her enrollment status changes, whichever is earlier. Verification or
37 notification may be made directly by the employee, or through his or~~

1 ~~her employer or the carrier providing the small employer health benefit~~
2 ~~plan. When necessary, the administrator has the authority to perform~~
3 ~~retrospective audits on premium subsidy accounts. The administrator~~
4 ~~may suspend or terminate an employee's participation in the program and~~
5 ~~seek repayment of any subsidy amounts paid due to the omission or~~
6 ~~misrepresentation of an applicant or enrolled employee. The~~
7 ~~administrator shall adopt rules to define the appropriate application~~
8 ~~of these sanctions and the processes to implement the sanctions~~
9 ~~provided in this subsection, within available resources.))~~

10 **Sec. 7.** RCW 48.21.045 and 2004 c 244 s 1 are each amended to read
11 as follows:

12 (1)(a) An insurer offering any health benefit plan to a small
13 employer, either directly or through an association or member-governed
14 group formed specifically for the purpose of purchasing health care,
15 may offer and actively market to the small employer a health benefit
16 plan featuring a limited schedule of covered health care services.
17 Nothing in this subsection shall preclude an insurer from offering, or
18 a small employer from purchasing, other health benefit plans that may
19 have more comprehensive benefits than those included in the product
20 offered under this subsection. An insurer offering a health benefit
21 plan under this subsection shall clearly disclose all covered benefits
22 to the small employer in a brochure filed with the commissioner.

23 (b) A health benefit plan offered under this subsection shall
24 provide coverage for hospital expenses and services rendered by a
25 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
26 to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142,
27 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200,
28 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240, 48.21.244,
29 48.21.250, 48.21.300, 48.21.310, or 48.21.320.

30 (2) Nothing in this section shall prohibit an insurer from
31 offering, or a purchaser from seeking, health benefit plans with
32 benefits in excess of the health benefit plan offered under subsection
33 (1) of this section. All forms, policies, and contracts shall be
34 submitted for approval to the commissioner, and the rates of any plan
35 offered under this section shall be reasonable in relation to the
36 benefits thereto.

1 (3) Premium rates for health benefit plans for small employers as
2 defined in this section shall be subject to the following provisions:

3 (a) The insurer shall develop its rates based on an adjusted
4 community rate and may only vary the adjusted community rate for:

- 5 (i) Geographic area;
- 6 (ii) Family size;
- 7 (iii) Age; and
- 8 (iv) Wellness activities.

9 (b) The adjustment for age in (a)(iii) of this subsection may not
10 use age brackets smaller than five-year increments, which shall begin
11 with age twenty and end with age sixty-five. Employees under the age
12 of twenty shall be treated as those age twenty.

13 (c) The insurer shall be permitted to develop separate rates for
14 individuals age sixty-five or older for coverage for which medicare is
15 the primary payer and coverage for which medicare is not the primary
16 payer. Both rates shall be subject to the requirements of this
17 subsection (3).

18 (d) The permitted rates for any age group shall be no more than
19 four hundred twenty-five percent of the lowest rate for all age groups
20 on January 1, 1996, four hundred percent on January 1, 1997, and three
21 hundred seventy-five percent on January 1, 2000, and thereafter.

22 (e) A discount for wellness activities shall be permitted to
23 reflect actuarially justified differences in utilization or cost
24 attributed to such programs.

25 (f) The rate charged for a health benefit plan offered under this
26 section may not be adjusted more frequently than annually except that
27 the premium may be changed to reflect:

- 28 (i) Changes to the enrollment of the small employer;
- 29 (ii) Changes to the family composition of the employee;
- 30 (iii) Changes to the health benefit plan requested by the small
31 employer; or
- 32 (iv) Changes in government requirements affecting the health
33 benefit plan.

34 (g) Rating factors shall produce premiums for identical groups that
35 differ only by the amounts attributable to plan design, with the
36 exception of discounts for health improvement programs.

37 (h) For the purposes of this section, a health benefit plan that
38 contains a restricted network provision shall not be considered similar

1 coverage to a health benefit plan that does not contain such a
2 provision, provided that the restrictions of benefits to network
3 providers result in substantial differences in claims costs. A carrier
4 may develop its rates based on claims costs due to network provider
5 reimbursement schedules or type of network. This subsection does not
6 restrict or enhance the portability of benefits as provided in RCW
7 48.43.015.

8 (i) Adjusted community rates established under this section shall
9 pool the medical experience of all small groups purchasing coverage,
10 including the small group participants in the health insurance
11 partnership established in RCW 70.47A.030. However, annual rate
12 adjustments for each small group health benefit plan may vary by up to
13 plus or minus four percentage points from the overall adjustment of a
14 carrier's entire small group pool, such overall adjustment to be
15 approved by the commissioner, upon a showing by the carrier, certified
16 by a member of the American academy of actuaries that: (i) The
17 variation is a result of deductible leverage, benefit design, or
18 provider network characteristics; and (ii) for a rate renewal period,
19 the projected weighted average of all small group benefit plans will
20 have a revenue neutral effect on the carrier's small group pool.
21 Variations of greater than four percentage points are subject to review
22 by the commissioner, and must be approved or denied within sixty days
23 of submittal. A variation that is not denied within sixty days shall
24 be deemed approved. The commissioner must provide to the carrier a
25 detailed actuarial justification for any denial within thirty days of
26 the denial.

27 (4) Nothing in this section shall restrict the right of employees
28 to collectively bargain for insurance providing benefits in excess of
29 those provided herein.

30 (5)(a) Except as provided in this subsection, requirements used by
31 an insurer in determining whether to provide coverage to a small
32 employer shall be applied uniformly among all small employers applying
33 for coverage or receiving coverage from the carrier.

34 (b) An insurer shall not require a minimum participation level
35 greater than:

36 (i) One hundred percent of eligible employees working for groups
37 with three or less employees; and

1 (ii) Seventy-five percent of eligible employees working for groups
2 with more than three employees.

3 (c) In applying minimum participation requirements with respect to
4 a small employer, a small employer shall not consider employees or
5 dependents who have similar existing coverage in determining whether
6 the applicable percentage of participation is met.

7 (d) An insurer may not increase any requirement for minimum
8 employee participation or modify any requirement for minimum employer
9 contribution applicable to a small employer at any time after the small
10 employer has been accepted for coverage.

11 (6) An insurer must offer coverage to all eligible employees of a
12 small employer and their dependents. An insurer may not offer coverage
13 to only certain individuals or dependents in a small employer group or
14 to only part of the group. An insurer may not modify a health plan
15 with respect to a small employer or any eligible employee or dependent,
16 through riders, endorsements or otherwise, to restrict or exclude
17 coverage or benefits for specific diseases, medical conditions, or
18 services otherwise covered by the plan.

19 (7) As used in this section, "health benefit plan," "small
20 employer," "adjusted community rate," and "wellness activities" mean
21 the same as defined in RCW 48.43.005.

22 **Sec. 8.** RCW 48.44.023 and 2004 c 244 s 7 are each amended to read
23 as follows:

24 (1)(a) A health care services contractor offering any health
25 benefit plan to a small employer, either directly or through an
26 association or member-governed group formed specifically for the
27 purpose of purchasing health care, may offer and actively market to the
28 small employer a health benefit plan featuring a limited schedule of
29 covered health care services. Nothing in this subsection shall
30 preclude a contractor from offering, or a small employer from
31 purchasing, other health benefit plans that may have more comprehensive
32 benefits than those included in the product offered under this
33 subsection. A contractor offering a health benefit plan under this
34 subsection shall clearly disclose all covered benefits to the small
35 employer in a brochure filed with the commissioner.

36 (b) A health benefit plan offered under this subsection shall
37 provide coverage for hospital expenses and services rendered by a

1 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
2 to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290,
3 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335,
4 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and
5 48.44.460.

6 (2) Nothing in this section shall prohibit a health care service
7 contractor from offering, or a purchaser from seeking, health benefit
8 plans with benefits in excess of the health benefit plan offered under
9 subsection (1) of this section. All forms, policies, and contracts
10 shall be submitted for approval to the commissioner, and the rates of
11 any plan offered under this section shall be reasonable in relation to
12 the benefits thereto.

13 (3) Premium rates for health benefit plans for small employers as
14 defined in this section shall be subject to the following provisions:

15 (a) The contractor shall develop its rates based on an adjusted
16 community rate and may only vary the adjusted community rate for:

- 17 (i) Geographic area;
- 18 (ii) Family size;
- 19 (iii) Age; and
- 20 (iv) Wellness activities.

21 (b) The adjustment for age in (a)(iii) of this subsection may not
22 use age brackets smaller than five-year increments, which shall begin
23 with age twenty and end with age sixty-five. Employees under the age
24 of twenty shall be treated as those age twenty.

25 (c) The contractor shall be permitted to develop separate rates for
26 individuals age sixty-five or older for coverage for which medicare is
27 the primary payer and coverage for which medicare is not the primary
28 payer. Both rates shall be subject to the requirements of this
29 subsection (3).

30 (d) The permitted rates for any age group shall be no more than
31 four hundred twenty-five percent of the lowest rate for all age groups
32 on January 1, 1996, four hundred percent on January 1, 1997, and three
33 hundred seventy-five percent on January 1, 2000, and thereafter.

34 (e) A discount for wellness activities shall be permitted to
35 reflect actuarially justified differences in utilization or cost
36 attributed to such programs.

37 (f) The rate charged for a health benefit plan offered under this

1 section may not be adjusted more frequently than annually except that
2 the premium may be changed to reflect:

3 (i) Changes to the enrollment of the small employer;

4 (ii) Changes to the family composition of the employee;

5 (iii) Changes to the health benefit plan requested by the small
6 employer; or

7 (iv) Changes in government requirements affecting the health
8 benefit plan.

9 (g) Rating factors shall produce premiums for identical groups that
10 differ only by the amounts attributable to plan design, with the
11 exception of discounts for health improvement programs.

12 (h) For the purposes of this section, a health benefit plan that
13 contains a restricted network provision shall not be considered similar
14 coverage to a health benefit plan that does not contain such a
15 provision, provided that the restrictions of benefits to network
16 providers result in substantial differences in claims costs. A carrier
17 may develop its rates based on claims costs due to network provider
18 reimbursement schedules or type of network. This subsection does not
19 restrict or enhance the portability of benefits as provided in RCW
20 48.43.015.

21 (i) Adjusted community rates established under this section shall
22 pool the medical experience of all groups purchasing coverage,
23 including the small group participants in the health insurance
24 partnership established in RCW 70.47A.030. However, annual rate
25 adjustments for each small group health benefit plan may vary by up to
26 plus or minus four percentage points from the overall adjustment of a
27 carrier's entire small group pool, such overall adjustment to be
28 approved by the commissioner, upon a showing by the carrier, certified
29 by a member of the American academy of actuaries that: (i) The
30 variation is a result of deductible leverage, benefit design, or
31 provider network characteristics; and (ii) for a rate renewal period,
32 the projected weighted average of all small group benefit plans will
33 have a revenue neutral effect on the carrier's small group pool.
34 Variations of greater than four percentage points are subject to review
35 by the commissioner, and must be approved or denied within sixty days
36 of submittal. A variation that is not denied within sixty days shall
37 be deemed approved. The commissioner must provide to the carrier a

1 detailed actuarial justification for any denial within thirty days of
2 the denial.

3 (4) Nothing in this section shall restrict the right of employees
4 to collectively bargain for insurance providing benefits in excess of
5 those provided herein.

6 (5)(a) Except as provided in this subsection, requirements used by
7 a contractor in determining whether to provide coverage to a small
8 employer shall be applied uniformly among all small employers applying
9 for coverage or receiving coverage from the carrier.

10 (b) A contractor shall not require a minimum participation level
11 greater than:

12 (i) One hundred percent of eligible employees working for groups
13 with three or less employees; and

14 (ii) Seventy-five percent of eligible employees working for groups
15 with more than three employees.

16 (c) In applying minimum participation requirements with respect to
17 a small employer, a small employer shall not consider employees or
18 dependents who have similar existing coverage in determining whether
19 the applicable percentage of participation is met.

20 (d) A contractor may not increase any requirement for minimum
21 employee participation or modify any requirement for minimum employer
22 contribution applicable to a small employer at any time after the small
23 employer has been accepted for coverage.

24 (6) A contractor must offer coverage to all eligible employees of
25 a small employer and their dependents. A contractor may not offer
26 coverage to only certain individuals or dependents in a small employer
27 group or to only part of the group. A contractor may not modify a
28 health plan with respect to a small employer or any eligible employee
29 or dependent, through riders, endorsements or otherwise, to restrict or
30 exclude coverage or benefits for specific diseases, medical conditions,
31 or services otherwise covered by the plan.

32 **Sec. 9.** RCW 48.46.066 and 2004 c 244 s 9 are each amended to read
33 as follows:

34 (1)(a) A health maintenance organization offering any health
35 benefit plan to a small employer, either directly or through an
36 association or member-governed group formed specifically for the
37 purpose of purchasing health care, may offer and actively market to the

1 small employer a health benefit plan featuring a limited schedule of
2 covered health care services. Nothing in this subsection shall
3 preclude a health maintenance organization from offering, or a small
4 employer from purchasing, other health benefit plans that may have more
5 comprehensive benefits than those included in the product offered under
6 this subsection. A health maintenance organization offering a health
7 benefit plan under this subsection shall clearly disclose all the
8 covered benefits to the small employer in a brochure filed with the
9 commissioner.

10 (b) A health benefit plan offered under this subsection shall
11 provide coverage for hospital expenses and services rendered by a
12 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
13 to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290,
14 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510,
15 48.46.520, and 48.46.530.

16 (2) Nothing in this section shall prohibit a health maintenance
17 organization from offering, or a purchaser from seeking, health benefit
18 plans with benefits in excess of the health benefit plan offered under
19 subsection (1) of this section. All forms, policies, and contracts
20 shall be submitted for approval to the commissioner, and the rates of
21 any plan offered under this section shall be reasonable in relation to
22 the benefits thereto.

23 (3) Premium rates for health benefit plans for small employers as
24 defined in this section shall be subject to the following provisions:

25 (a) The health maintenance organization shall develop its rates
26 based on an adjusted community rate and may only vary the adjusted
27 community rate for:

- 28 (i) Geographic area;
- 29 (ii) Family size;
- 30 (iii) Age; and
- 31 (iv) Wellness activities.

32 (b) The adjustment for age in (a)(iii) of this subsection may not
33 use age brackets smaller than five-year increments, which shall begin
34 with age twenty and end with age sixty-five. Employees under the age
35 of twenty shall be treated as those age twenty.

36 (c) The health maintenance organization shall be permitted to
37 develop separate rates for individuals age sixty-five or older for

1 coverage for which medicare is the primary payer and coverage for which
2 medicare is not the primary payer. Both rates shall be subject to the
3 requirements of this subsection (3).

4 (d) The permitted rates for any age group shall be no more than
5 four hundred twenty-five percent of the lowest rate for all age groups
6 on January 1, 1996, four hundred percent on January 1, 1997, and three
7 hundred seventy-five percent on January 1, 2000, and thereafter.

8 (e) A discount for wellness activities shall be permitted to
9 reflect actuarially justified differences in utilization or cost
10 attributed to such programs.

11 (f) The rate charged for a health benefit plan offered under this
12 section may not be adjusted more frequently than annually except that
13 the premium may be changed to reflect:

14 (i) Changes to the enrollment of the small employer;

15 (ii) Changes to the family composition of the employee;

16 (iii) Changes to the health benefit plan requested by the small
17 employer; or

18 (iv) Changes in government requirements affecting the health
19 benefit plan.

20 (g) Rating factors shall produce premiums for identical groups that
21 differ only by the amounts attributable to plan design, with the
22 exception of discounts for health improvement programs.

23 (h) For the purposes of this section, a health benefit plan that
24 contains a restricted network provision shall not be considered similar
25 coverage to a health benefit plan that does not contain such a
26 provision, provided that the restrictions of benefits to network
27 providers result in substantial differences in claims costs. A carrier
28 may develop its rates based on claims costs due to network provider
29 reimbursement schedules or type of network. This subsection does not
30 restrict or enhance the portability of benefits as provided in RCW
31 48.43.015.

32 (i) Adjusted community rates established under this section shall
33 pool the medical experience of all groups purchasing coverage,
34 including the small group participants in the health insurance
35 partnership established in RCW 70.47A.030. However, annual rate
36 adjustments for each small group health benefit plan may vary by up to
37 plus or minus four percentage points from the overall adjustment of a
38 carrier's entire small group pool, such overall adjustment to be

1 approved by the commissioner, upon a showing by the carrier, certified
2 by a member of the American academy of actuaries that: (i) The
3 variation is a result of deductible leverage, benefit design, or
4 provider network characteristics; and (ii) for a rate renewal period,
5 the projected weighted average of all small group benefit plans will
6 have a revenue neutral effect on the carrier's small group pool.
7 Variations of greater than four percentage points are subject to review
8 by the commissioner, and must be approved or denied within sixty days
9 of submittal. A variation that is not denied within sixty days shall
10 be deemed approved. The commissioner must provide to the carrier a
11 detailed actuarial justification for any denial within thirty days of
12 the denial.

13 (4) Nothing in this section shall restrict the right of employees
14 to collectively bargain for insurance providing benefits in excess of
15 those provided herein.

16 (5)(a) Except as provided in this subsection, requirements used by
17 a health maintenance organization in determining whether to provide
18 coverage to a small employer shall be applied uniformly among all small
19 employers applying for coverage or receiving coverage from the carrier.

20 (b) A health maintenance organization shall not require a minimum
21 participation level greater than:

22 (i) One hundred percent of eligible employees working for groups
23 with three or less employees; and

24 (ii) Seventy-five percent of eligible employees working for groups
25 with more than three employees.

26 (c) In applying minimum participation requirements with respect to
27 a small employer, a small employer shall not consider employees or
28 dependents who have similar existing coverage in determining whether
29 the applicable percentage of participation is met.

30 (d) A health maintenance organization may not increase any
31 requirement for minimum employee participation or modify any
32 requirement for minimum employer contribution applicable to a small
33 employer at any time after the small employer has been accepted for
34 coverage.

35 (6) A health maintenance organization must offer coverage to all
36 eligible employees of a small employer and their dependents. A health
37 maintenance organization may not offer coverage to only certain
38 individuals or dependents in a small employer group or to only part of

1 the group. A health maintenance organization may not modify a health
2 plan with respect to a small employer or any eligible employee or
3 dependent, through riders, endorsements or otherwise, to restrict or
4 exclude coverage or benefits for specific diseases, medical conditions,
5 or services otherwise covered by the plan.

6 NEW SECTION. **Sec. 10.** On or before December 1, 2008, the health
7 insurance partnership board shall submit a preliminary report to the
8 governor and the legislature that includes an implementation plan to
9 incorporate the individual and small group health insurance markets
10 into the partnership program. In preparing the report, the board shall
11 examine at least the following issues:

12 (1) The impact of these markets being incorporated into the
13 partnership, with respect to the utilization of services and cost of
14 health plans offered through the partnership;

15 (2) The impact of applying small group health benefit plan
16 regulations on access to health services and the cost of coverage for
17 these markets; and

18 (3) How the composition of the board should be modified to reflect
19 the incorporation of the individual and small group markets in the
20 partnership.

21 NEW SECTION. **Sec. 11.** On or before September 1, 2009, the health
22 insurance partnership board shall submit a report and recommendations
23 to the governor and the legislature regarding:

24 (1) The risks and benefits of additional markets participating in
25 the partnership:

26 (a) The report shall examine the following markets:

27 (i) Washington state health insurance pool under chapter 48.41 RCW;

28 (ii) Basic health plan under chapter 70.47 RCW;

29 (iii) Public employees' benefits board enrollees under chapter
30 41.05 RCW;

31 (iv) Public school employees; and

32 (v) Any final recommendations for the individual and small group
33 markets, relevant to the study outlined in section 10 of this act; and

34 (b) The report shall examine at least the following issues:

35 (i) The impact of these markets participating in the partnership,

1 with respect to the utilization of services and cost of health plans
2 offered through the partnership;

3 (ii) Whether any distinction should be made in participation
4 between active and retired employees enrolled in public employees'
5 benefits board plans, giving consideration to the implicit subsidy that
6 nonmedicare-eligible retirees currently benefit from by being pooled
7 with active employees, and how medicare-eligible retirees would be
8 affected;

9 (iii) The impact of applying small group health benefit plan
10 regulations on access to health services and the cost of coverage for
11 these markets; and

12 (iv) If the board recommends the inclusion of additional markets,
13 how the composition of the board should be modified to reflect the
14 participation of these markets; and

15 (2) The risks and benefits of establishing a requirement that
16 residents of the state of Washington age eighteen and over obtain and
17 maintain affordable creditable coverage, as defined in the federal
18 health insurance portability and accountability act of 1996 (42 U.S.C.
19 Sec. 300gg(c)). The report shall address the question of how a
20 requirement that residents maintain coverage could be enforced in the
21 state of Washington.

22 **Sec. 12.** RCW 70.47A.050 and 2006 c 255 s 5 are each amended to
23 read as follows:

24 Enrollment in the ((small-employer)) health insurance partnership
25 ((program)) is not an entitlement and shall not result in expenditures
26 that exceed the amount that has been appropriated for the program in
27 the operating budget. If it appears that continued enrollment will
28 result in expenditures exceeding the appropriated level for a
29 particular fiscal year, the administrator may freeze new enrollment in
30 the program and establish a waiting list of eligible employees who
31 shall receive subsidies only when sufficient funds are available.

32 **Sec. 13.** RCW 70.47A.060 and 2006 c 255 s 6 are each amended to
33 read as follows:

34 The administrator shall adopt all rules necessary for the
35 implementation and operation of the ((small-employer)) health insurance
36 partnership ((program)). As part of the rule development process, the

1 administrator shall consult with small employers, carriers, employee
2 organizations, and the office of the insurance commissioner under Title
3 48 RCW to determine an effective and efficient method for the payment
4 of subsidies under this chapter. All rules shall be adopted in
5 accordance with chapter 34.05 RCW.

6 **Sec. 14.** RCW 70.47A.080 and 2006 c 255 s 8 are each amended to
7 read as follows:

8 The (~~small employer~~) health insurance partnership (~~program~~)
9 account is hereby established in the custody of the state treasurer.
10 Any nongeneral fund--state funds collected for the (~~small employer~~)
11 health insurance partnership (~~program~~) shall be deposited in the
12 (~~small employer~~) health insurance partnership (~~program~~) account.
13 Moneys in the account shall be used exclusively for the purposes of
14 administering the (~~small employer~~) health insurance partnership
15 (~~program~~), including payments to (~~participating managed health care~~
16 ~~systems~~) insurance carriers on behalf of (~~small employer~~) health
17 insurance partnership enrollees. Only the administrator of the health
18 care authority or his or her designee may authorize expenditures from
19 the account. The account is subject to allotment procedures under
20 chapter 43.88 RCW, but an appropriation is not required for
21 expenditures.

22 NEW SECTION. **Sec. 15.** (1) The office of the insurance
23 commissioner shall contract for an independent study of health benefit
24 mandates, rating requirements, and insurance statutes and rules to
25 determine the impact on premiums and individuals' health if those
26 statutes or rules were amended or repealed.

27 (2) The office of the insurance commissioner shall submit an
28 interim report to the governor and appropriate committees of the
29 legislature by December 1, 2007, and a final report by December 1,
30 2008.

31 NEW SECTION. **Sec. 16.** 2006 c 255 s 10 (uncodified) is repealed.

32 ****NEW SECTION. Sec. 17. Sections 1 through 6 of this act are***
33 ***necessary for the immediate preservation of the public peace, health,***

1 **or safety, or support of the state government and its existing public**
2 **institutions, and take effect July 1, 2007.**

**Sec. 17 was vetoed. See message at end of chapter.*

3 NEW SECTION. **Sec. 18.** If specific funding for the purposes of the
4 following sections of this act, referencing the section of this act by
5 bill or chapter number and section number, is not provided by June 30,
6 2007, in the omnibus appropriations act, the section is null and void:

- 7 (1) Section 5 (health insurance partnership board);
8 (2) Section 15 (office of insurance commissioner independent
9 study).

Passed by the House April 16, 2007.

Passed by the Senate April 12, 2007.

Approved by the Governor May 2, 2007, with the exception of
certain items that were vetoed.

Filed in Office of Secretary of State May 3, 2007.

Note: Governor's explanation of partial veto is as follows:

"I am returning, without my approval as to Sections 3 and 17,
Engrossed Second Substitute House Bill 1569 entitled:

"AN ACT Relating to improving health insurance coverage by
establishing a health insurance partnership for the purchase of small
employer health insurance coverage, evaluating the inclusion of
additional health insurance markets in the health insurance
partnership, and studying the impact of health insurance mandates."

This bill creates the Washington Health Insurance Partnership (WHP),
an innovative approach to providing affordable health care in this
state. By combining public and private resources, and creating a
mechanism to organize and improve access to the insurance market, WHP
will offer choice and assistance to small business employees seeking
coverage for themselves and their families, and I welcome it.

Section 3 of the bill, which sets forth many of the operational
details of the WHP program, is virtually identical to Section 58 of
Engrossed Second Substitute Senate Bill 5930. However, it adds the
requirement that eligible employees who transition from employer-
sponsored insurance to the WHP program wait six months before
receiving a subsidy. This requirement could unintentionally delay
assistance to someone at the very point they most need it -- when
they have lost their job and are attempting to retain health benefits
provided through the WHP.

Section 17 of the bill is an emergency clause, and would allow
certain sections of the bill to become effective on July 1. The
emergency clause is not essential to the proper and timely
implementation of the bill.

For these reasons, I have vetoed Sections 3 and 17 of Engrossed
Second Substitute House Bill 1569.

With the exception of Sections 3 and 17, Engrossed Second Substitute
House Bill 1569 is approved."

CERTIFICATION OF ENROLLMENT

ENGROSSED SECOND SUBSTITUTE SENATE BILL 5930

Chapter 259, Laws of 2007

(partial veto)

60th Legislature
2007 Regular Session

BLUE RIBBON COMMISSION ON HEALTH CARE COSTS AND ACCESS--
IMPLEMENTING RECOMMENDATIONS

EFFECTIVE DATE: 07/22/07 - Except sections 18 through 22, which become effective 01/01/09; and section 30, which becomes effective 05/02/07.

Passed by the Senate April 21, 2007
YEAS 31 NAYS 17

BRAD OWEN

President of the Senate

Passed by the House April 20, 2007
YEAS 63 NAYS 35

FRANK CHOPP

Speaker of the House of Representatives

Approved May 2, 2007, 10:36 a.m., with the exception of sections 59 and 74 which are vetoed.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE SENATE BILL 5930** as passed by the Senate and the House of Representatives on the dates hereon set forth.

THOMAS HOEMANN

Secretary

FILED

May 3, 2007

**Secretary of State
State of Washington**

ENGROSSED SECOND SUBSTITUTE SENATE BILL 5930

AS RECOMMENDED BY THE CONFERENCE COMMITTEE

Passed Legislature - 2007 Regular Session

State of Washington 60th Legislature 2007 Regular Session

By Senate Committee on Ways & Means (originally sponsored by Senators Keiser, Kohl-Welles, Shin and Rasmussen; by request of Governor Gregoire)

READ FIRST TIME 03/05/07.

1 AN ACT Relating to providing high quality, affordable health care
2 to Washingtonians based on the recommendations of the blue ribbon
3 commission on health care costs and access; amending RCW 7.70.060,
4 70.83.040, 43.70.110, 70.56.030, 48.41.110, 48.41.160, 48.41.200,
5 48.41.037, 48.41.100, 48.41.120, 48.43.005, 48.41.190, 41.05.075,
6 70.47.020, 70.47.060, 48.43.018, 43.70.670, 41.05.540, 70.38.015,
7 70.38.135, 70.47A.030, 43.70.520, and 70.48.130; reenacting and
8 amending RCW 42.56.360; adding new sections to chapter 41.05 RCW;
9 adding new sections to chapter 74.09 RCW; adding new sections to
10 chapter 43.70 RCW; adding a new section to chapter 70.83 RCW; adding a
11 new section to chapter 48.20 RCW; adding a new section to chapter 48.21
12 RCW; adding a new section to chapter 48.44 RCW; adding a new section to
13 chapter 48.46 RCW; adding a new section to chapter 48.43 RCW; adding a
14 new section to chapter 70.47A RCW; adding a new chapter to Title 70
15 RCW; adding a new chapter to Title 43 RCW; repealing RCW 70.38.919;
16 repealing 2006 c 255 s 10 (uncodified); prescribing penalties;
17 providing effective dates; providing expiration dates; and declaring an
18 emergency.

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

1 **USE STATE PURCHASING TO IMPROVE HEALTH CARE QUALITY**

2 NEW SECTION. **Sec. 1.** (1) The health care authority and the
3 department of social and health services shall, by September 1, 2007,
4 develop a five-year plan to change reimbursement within their health
5 care programs to:

6 (a) Reward quality health outcomes rather than simply paying for
7 the receipt of particular services or procedures;

8 (b) Pay for care that reflects patient preference and is of proven
9 value;

10 (c) Require the use of evidence-based standards of care where
11 available;

12 (d) Tie provider rate increases to measurable improvements in
13 access to quality care;

14 (e) Direct enrollees to quality care systems;

15 (f) Better support primary care and provide a medical home to all
16 enrollees through reimbursement policies that create incentives for
17 providers to enter and remain in primary care practice and that address
18 disparities in payment between specialty procedures and primary care
19 services; and

20 (g) Pay for e-mail consultations, telemedicine, and telehealth
21 where doing so reduces the overall cost of care.

22 (2) In developing any component of the plan that links payment to
23 health care provider performance, the authority and the department
24 shall work in collaboration with the department of health, health
25 carriers, local public health jurisdictions, physicians and other
26 health care providers, the Puget Sound health alliance, and other
27 purchasers.

28 (3) The plan shall (a) identify any existing barriers and
29 opportunities to support implementation, including needed changes to
30 state or federal law; (b) identify the goals the plan is intended to
31 achieve and how progress toward those goals will be measured; and (c)
32 be submitted to the governor and the legislature upon completion. The
33 agencies shall report to the legislature by September 1, 2007. Any
34 component of the plan that links payment to health care provider
35 performance must be submitted to the legislature for consideration
36 prior to implementation by the department or the authority.

1 NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05 RCW
2 to read as follows:

3 (1) The legislature finds that there is growing evidence that, for
4 preference-sensitive care involving elective surgery, patient-
5 practitioner communication is improved through the use of high-quality
6 decision aids that detail the benefits, harms, and uncertainty of
7 available treatment options. Improved communication leads to more
8 fully informed patient decisions. The legislature intends to increase
9 the extent to which patients make genuinely informed, preference-based
10 treatment decisions, by promoting public/private collaborative efforts
11 to broaden the development, certification, use, and evaluation of
12 effective decision aids and by recognition of shared decision making
13 and patient decision aids in the state's laws on informed consent.

14 (2) The health care authority shall implement a shared
15 decision-making demonstration project. The demonstration project shall
16 be conducted at one or more multispecialty group practice sites
17 providing state purchased health care in the state of Washington, and
18 may include other practice sites providing state purchased health care.
19 The demonstration project shall include the following elements:

20 (a) Incorporation into clinical practice of one or more decision
21 aids for one or more identified preference-sensitive care areas
22 combined with ongoing training and support of involved practitioners
23 and practice teams, preferably at sites with necessary supportive
24 health information technology;

25 (b) An evaluation of the impact of the use of shared decision
26 making with decision aids, including the use of preference-sensitive
27 health care services selected for the demonstration project and
28 expenditures for those services, the impact on patients, including
29 patient understanding of the treatment options presented and
30 concordance between patient values and the care received, and patient
31 and practitioner satisfaction with the shared decision-making process;
32 and

33 (c) As a condition of participating in the demonstration project,
34 a participating practice site must bear the cost of selecting,
35 purchasing, and incorporating the chosen decision aids into clinical
36 practice.

37 (3) The health care authority may solicit and accept funding and

1 in-kind contributions to support the demonstration and evaluation, and
2 may scale the evaluation to fall within resulting resource parameters.

3 **Sec. 3.** RCW 7.70.060 and 1975-'76 2nd ex.s. c 56 s 11 are each
4 amended to read as follows:

5 (1) If a patient while legally competent, or his or her
6 representative if he or she is not competent, signs a consent form
7 which sets forth the following, the signed consent form shall
8 constitute prima facie evidence that the patient gave his or her
9 informed consent to the treatment administered and the patient has the
10 burden of rebutting this by a preponderance of the evidence:

11 ~~((1))~~ (a) A description, in language the patient could reasonably
12 be expected to understand, of:

13 ~~((a))~~ (i) The nature and character of the proposed treatment;

14 ~~((b))~~ (ii) The anticipated results of the proposed treatment;

15 ~~((c))~~ (iii) The recognized possible alternative forms of
16 treatment; and

17 ~~((d))~~ (iv) The recognized serious possible risks, complications,
18 and anticipated benefits involved in the treatment and in the
19 recognized possible alternative forms of treatment, including
20 nontreatment;

21 ~~((2))~~ (b) Or as an alternative, a statement that the patient
22 elects not to be informed of the elements set forth in (a) of this
23 subsection ~~((1) of this section)~~.

24 (2) If a patient while legally competent, or his or her
25 representative if he or she is not competent, signs an acknowledgement
26 of shared decision making as described in this section, such
27 acknowledgement shall constitute prima facie evidence that the patient
28 gave his or her informed consent to the treatment administered and the
29 patient has the burden of rebutting this by clear and convincing
30 evidence. An acknowledgement of shared decision making shall include:

31 (a) A statement that the patient, or his or her representative, and
32 the health care provider have engaged in shared decision making as an
33 alternative means of meeting the informed consent requirements set
34 forth by laws, accreditation standards, and other mandates;

35 (b) A brief description of the services that the patient and
36 provider jointly have agreed will be furnished;

1 (c) A brief description of the patient decision aid or aids that
2 have been used by the patient and provider to address the needs for (i)
3 high-quality, up-to-date information about the condition, including
4 risk and benefits of available options and, if appropriate, a
5 discussion of the limits of scientific knowledge about outcomes; (ii)
6 values clarification to help patients sort out their values and
7 preferences; and (iii) guidance or coaching in deliberation, designed
8 to improve the patient's involvement in the decision process;

9 (d) A statement that the patient or his or her representative
10 understands: The risk or seriousness of the disease or condition to be
11 prevented or treated; the available treatment alternatives, including
12 nontreatment; and the risks, benefits, and uncertainties of the
13 treatment alternatives, including nontreatment; and

14 (e) A statement certifying that the patient or his or her
15 representative has had the opportunity to ask the provider questions,
16 and to have any questions answered to the patient's satisfaction, and
17 indicating the patient's intent to receive the identified services.

18 (3) As used in this section, "shared decision making" means a
19 process in which the physician or other health care practitioner
20 discusses with the patient or his or her representative the information
21 specified in subsection (2) of this section with the use of a patient
22 decision aid and the patient shares with the provider such relevant
23 personal information as might make one treatment or side effect more or
24 less tolerable than others.

25 (4) As used in this section, "patient decision aid" means a
26 written, audio-visual, or online tool that provides a balanced
27 presentation of the condition and treatment options, benefits, and
28 harms, including, if appropriate, a discussion of the limits of
29 scientific knowledge about outcomes, and that is certified by one or
30 more national certifying organizations.

31 (5) Failure to use a form or to engage in shared decision making,
32 with or without the use of a patient decision aid, shall not be
33 admissible as evidence of failure to obtain informed consent. There
34 shall be no liability, civil or otherwise, resulting from a health care
35 provider choosing either the signed consent form set forth in
36 subsection (1)(a) of this section or the signed acknowledgement of
37 shared decision making as set forth in subsection (2) of this section.

1 **PREVENTION AND MANAGEMENT OF CHRONIC ILLNESS**

2 NEW SECTION. **Sec. 4.** A new section is added to chapter 74.09 RCW
3 to read as follows:

4 (1) The department of social and health services, in collaboration
5 with the department of health, shall:

6 (a) Design and implement medical homes for its aged, blind, and
7 disabled clients in conjunction with chronic care management programs
8 to improve health outcomes, access, and cost-effectiveness. Programs
9 must be evidence based, facilitating the use of information technology
10 to improve quality of care, must acknowledge the role of primary care
11 providers and include financial and other supports to enable these
12 providers to effectively carry out their role in chronic care
13 management, and must improve coordination of primary, acute, and long-
14 term care for those clients with multiple chronic conditions. The
15 department shall consider expansion of existing medical home and
16 chronic care management programs and build on the Washington state
17 collaborative initiative. The department shall use best practices in
18 identifying those clients best served under a chronic care management
19 model using predictive modeling through claims or other health risk
20 information; and

21 (b) Evaluate the effectiveness of current chronic care management
22 efforts in the health and recovery services administration and the
23 aging and disability services administration, comparison to best
24 practices, and recommendations for future efforts and organizational
25 structure to improve chronic care management.

26 (2) For purposes of this section:

27 (a) "Medical home" means a site of care that provides comprehensive
28 preventive and coordinated care centered on the patient needs and
29 assures high quality, accessible, and efficient care.

30 (b) "Chronic care management" means the department's program that
31 provides care management and coordination activities for medical
32 assistance clients determined to be at risk for high medical costs.
33 "Chronic care management" provides education and training and/or
34 coordination that assist program participants in improving self-
35 management skills to improve health outcomes and reduce medical costs
36 by educating clients to better utilize services.

1 NEW SECTION. **Sec. 5.** A new section is added to chapter 43.70 RCW
2 to read as follows:

3 (1) The department shall conduct a program of training and
4 technical assistance regarding care of people with chronic conditions
5 for providers of primary care. The program shall emphasize evidence-
6 based high quality preventive and chronic disease care. The department
7 may designate one or more chronic conditions to be the subject of the
8 program.

9 (2) The training and technical assistance program shall include the
10 following elements:

11 (a) Clinical information systems and sharing and organization of
12 patient data;

13 (b) Decision support to promote evidence-based care;

14 (c) Clinical delivery system design;

15 (d) Support for patients managing their own conditions; and

16 (e) Identification and use of community resources that are
17 available in the community for patients and their families.

18 (3) In selecting primary care providers to participate in the
19 program, the department shall consider the number and type of patients
20 with chronic conditions the provider serves, and the provider's
21 participation in the medicaid program, the basic health plan, and
22 health plans offered through the public employees' benefits board.

23 NEW SECTION. **Sec. 6.** (1) The health care authority, in
24 collaboration with the department of health, shall design and implement
25 a chronic care management program for state employees enrolled in the
26 state's self-insured uniform medical plan. Programs must be evidence
27 based, facilitating the use of information technology to improve
28 quality of care and must improve coordination of primary, acute, and
29 long-term care for those enrollees with multiple chronic conditions.
30 The authority shall consider expansion of existing medical home and
31 chronic care management programs. The authority shall use best
32 practices in identifying those employees best served under a chronic
33 care management model using predictive modeling through claims or other
34 health risk information.

35 (2) For purposes of this section:

36 (a) "Medical home" means a site of care that provides comprehensive

1 preventive and coordinated care centered on the patient needs and
2 assures high-quality, accessible, and efficient care.

3 (b) "Chronic care management" means the authority's program that
4 provides care management and coordination activities for health plan
5 enrollees determined to be at risk for high medical costs. "Chronic
6 care management" provides education and training and/or coordination
7 that assist program participants in improving self-management skills to
8 improve health outcomes and reduce medical costs by educating clients
9 to better utilize services.

10 **Sec. 7.** RCW 70.83.040 and 2005 c 518 s 938 are each amended to
11 read as follows:

12 When notified of positive screening tests, the state department of
13 health shall offer the use of its services and facilities, designed to
14 prevent mental retardation or physical defects in such children, to the
15 attending physician, or the parents of the newborn child if no
16 attending physician can be identified.

17 The services and facilities of the department, and other state and
18 local agencies cooperating with the department in carrying out programs
19 of detection and prevention of mental retardation and physical defects
20 shall be made available to the family and physician to the extent
21 required in order to carry out the intent of this chapter and within
22 the availability of funds. ~~((The department has the authority to
23 collect a reasonable fee, from the parents or other responsible party
24 of each infant screened to fund specialty clinics that provide
25 treatment services for hemoglobin diseases, phenylketonuria, congenital
26 adrenal hyperplasia, congenital hypothyroidism, and, during the 2005-07
27 fiscal biennium, other disorders defined by the board of health under
28 RCW 70.83.020. The fee may be collected through the facility where the
29 screening specimen is obtained.))~~

30 NEW SECTION. **Sec. 8.** A new section is added to chapter 70.83 RCW
31 to read as follows:

32 The department has the authority to collect a fee of three dollars
33 and fifty cents from the parents or other responsible party of each
34 infant screened for congenital disorders as defined by the state board
35 of health under RCW 70.83.020 to fund specialty clinics that provide

1 treatment services for those with the defined disorders. The fee may
2 be collected through the facility where a screening specimen is
3 obtained.

4 **COST AND QUALITY INFORMATION FOR CONSUMERS AND PROVIDERS**

5 NEW SECTION. **Sec. 9.** A new section is added to chapter 41.05 RCW
6 to read as follows:

7 The Washington state quality forum is established within the
8 authority. In collaboration with the Puget Sound health alliance and
9 other local organizations, the forum shall:

10 (1) Collect and disseminate research regarding health care quality,
11 evidence-based medicine, and patient safety to promote best practices,
12 in collaboration with the technology assessment program and the
13 prescription drug program;

14 (2) Coordinate the collection of health care quality data among
15 state health care purchasing agencies;

16 (3) Adopt a set of measures to evaluate and compare health care
17 cost and quality and provider performance;

18 (4) Identify and disseminate information regarding variations in
19 clinical practice patterns across the state; and

20 (5) Produce an annual quality report detailing clinical practice
21 patterns for purchasers, providers, insurers, and policy makers. The
22 agencies shall report to the legislature by September 1, 2007.

23 NEW SECTION. **Sec. 10.** A new section is added to chapter 41.05 RCW
24 to read as follows:

25 (1) The administrator shall design and pilot a consumer-centric
26 health information infrastructure and the first health record banks
27 that will facilitate the secure exchange of health information when and
28 where needed and shall:

29 (a) Complete the plan of initial implementation, including but not
30 limited to determining the technical infrastructure for health record
31 banks and the account locator service, setting criteria and standards
32 for health record banks, and determining oversight of health record
33 banks;

34 (b) Implement the first health record banks in pilot sites as
35 funding allows;

1 (c) Involve health care consumers in meaningful ways in the design,
2 implementation, oversight, and dissemination of information on the
3 health record bank system; and

4 (d) Promote adoption of electronic medical records and health
5 information exchange through continuation of the Washington health
6 information collaborative, and by working with private payors and other
7 organizations in restructuring reimbursement to provide incentives for
8 providers to adopt electronic medical records in their practices.

9 (2) The administrator may establish an advisory board, a
10 stakeholder committee, and subcommittees to assist in carrying out the
11 duties under this section. The administrator may reappoint health
12 information infrastructure advisory board members to assure continuity
13 and shall appoint any additional representatives that may be required
14 for their expertise and experience.

15 (a) The administrator shall appoint the chair of the advisory
16 board, chairs, and cochairs of the stakeholder committee, if formed;

17 (b) Meetings of the board, stakeholder committee, and any advisory
18 group are subject to chapter 42.30 RCW, the open public meetings act,
19 including RCW 42.30.110(1)(1), which authorizes an executive session
20 during a regular or special meeting to consider proprietary or
21 confidential nonpublished information; and

22 (c) The members of the board, stakeholder committee, and any
23 advisory group:

24 (i) Shall agree to the terms and conditions imposed by the
25 administrator regarding conflicts of interest as a condition of
26 appointment;

27 (ii) Are immune from civil liability for any official acts
28 performed in good faith as members of the board, stakeholder committee,
29 or any advisory group.

30 (3) Members of the board may be compensated for participation in
31 accordance with a personal services contract to be executed after
32 appointment and before commencement of activities related to the work
33 of the board. Members of the stakeholder committee shall not receive
34 compensation but shall be reimbursed under RCW 43.03.050 and 43.03.060.

35 (4) The administrator may work with public and private entities to
36 develop and encourage the use of personal health records which are
37 portable, interoperable, secure, and respectful of patients' privacy.

1 (5) The administrator may enter into contracts to issue,
2 distribute, and administer grants that are necessary or proper to carry
3 out this section.

4 **Sec. 11.** RCW 43.70.110 and 2006 c 72 s 3 are each amended to read
5 as follows:

6 (1) The secretary shall charge fees to the licensee for obtaining
7 a license. After June 30, 1995, municipal corporations providing
8 emergency medical care and transportation services pursuant to chapter
9 18.73 RCW shall be exempt from such fees, provided that such other
10 emergency services shall only be charged for their pro rata share of
11 the cost of licensure and inspection, if appropriate. The secretary
12 may waive the fees when, in the discretion of the secretary, the fees
13 would not be in the best interest of public health and safety, or when
14 the fees would be to the financial disadvantage of the state.

15 (2) Except as provided in (~~RCW 18.79.202, until June 30, 2013, and~~
16 ~~except for the cost of regulating retired volunteer medical workers in~~
17 ~~accordance with RCW 18.130.360)) subsection (3) of this section, fees
18 charged shall be based on, but shall not exceed, the cost to the
19 department for the licensure of the activity or class of activities and
20 may include costs of necessary inspection.~~

21 (3) License fees shall include amounts in addition to the cost of
22 licensure activities in the following circumstances:

23 (a) For registered nurses and licensed practical nurses licensed
24 under chapter 18.79 RCW, support of a central nursing resource center
25 as provided in RCW 18.79.202, until June 30, 2013;

26 (b) For all health care providers licensed under RCW 18.130.040,
27 the cost of regulatory activities for retired volunteer medical worker
28 licensees as provided in RCW 18.130.360; and

29 (c) For physicians licensed under chapter 18.71 RCW, physician
30 assistants licensed under chapter 18.71A RCW, osteopathic physicians
31 licensed under chapter 18.57 RCW, osteopathic physicians' assistants
32 licensed under chapter 18.57A RCW, naturopaths licensed under chapter
33 18.36A RCW, podiatrists licensed under chapter 18.22 RCW, chiropractors
34 licensed under chapter 18.25 RCW, psychologists licensed under chapter
35 18.83 RCW, registered nurses licensed under chapter 18.79 RCW,
36 optometrists licensed under chapter 18.53 RCW, mental health counselors
37 licensed under chapter 18.225 RCW, massage therapists licensed under

1 chapter 18.108 RCW, clinical social workers licensed under chapter
2 18.225 RCW, and acupuncturists licensed under chapter 18.06 RCW, the
3 license fees shall include up to an additional twenty-five dollars to
4 be transferred by the department to the University of Washington for
5 the purposes of section 12 of this act.

6 (4) Department of health advisory committees may review fees
7 established by the secretary for licenses and comment upon the
8 appropriateness of the level of such fees.

9 NEW SECTION. Sec. 12. A new section is added to chapter 43.70 RCW
10 to read as follows:

11 Within the amounts transferred from the department of health under
12 RCW 43.70.110(3), the University of Washington shall, through the
13 health sciences library, provide online access to selected vital
14 clinical resources, medical journals, decision support tools, and
15 evidence-based reviews of procedures, drugs, and devices to the health
16 professionals listed in RCW 43.70.110(3)(c). Online access shall be
17 available no later than January 1, 2009.

18 **Sec. 13.** RCW 70.56.030 and 2006 c 8 s 107 are each amended to read
19 as follows:

20 (1) The department shall:

21 (a) Receive and investigate, where necessary, notifications and
22 reports of adverse events, including root cause analyses and corrective
23 action plans submitted as part of reports, and communicate to
24 individual facilities the department's conclusions, if any, regarding
25 an adverse event reported by a facility; (~~and~~)

26 (b) Provide to the Washington state quality forum established in
27 section 9 of this act such information from the adverse health events
28 and incidents reports made under this chapter as the department and the
29 Washington state quality forum determine will assist in the Washington
30 state quality forum's research regarding health care quality, evidence-
31 based medicine, and patient safety. Any shared information must be
32 aggregated and not identify an individual medical facility. As
33 determined by the department and the Washington state quality forum,
34 selected shared information may be disseminated on the Washington state
35 quality forum's web site and through other appropriate means; and

36 (c) Adopt rules as necessary to implement this chapter.

1 (2) The department may enforce the reporting requirements of RCW
2 70.56.020 using ((their)) its existing enforcement authority provided
3 in chapter 18.46 RCW for childbirth centers, chapter 70.41 RCW for
4 hospitals, and chapter 71.12 RCW for psychiatric hospitals.

5 **REDUCING UNNECESSARY EMERGENCY ROOM USE**

6 NEW SECTION. **Sec. 14.** The Washington state health care authority
7 and the department of social and health services shall report to the
8 legislature by December 1, 2007, on recent trends in unnecessary
9 emergency room use by enrollees in state purchased health care programs
10 that they administer and the uninsured, and then partner with community
11 organizations and local health care providers to develop reimbursement
12 incentive strategies and design a demonstration pilot to reduce such
13 unnecessary visits.

14 NEW SECTION. **Sec. 15.** A new section is added to chapter 41.05 RCW
15 to read as follows:

16 To the extent that sufficient funding is provided specifically for
17 this purpose, the administrator, in collaboration with the department
18 of social and health services, shall provide all persons enrolled in
19 health plans under this chapter and chapter 70.47 RCW with access to a
20 twenty-four hour, seven day a week nurse hotline.

21 NEW SECTION. **Sec. 16.** A new section is added to chapter 74.09 RCW
22 to read as follows:

23 To the extent that sufficient funding is provided specifically for
24 this purpose, the department, in collaboration with the health care
25 authority, shall provide all persons receiving services under this
26 chapter with access to a twenty-four hour, seven day a week nurse
27 hotline. The health care authority and the department of social and
28 health services shall determine the most appropriate way to provide the
29 nurse hotline under section 15 of this act and this section, which may
30 include use of the 211 system established in chapter 43.211 RCW.

31 **REDUCE HEALTH CARE ADMINISTRATIVE COSTS**

1 insurance contract that provides coverage for a participating member's
2 dependent must offer each participating member the option of covering
3 any unmarried dependent under the age of twenty-five.

4 NEW SECTION. **Sec. 21.** A new section is added to chapter 48.44 RCW
5 to read as follows:

6 (1) Any individual health care service plan contract that provides
7 coverage for a subscriber's dependent must offer the option of covering
8 any unmarried dependent under the age of twenty-five.

9 (2) Any group health care service plan contract that provides
10 coverage for a participating member's dependent must offer each
11 participating member the option of covering any unmarried dependent
12 under the age of twenty-five.

13 NEW SECTION. **Sec. 22.** A new section is added to chapter 48.46 RCW
14 to read as follows:

15 (1) Any individual health maintenance agreement that provides
16 coverage for a subscriber's dependent must offer the option of covering
17 any unmarried dependent under the age of twenty-five.

18 (2) Any group health maintenance agreement that provides coverage
19 for a participating member's dependent must offer each participating
20 member the option of covering any unmarried dependent under the age of
21 twenty-five.

22 **SUSTAINABILITY AND ACCESS TO PUBLIC PROGRAMS**

23 NEW SECTION. **Sec. 23.** (1) The department of social and health
24 services shall develop a series of options that require federal waivers
25 and state plan amendments to expand coverage and leverage federal and
26 state resources for the state's basic health program, for the medical
27 assistance program, as codified at Title XIX of the federal social
28 security act, and the state's children's health insurance program, as
29 codified at Title XXI of the federal social security act. The
30 department shall propose options including but not limited to:

31 (a) Offering alternative benefit designs to promote high quality
32 care, improve health outcomes, and encourage cost-effective treatment
33 options and redirect savings to finance additional coverage;

1 (b) Creation of a health opportunity account demonstration program
2 for individuals eligible for transitional medical benefits. When a
3 participant in the health opportunity account demonstration program
4 satisfies his or her deductible, the benefits provided shall be those
5 included in the medicaid benefit package in effect during the period of
6 the demonstration program; and

7 (c) Promoting private health insurance plans and premium subsidies
8 to purchase employer-sponsored insurance wherever possible, including
9 federal approval to expand the department's employer-sponsored
10 insurance premium assistance program to enrollees covered through the
11 state's children's health insurance program.

12 (2) Prior to submitting requests for federal waivers or state plan
13 amendments, the department shall consult with and seek input from
14 stakeholders and other interested parties.

15 (3) The department of social and health services, in collaboration
16 with the Washington state health care authority, shall ensure that
17 enrollees are not simultaneously enrolled in the state's basic health
18 program and the medical assistance program or the state's children's
19 health insurance program to ensure coverage for the maximum number of
20 people within available funds.

21 NEW SECTION. **Sec. 24.** A new section is added to chapter 48.43 RCW
22 to read as follows:

23 When the department of social and health services determines that
24 it is cost-effective to enroll a person eligible for medical assistance
25 under chapter 74.09 RCW in an employer-sponsored health plan, a carrier
26 shall permit the enrollment of the person in the health plan for which
27 he or she is otherwise eligible without regard to any open enrollment
28 period restrictions.

29 **REINSURANCE**

30 NEW SECTION. **Sec. 25.** (1) The office of financial management, in
31 collaboration with the office of the insurance commissioner, shall
32 evaluate options and design a state-supported reinsurance program to
33 address the impact of high cost enrollees in the individual and small
34 group health insurance markets, and submit an interim report to the
35 governor and the legislature by December 1, 2007, and a final report,

1 including implementing legislation and supporting information,
2 including financing options, by September 1, 2008. In designing the
3 program, the office of financial management shall:

4 (a) Estimate the quantitative impact on premium savings, premium
5 stability over time and across groups of enrollees, individual and
6 employer take-up, number of uninsured, and government costs associated
7 with a government-funded stop-loss insurance program, including
8 distinguishing between one-time premium savings and savings in
9 subsequent years. In evaluating the various reinsurance models,
10 evaluate and consider (i) the reduction in total health care costs to
11 the state and private sector, and (ii) the reduction in individual
12 premiums paid by employers, employees, and individuals;

13 (b) Identify all relevant design issues and alternative options for
14 each issue. At a minimum, the evaluation shall examine (i) a
15 reinsurance corridor of ten thousand dollars to ninety thousand
16 dollars, and a reimbursement of ninety percent; (ii) the impacts of
17 providing reinsurance for all small group products or a subset of
18 products; and (iii) the applicability of a chronic care program such as
19 the approach used by the department of labor and industries with the
20 centers of occupational health and education. Where quantitative
21 impacts cannot be estimated, the office of financial management shall
22 assess qualitative impacts of design issues and their options,
23 including potential disincentives for reducing premiums, achieving
24 premium stability, sustaining/increasing take-up, decreasing the number
25 of uninsured, and managing government's stop-loss insurance costs;

26 (c) Identify market and regulatory changes needed to maximize the
27 chance of the program achieving its policy goals, including how the
28 program will relate to other coverage programs and markets. Design
29 efforts shall coordinate with other design efforts targeting small
30 group programs that may be directed by the legislature, as well as
31 other approaches examining alternatives to managing risk;

32 (d) Address conditions under which overall expenditures could
33 increase as a result of a government-funded stop-loss program and
34 options to mitigate those conditions, such as passive versus aggressive
35 use of disease and care management programs by insurers;

36 (e) Determine whether the Washington state health insurance pool
37 should be retained, and if so, develop options for additional sources
38 of funding;

1 (f) Evaluate, and quantify where possible, the behavioral responses
2 of insurers to the program including impacts on insurer premiums and
3 practices for settling legal disputes around large claims; and

4 (g) Provide alternatives for transitioning from the status quo and,
5 where applicable, alternatives for phasing in some design elements,
6 such as threshold or corridor levels, to balance government costs and
7 premium savings.

8 (2) Within funds specifically appropriated for this purpose, the
9 office of financial management may contract with actuaries and other
10 experts as necessary to meet the requirements of this section.

11 **THE WASHINGTON STATE HEALTH INSURANCE POOL AND THE BASIC HEALTH PLAN**

12 **Sec. 26.** RCW 48.41.110 and 2001 c 196 s 4 are each amended to read
13 as follows:

14 (1) The pool shall offer one or more care management plans of
15 coverage. Such plans may, but are not required to, include point of
16 service features that permit participants to receive in-network
17 benefits or out-of-network benefits subject to differential cost
18 shares. (~~Covered persons enrolled in the pool on January 1, 2001, may~~
19 ~~continue coverage under the pool plan in which they are enrolled on~~
20 ~~that date. However,~~) The pool may incorporate managed care features
21 into ((such)) existing plans.

22 (2) The administrator shall prepare a brochure outlining the
23 benefits and exclusions of ((the)) pool ((policy)) policies in plain
24 language. After approval by the board, such brochure shall be made
25 reasonably available to participants or potential participants.

26 (3) The health insurance ((policy)) policies issued by the pool
27 shall pay only reasonable amounts for medically necessary eligible
28 health care services rendered or furnished for the diagnosis or
29 treatment of covered illnesses, injuries, and conditions (~~which are~~
30 ~~not otherwise limited or excluded~~). Eligible expenses are the
31 reasonable amounts for the health care services and items for which
32 benefits are extended under ((the)) a pool policy. (~~Such benefits~~
33 ~~shall at minimum include, but not be limited to, the following services~~
34 ~~or related items:~~)

35 (4) The pool shall offer at least two policies, one of which will

1 be a comprehensive policy that must comply with RCW 48.41.120 and must
2 at a minimum include the following services or related items:

3 (a) Hospital services, including charges for the most common
4 semiprivate room, for the most common private room if semiprivate rooms
5 do not exist in the health care facility, or for the private room if
6 medically necessary, (~~but limited to~~) including no less than a total
7 of one hundred eighty inpatient days in a calendar year, and (~~limited~~
8 ~~to~~) no less than thirty days inpatient care for mental and nervous
9 conditions, or alcohol, drug, or chemical dependency or abuse per
10 calendar year;

11 (b) Professional services including surgery for the treatment of
12 injuries, illnesses, or conditions, other than dental, which are
13 rendered by a health care provider, or at the direction of a health
14 care provider, by a staff of registered or licensed practical nurses,
15 or other health care providers;

16 (c) (~~The first~~) No less than twenty outpatient professional
17 visits for the diagnosis or treatment of one or more mental or nervous
18 conditions or alcohol, drug, or chemical dependency or abuse rendered
19 during a calendar year by one or more physicians, psychologists, or
20 community mental health professionals, or, at the direction of a
21 physician, by other qualified licensed health care practitioners, in
22 the case of mental or nervous conditions, and rendered by a state
23 certified chemical dependency program approved under chapter 70.96A
24 RCW, in the case of alcohol, drug, or chemical dependency or abuse;

25 (d) Drugs and contraceptive devices requiring a prescription;

26 (e) Services of a skilled nursing facility, excluding custodial and
27 convalescent care, for not (~~more~~) less than one hundred days in a
28 calendar year as prescribed by a physician;

29 (f) Services of a home health agency;

30 (g) Chemotherapy, radioisotope, radiation, and nuclear medicine
31 therapy;

32 (h) Oxygen;

33 (i) Anesthesia services;

34 (j) Prostheses, other than dental;

35 (k) Durable medical equipment which has no personal use in the
36 absence of the condition for which prescribed;

37 (l) Diagnostic x-rays and laboratory tests;

1 (m) Oral surgery (~~limited to~~) including at least the following:
2 Fractures of facial bones; excisions of mandibular joints, lesions of
3 the mouth, lip, or tongue, tumors, or cysts excluding treatment for
4 temporomandibular joints; incision of accessory sinuses, mouth salivary
5 glands or ducts; dislocations of the jaw; plastic reconstruction or
6 repair of traumatic injuries occurring while covered under the pool;
7 and excision of impacted wisdom teeth;

8 (n) Maternity care services;

9 (o) Services of a physical therapist and services of a speech
10 therapist;

11 (p) Hospice services;

12 (q) Professional ambulance service to the nearest health care
13 facility qualified to treat the illness or injury; and

14 (r) Other medical equipment, services, or supplies required by
15 physician's orders and medically necessary and consistent with the
16 diagnosis, treatment, and condition.

17 ~~((4))~~ (5) The board shall design and employ cost containment
18 measures and requirements such as, but not limited to, care
19 coordination, provider network limitations, preadmission certification,
20 and concurrent inpatient review which may make the pool more cost-
21 effective.

22 ~~((5))~~ (6) The pool benefit policy may contain benefit
23 limitations, exceptions, and cost shares such as copayments,
24 coinsurance, and deductibles that are consistent with managed care
25 products, except that differential cost shares may be adopted by the
26 board for nonnetwork providers under point of service plans. ~~((The
27 pool benefit policy cost shares and limitations must be consistent with
28 those that are generally included in health plans approved by the
29 insurance commissioner; however,))~~ No limitation, exception, or
30 reduction may be used that would exclude coverage for any disease,
31 illness, or injury.

32 ~~((6))~~ (7) The pool may not reject an individual for health plan
33 coverage based upon preexisting conditions of the individual or deny,
34 exclude, or otherwise limit coverage for an individual's preexisting
35 health conditions; except that it shall impose a six-month benefit
36 waiting period for preexisting conditions for which medical advice was
37 given, for which a health care provider recommended or provided
38 treatment, or for which a prudent layperson would have sought advice or

1 treatment, within six months before the effective date of coverage.
2 The preexisting condition waiting period shall not apply to prenatal
3 care services. The pool may not avoid the requirements of this section
4 through the creation of a new rate classification or the modification
5 of an existing rate classification. Credit against the waiting period
6 shall be as provided in subsection ~~((7))~~ (8) of this section.

7 ~~((7))~~ (8)(a) Except as provided in (b) of this subsection, the
8 pool shall credit any preexisting condition waiting period in its plans
9 for a person who was enrolled at any time during the sixty-three day
10 period immediately preceding the date of application for the new pool
11 plan. For the person previously enrolled in a group health benefit
12 plan, the pool must credit the aggregate of all periods of preceding
13 coverage not separated by more than sixty-three days toward the waiting
14 period of the new health plan. For the person previously enrolled in
15 an individual health benefit plan other than a catastrophic health
16 plan, the pool must credit the period of coverage the person was
17 continuously covered under the immediately preceding health plan toward
18 the waiting period of the new health plan. For the purposes of this
19 subsection, a preceding health plan includes an employer-provided self-
20 funded health plan.

21 (b) The pool shall waive any preexisting condition waiting period
22 for a person who is an eligible individual as defined in section
23 2741(b) of the federal health insurance portability and accountability
24 act of 1996 (42 U.S.C. 300gg-41(b)).

25 ~~((8))~~ (9) If an application is made for the pool policy as a
26 result of rejection by a carrier, then the date of application to the
27 carrier, rather than to the pool, should govern for purposes of
28 determining preexisting condition credit.

29 (10) The pool shall contract with organizations that provide care
30 management that has been demonstrated to be effective and shall
31 encourage enrollees who are eligible for care management services to
32 participate. The pool may encourage the use of shared decision making
33 and certified decision aids for preference-sensitive care areas.

34 **Sec. 27.** RCW 48.41.160 and 1987 c 431 s 16 are each amended to
35 read as follows:

36 (1) ~~((A pool policy offered under this chapter shall contain~~
37 ~~provisions under which the pool is obligated to renew the policy until~~

1 ~~the day on which the individual in whose name the policy is issued~~
2 ~~first becomes eligible for medicare coverage. At that time, coverage~~
3 ~~of dependents shall terminate if such dependents are eligible for~~
4 ~~coverage under a different health plan. Dependents who become eligible~~
5 ~~for medicare prior to the individual in whose name the policy is~~
6 ~~issued, shall receive benefits in accordance with RCW 48.41.150)) On or~~
7 ~~before December 31, 2007, the pool shall cancel all existing pool~~
8 ~~policies and replace them with policies that are identical to the~~
9 ~~existing policies except for the inclusion of a provision providing for~~
10 ~~a guarantee of the continuity of coverage consistent with this section.~~
11 ~~As a means to minimize the number of policy changes for enrollees,~~
12 ~~replacement policies provided under this subsection also may include~~
13 ~~the plan modifications authorized in RCW 48.41.100, 48.41.110, and~~
14 ~~48.41.120.~~

15 (2) A pool policy shall contain a guarantee of the individual's
16 right to continued coverage, subject to the provisions of subsections
17 (4) and (5) of this section.

18 (3) The guarantee of continuity of coverage required by this
19 section shall not prevent the pool from canceling or nonrenewing a
20 policy for:

21 (a) Nonpayment of premium;

22 (b) Violation of published policies of the pool;

23 (c) Failure of a covered person who becomes eligible for medicare
24 benefits by reason of age to apply for a pool medical supplement plan,
25 or a medicare supplement plan or other similar plan offered by a
26 carrier pursuant to federal laws and regulations;

27 (d) Failure of a covered person to pay any deductible or copayment
28 amount owed to the pool and not the provider of health care services;

29 (e) Covered persons committing fraudulent acts as to the pool;

30 (f) Covered persons materially breaching the pool policy; or

31 (g) Changes adopted to federal or state laws when such changes no
32 longer permit the continued offering of such coverage.

33 (4)(a) The guarantee of continuity of coverage provided by this
34 section requires that if the pool replaces a plan, it must make the
35 replacement plan available to all individuals in the plan being
36 replaced. The replacement plan must include all of the services
37 covered under the replaced plan, and must not significantly limit
38 access to the kind of services covered under the replacement plan

1 through unreasonable cost-sharing requirements or otherwise. The pool
2 may also allow individuals who are covered by a plan that is being
3 replaced an unrestricted right to transfer to a fully comparable plan.

4 (b) The guarantee of continuity of coverage provided by this
5 section requires that if the pool discontinues offering a plan: (i)
6 The pool must provide notice to each individual of the discontinuation
7 at least ninety days prior to the date of the discontinuation; (ii) the
8 pool must offer to each individual provided coverage under the
9 discontinued plan the option to enroll in any other plan currently
10 offered by the pool for which the individual is otherwise eligible; and
11 (iii) in exercising the option to discontinue a plan and in offering
12 the option of coverage under (b)(ii) of this subsection, the pool must
13 act uniformly without regard to any health status-related factor of
14 enrolled individuals or individuals who may become eligible for this
15 coverage.

16 (c) The pool cannot replace or discontinue a plan under this
17 subsection (4) until it has completed an evaluation of the impact of
18 replacing the plan upon:

- 19 (i) The cost and quality of care to pool enrollees;
20 (ii) Pool financing and enrollment;
21 (iii) The board's ability to offer comprehensive and other plans to
22 its enrollees;
23 (iv) Other items identified by the board.

24 In its evaluation, the board must request input from the
25 constituents represented by the board members.

26 (d) The guarantee of continuity of coverage provided by this
27 section does not apply if the pool has zero enrollment in a plan.

28 (5) The pool may not change the rates for pool policies except on
29 a class basis, with a clear disclosure in the policy of the pool's
30 right to do so.

31 ((+3)) (6) A pool policy offered under this chapter shall provide
32 that, upon the death of the individual in whose name the policy is
33 issued, every other individual then covered under the policy may elect,
34 within a period specified in the policy, to continue coverage under the
35 same or a different policy.

36 **Sec. 28.** RCW 48.41.200 and 2000 c 79 s 17 are each amended to read
37 as follows:

1 (1) The pool shall determine the standard risk rate by calculating
2 the average individual standard rate charged for coverage comparable to
3 pool coverage by the five largest members, measured in terms of
4 individual market enrollment, offering such coverages in the state. In
5 the event five members do not offer comparable coverage, the standard
6 risk rate shall be established using reasonable actuarial techniques
7 and shall reflect anticipated experience and expenses for such coverage
8 in the individual market.

9 (2) Subject to subsection (3) of this section, maximum rates for
10 pool coverage shall be as follows:

11 (a) Maximum rates for a pool indemnity health plan shall be one
12 hundred fifty percent of the rate calculated under subsection (1) of
13 this section;

14 (b) Maximum rates for a pool care management plan shall be one
15 hundred twenty-five percent of the rate calculated under subsection (1)
16 of this section; and

17 (c) Maximum rates for a person eligible for pool coverage pursuant
18 to RCW 48.41.100(1)(a) who was enrolled at any time during the sixty-
19 three day period immediately prior to the date of application for pool
20 coverage in a group health benefit plan or an individual health benefit
21 plan other than a catastrophic health plan as defined in RCW 48.43.005,
22 where such coverage was continuous for at least eighteen months, shall
23 be:

24 (i) For a pool indemnity health plan, one hundred twenty-five
25 percent of the rate calculated under subsection (1) of this section;
26 and

27 (ii) For a pool care management plan, one hundred ten percent of
28 the rate calculated under subsection (1) of this section.

29 (3)(a) Subject to (b) and (c) of this subsection:

30 (i) The rate for any person (~~aged fifty to sixty four~~) whose
31 current gross family income is less than two hundred fifty-one percent
32 of the federal poverty level shall be reduced by thirty percent from
33 what it would otherwise be;

34 (ii) The rate for any person (~~aged fifty to sixty four~~) whose
35 current gross family income is more than two hundred fifty but less
36 than three hundred one percent of the federal poverty level shall be
37 reduced by fifteen percent from what it would otherwise be;

1 (iii) The rate for any person who has been enrolled in the pool for
2 more than thirty-six months shall be reduced by five percent from what
3 it would otherwise be.

4 (b) In no event shall the rate for any person be less than one
5 hundred ten percent of the rate calculated under subsection (1) of this
6 section.

7 (c) Rate reductions under (a)(i) and (ii) of this subsection shall
8 be available only to the extent that funds are specifically
9 appropriated for this purpose in the omnibus appropriations act.

10 **Sec. 29.** RCW 48.41.037 and 2000 c 79 s 36 are each amended to read
11 as follows:

12 The Washington state health insurance pool account is created in
13 the custody of the state treasurer. All receipts from moneys
14 specifically appropriated to the account must be deposited in the
15 account. Expenditures from this account shall be used to cover
16 deficits incurred by the Washington state health insurance pool under
17 this chapter in excess of the threshold established in this section.
18 To the extent funds are available in the account, funds shall be
19 expended from the account to offset that portion of the deficit that
20 would otherwise have to be recovered by imposing an assessment on
21 members in excess of a threshold of seventy cents per insured person
22 per month. The commissioner shall authorize expenditures from the
23 account, to the extent that funds are available in the account, upon
24 certification by the pool board that assessments will exceed the
25 threshold level established in this section. The account is subject to
26 the allotment procedures under chapter 43.88 RCW, but an appropriation
27 is not required for expenditures.

28 Whether the assessment has reached the threshold of seventy cents
29 per insured person per month shall be determined by dividing the total
30 aggregate amount of assessment by the proportion of total assessed
31 members. Thus, stop loss members shall be counted as one-tenth of a
32 whole member in the denominator given that is the amount they are
33 assessed proportionately relative to a fully insured medical member.

34 **Sec. 30.** RCW 48.41.100 and 2001 c 196 s 3 are each amended to read
35 as follows:

1 (1) The following persons who are residents of this state are
2 eligible for pool coverage:

3 (a) Any person who provides evidence of a carrier's decision not to
4 accept him or her for enrollment in an individual health benefit plan
5 as defined in RCW 48.43.005 based upon, and within ninety days of the
6 receipt of, the results of the standard health questionnaire designated
7 by the board and administered by health carriers under RCW 48.43.018;

8 (b) Any person who continues to be eligible for pool coverage based
9 upon the results of the standard health questionnaire designated by the
10 board and administered by the pool administrator pursuant to subsection
11 (3) of this section;

12 (c) Any person who resides in a county of the state where no
13 carrier or insurer eligible under chapter 48.15 RCW offers to the
14 public an individual health benefit plan other than a catastrophic
15 health plan as defined in RCW 48.43.005 at the time of application to
16 the pool, and who makes direct application to the pool; and

17 (d) Any medicare eligible person upon providing evidence of
18 rejection for medical reasons, a requirement of restrictive riders, an
19 up-rated premium, or a preexisting conditions limitation on a medicare
20 supplemental insurance policy under chapter 48.66 RCW, the effect of
21 which is to substantially reduce coverage from that received by a
22 person considered a standard risk by at least one member within six
23 months of the date of application.

24 (2) The following persons are not eligible for coverage by the
25 pool:

26 (a) Any person having terminated coverage in the pool unless (i)
27 twelve months have lapsed since termination, or (ii) that person can
28 show continuous other coverage which has been involuntarily terminated
29 for any reason other than nonpayment of premiums. However, these
30 exclusions do not apply to eligible individuals as defined in section
31 2741(b) of the federal health insurance portability and accountability
32 act of 1996 (42 U.S.C. Sec. 300gg-41(b));

33 (b) Any person on whose behalf the pool has paid out (~~one~~) two
34 million dollars in benefits;

35 (c) Inmates of public institutions and persons whose benefits are
36 duplicated under public programs. However, these exclusions do not
37 apply to eligible individuals as defined in section 2741(b) of the

1 federal health insurance portability and accountability act of 1996 (42
2 U.S.C. Sec. 300gg-41(b));

3 (d) Any person who resides in a county of the state where any
4 carrier or insurer regulated under chapter 48.15 RCW offers to the
5 public an individual health benefit plan other than a catastrophic
6 health plan as defined in RCW 48.43.005 at the time of application to
7 the pool and who does not qualify for pool coverage based upon the
8 results of the standard health questionnaire, or pursuant to subsection
9 (1)(d) of this section.

10 (3) When a carrier or insurer regulated under chapter 48.15 RCW
11 begins to offer an individual health benefit plan in a county where no
12 carrier had been offering an individual health benefit plan:

13 (a) If the health benefit plan offered is other than a catastrophic
14 health plan as defined in RCW 48.43.005, any person enrolled in a pool
15 plan pursuant to subsection (1)(c) of this section in that county shall
16 no longer be eligible for coverage under that plan pursuant to
17 subsection (1)(c) of this section, but may continue to be eligible for
18 pool coverage based upon the results of the standard health
19 questionnaire designated by the board and administered by the pool
20 administrator. The pool administrator shall offer to administer the
21 questionnaire to each person no longer eligible for coverage under
22 subsection (1)(c) of this section within thirty days of determining
23 that he or she is no longer eligible;

24 (b) Losing eligibility for pool coverage under this subsection (3)
25 does not affect a person's eligibility for pool coverage under
26 subsection (1)(a), (b), or (d) of this section; and

27 (c) The pool administrator shall provide written notice to any
28 person who is no longer eligible for coverage under a pool plan under
29 this subsection (3) within thirty days of the administrator's
30 determination that the person is no longer eligible. The notice shall:
31 (i) Indicate that coverage under the plan will cease ninety days from
32 the date that the notice is dated; (ii) describe any other coverage
33 options, either in or outside of the pool, available to the person;
34 (iii) describe the procedures for the administration of the standard
35 health questionnaire to determine the person's continued eligibility
36 for coverage under subsection (1)(b) of this section; and (iv) describe
37 the enrollment process for the available options outside of the pool.

1 (4) The board shall ensure that an independent analysis of the
2 eligibility standards for the pool coverage is conducted, including
3 examining the eight percent eligibility threshold, eligibility for
4 medicaid enrollees and other publicly sponsored enrollees, and the
5 impacts on the pool and the state budget. The board shall report the
6 findings to the legislature by December 1, 2007.

7 **Sec. 31.** RCW 48.41.120 and 2000 c 79 s 14 are each amended to read
8 as follows:

9 (1) Subject to the limitation provided in subsection (3) of this
10 section, ((a)) the comprehensive pool policy offered ((in accordance
11 with)) under RCW 48.41.110((+3)) (4) shall impose a deductible as
12 provided in this subsection. Deductibles of five hundred dollars and
13 one thousand dollars on a per person per calendar year basis shall
14 initially be offered. The board may authorize deductibles in other
15 amounts. The deductible shall be applied to the first five hundred
16 dollars, one thousand dollars, or other authorized amount of eligible
17 expenses incurred by the covered person.

18 (2) Subject to the limitations provided in subsection (3) of this
19 section, a mandatory coinsurance requirement shall be imposed at
20 ((the)) a rate ((of)) not to exceed twenty percent of eligible expenses
21 in excess of the mandatory deductible and which supports the efficient
22 delivery of high quality health care services for the medical
23 conditions of pool enrollees.

24 (3) The maximum aggregate out of pocket payments for eligible
25 expenses by the insured in the form of deductibles and coinsurance
26 under ((a)) the comprehensive pool policy offered ((in accordance
27 with)) under RCW 48.41.110((+3)) (4) shall not exceed in a calendar
28 year:

29 (a) One thousand five hundred dollars per individual, or three
30 thousand dollars per family, per calendar year for the five hundred
31 dollar deductible policy;

32 (b) Two thousand five hundred dollars per individual, or five
33 thousand dollars per family per calendar year for the one thousand
34 dollar deductible policy; or

35 (c) An amount authorized by the board for any other deductible
36 policy.

1 (4) Except for those enrolled in a high deductible health plan
2 qualified under federal law for use with a health savings account,
3 eligible expenses incurred by a covered person in the last three months
4 of a calendar year, and applied toward a deductible, shall also be
5 applied toward the deductible amount in the next calendar year.

6 (5) The board may modify cost-sharing as an incentive for enrollees
7 to participate in care management services and other cost-effective
8 programs and policies.

9 **Sec. 32.** RCW 48.43.005 and 2006 c 25 s 16 are each amended to read
10 as follows:

11 Unless otherwise specifically provided, the definitions in this
12 section apply throughout this chapter.

13 (1) "Adjusted community rate" means the rating method used to
14 establish the premium for health plans adjusted to reflect actuarially
15 demonstrated differences in utilization or cost attributable to
16 geographic region, age, family size, and use of wellness activities.

17 (2) "Basic health plan" means the plan described under chapter
18 70.47 RCW, as revised from time to time.

19 (3) "Basic health plan model plan" means a health plan as required
20 in RCW 70.47.060(2)(e).

21 (4) "Basic health plan services" means that schedule of covered
22 health services, including the description of how those benefits are to
23 be administered, that are required to be delivered to an enrollee under
24 the basic health plan, as revised from time to time.

25 (5) "Catastrophic health plan" means:

26 (a) In the case of a contract, agreement, or policy covering a
27 single enrollee, a health benefit plan requiring a calendar year
28 deductible of, at a minimum, one thousand (~~five~~) seven hundred fifty
29 dollars and an annual out-of-pocket expense required to be paid under
30 the plan (other than for premiums) for covered benefits of at least
31 three thousand five hundred dollars, both amounts to be adjusted
32 annually by the insurance commissioner; and

33 (b) In the case of a contract, agreement, or policy covering more
34 than one enrollee, a health benefit plan requiring a calendar year
35 deductible of, at a minimum, three thousand five hundred dollars and an
36 annual out-of-pocket expense required to be paid under the plan (other

1 than for premiums) for covered benefits of at least ((five)) six
2 thousand ((five hundred)) dollars, both amounts to be adjusted annually
3 by the insurance commissioner; or

4 (c) Any health benefit plan that provides benefits for hospital
5 inpatient and outpatient services, professional and prescription drugs
6 provided in conjunction with such hospital inpatient and outpatient
7 services, and excludes or substantially limits outpatient physician
8 services and those services usually provided in an office setting.

9 In July, 2008, and in each July thereafter, the insurance
10 commissioner shall adjust the minimum deductible and out-of-pocket
11 expense required for a plan to qualify as a catastrophic plan to
12 reflect the percentage change in the consumer price index for medical
13 care for a preceding twelve months, as determined by the United States
14 department of labor. The adjusted amount shall apply on the following
15 January 1st.

16 (6) "Certification" means a determination by a review organization
17 that an admission, extension of stay, or other health care service or
18 procedure has been reviewed and, based on the information provided,
19 meets the clinical requirements for medical necessity, appropriateness,
20 level of care, or effectiveness under the auspices of the applicable
21 health benefit plan.

22 (7) "Concurrent review" means utilization review conducted during
23 a patient's hospital stay or course of treatment.

24 (8) "Covered person" or "enrollee" means a person covered by a
25 health plan including an enrollee, subscriber, policyholder,
26 beneficiary of a group plan, or individual covered by any other health
27 plan.

28 (9) "Dependent" means, at a minimum, the enrollee's legal spouse
29 and unmarried dependent children who qualify for coverage under the
30 enrollee's health benefit plan.

31 (10) "Eligible employee" means an employee who works on a full-time
32 basis with a normal work week of thirty or more hours. The term
33 includes a self-employed individual, including a sole proprietor, a
34 partner of a partnership, and may include an independent contractor, if
35 the self-employed individual, sole proprietor, partner, or independent
36 contractor is included as an employee under a health benefit plan of a
37 small employer, but does not work less than thirty hours per week and
38 derives at least seventy-five percent of his or her income from a trade

1 or business through which he or she has attempted to earn taxable
2 income and for which he or she has filed the appropriate internal
3 revenue service form. Persons covered under a health benefit plan
4 pursuant to the consolidated omnibus budget reconciliation act of 1986
5 shall not be considered eligible employees for purposes of minimum
6 participation requirements of chapter 265, Laws of 1995.

7 (11) "Emergency medical condition" means the emergent and acute
8 onset of a symptom or symptoms, including severe pain, that would lead
9 a prudent layperson acting reasonably to believe that a health
10 condition exists that requires immediate medical attention, if failure
11 to provide medical attention would result in serious impairment to
12 bodily functions or serious dysfunction of a bodily organ or part, or
13 would place the person's health in serious jeopardy.

14 (12) "Emergency services" means otherwise covered health care
15 services medically necessary to evaluate and treat an emergency medical
16 condition, provided in a hospital emergency department.

17 (13) "Enrollee point-of-service cost-sharing" means amounts paid to
18 health carriers directly providing services, health care providers, or
19 health care facilities by enrollees and may include copayments,
20 coinsurance, or deductibles.

21 (14) "Grievance" means a written complaint submitted by or on
22 behalf of a covered person regarding: (a) Denial of payment for
23 medical services or nonprovision of medical services included in the
24 covered person's health benefit plan, or (b) service delivery issues
25 other than denial of payment for medical services or nonprovision of
26 medical services, including dissatisfaction with medical care, waiting
27 time for medical services, provider or staff attitude or demeanor, or
28 dissatisfaction with service provided by the health carrier.

29 (15) "Health care facility" or "facility" means hospices licensed
30 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
31 rural health care facilities as defined in RCW 70.175.020, psychiatric
32 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
33 under chapter 18.51 RCW, community mental health centers licensed under
34 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed
35 under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical
36 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment
37 facilities licensed under chapter 70.96A RCW, and home health agencies
38 licensed under chapter 70.127 RCW, and includes such facilities if

1 owned and operated by a political subdivision or instrumentality of the
2 state and such other facilities as required by federal law and
3 implementing regulations.

4 (16) "Health care provider" or "provider" means:

5 (a) A person regulated under Title 18 or chapter 70.127 RCW, to
6 practice health or health-related services or otherwise practicing
7 health care services in this state consistent with state law; or

8 (b) An employee or agent of a person described in (a) of this
9 subsection, acting in the course and scope of his or her employment.

10 (17) "Health care service" means that service offered or provided
11 by health care facilities and health care providers relating to the
12 prevention, cure, or treatment of illness, injury, or disease.

13 (18) "Health carrier" or "carrier" means a disability insurer
14 regulated under chapter 48.20 or 48.21 RCW, a health care service
15 contractor as defined in RCW 48.44.010, or a health maintenance
16 organization as defined in RCW 48.46.020.

17 (19) "Health plan" or "health benefit plan" means any policy,
18 contract, or agreement offered by a health carrier to provide, arrange,
19 reimburse, or pay for health care services except the following:

20 (a) Long-term care insurance governed by chapter 48.84 RCW;

21 (b) Medicare supplemental health insurance governed by chapter
22 48.66 RCW;

23 (c) Coverage supplemental to the coverage provided under chapter
24 55, Title 10, United States Code;

25 (d) Limited health care services offered by limited health care
26 service contractors in accordance with RCW 48.44.035;

27 (e) Disability income;

28 (f) Coverage incidental to a property/casualty liability insurance
29 policy such as automobile personal injury protection coverage and
30 homeowner guest medical;

31 (g) Workers' compensation coverage;

32 (h) Accident only coverage;

33 (i) Specified disease and hospital confinement indemnity when
34 marketed solely as a supplement to a health plan;

35 (j) Employer-sponsored self-funded health plans;

36 (k) Dental only and vision only coverage; and

37 (l) Plans deemed by the insurance commissioner to have a short-term
38 limited purpose or duration, or to be a student-only plan that is

1 guaranteed renewable while the covered person is enrolled as a regular
2 full-time undergraduate or graduate student at an accredited higher
3 education institution, after a written request for such classification
4 by the carrier and subsequent written approval by the insurance
5 commissioner.

6 (20) "Material modification" means a change in the actuarial value
7 of the health plan as modified of more than five percent but less than
8 fifteen percent.

9 (21) "Preexisting condition" means any medical condition, illness,
10 or injury that existed any time prior to the effective date of
11 coverage.

12 (22) "Premium" means all sums charged, received, or deposited by a
13 health carrier as consideration for a health plan or the continuance of
14 a health plan. Any assessment or any "membership," "policy,"
15 "contract," "service," or similar fee or charge made by a health
16 carrier in consideration for a health plan is deemed part of the
17 premium. "Premium" shall not include amounts paid as enrollee point-
18 of-service cost-sharing.

19 (23) "Review organization" means a disability insurer regulated
20 under chapter 48.20 or 48.21 RCW, health care service contractor as
21 defined in RCW 48.44.010, or health maintenance organization as defined
22 in RCW 48.46.020, and entities affiliated with, under contract with, or
23 acting on behalf of a health carrier to perform a utilization review.

24 (24) "Small employer" or "small group" means any person, firm,
25 corporation, partnership, association, political subdivision, sole
26 proprietor, or self-employed individual that is actively engaged in
27 business that, on at least fifty percent of its working days during the
28 preceding calendar quarter, employed at least two but no more than
29 fifty eligible employees, with a normal work week of thirty or more
30 hours, the majority of whom were employed within this state, and is not
31 formed primarily for purposes of buying health insurance and in which
32 a bona fide employer-employee relationship exists. In determining the
33 number of eligible employees, companies that are affiliated companies,
34 or that are eligible to file a combined tax return for purposes of
35 taxation by this state, shall be considered an employer. Subsequent to
36 the issuance of a health plan to a small employer and for the purpose
37 of determining eligibility, the size of a small employer shall be
38 determined annually. Except as otherwise specifically provided, a

1 small employer shall continue to be considered a small employer until
2 the plan anniversary following the date the small employer no longer
3 meets the requirements of this definition. A self-employed individual
4 or sole proprietor must derive at least seventy-five percent of his or
5 her income from a trade or business through which the individual or
6 sole proprietor has attempted to earn taxable income and for which he
7 or she has filed the appropriate internal revenue service form 1040,
8 schedule C or F, for the previous taxable year except for a self-
9 employed individual or sole proprietor in an agricultural trade or
10 business, who must derive at least fifty-one percent of his or her
11 income from the trade or business through which the individual or sole
12 proprietor has attempted to earn taxable income and for which he or she
13 has filed the appropriate internal revenue service form 1040, for the
14 previous taxable year. A self-employed individual or sole proprietor
15 who is covered as a group of one on the day prior to June 10, 2004,
16 shall also be considered a "small employer" to the extent that
17 individual or group of one is entitled to have his or her coverage
18 renewed as provided in RCW 48.43.035(6).

19 (25) "Utilization review" means the prospective, concurrent, or
20 retrospective assessment of the necessity and appropriateness of the
21 allocation of health care resources and services of a provider or
22 facility, given or proposed to be given to an enrollee or group of
23 enrollees.

24 (26) "Wellness activity" means an explicit program of an activity
25 consistent with department of health guidelines, such as, smoking
26 cessation, injury and accident prevention, reduction of alcohol misuse,
27 appropriate weight reduction, exercise, automobile and motorcycle
28 safety, blood cholesterol reduction, and nutrition education for the
29 purpose of improving enrollee health status and reducing health service
30 costs.

31 **Sec. 33.** RCW 48.41.190 and 1989 c 121 s 10 are each amended to
32 read as follows:

33 ~~((Neither the participation by members, the establishment of rates,~~
34 ~~forms, or procedures for coverages issued by the pool, nor any other~~
35 ~~joint or collective action required by this chapter or the state of~~
36 ~~Washington shall be the basis of any legal action, civil or criminal~~
37 ~~liability or penalty against the pool, any member of the board of~~

1 ~~directors, or members of the pool either jointly or separately.))~~ The
2 pool, members of the pool, board directors of the pool, officers of the
3 pool, employees of the pool, the commissioner, the commissioner's
4 representatives, and the commissioner's employees shall not be civilly
5 or criminally liable and shall not have any penalty or cause of action
6 of any nature arise against them for any action taken or not taken,
7 including any discretionary decision or failure to make a discretionary
8 decision, when the action or inaction is done in good faith and in the
9 performance of the powers and duties under this chapter. Nothing in
10 this section prohibits legal actions against the pool to enforce the
11 pool's statutory or contractual duties or obligations.

12 **Sec. 34.** RCW 41.05.075 and 2006 c 103 s 3 are each amended to read
13 as follows:

14 (1) The administrator shall provide benefit plans designed by the
15 board through a contract or contracts with insuring entities, through
16 self-funding, self-insurance, or other methods of providing insurance
17 coverage authorized by RCW 41.05.140.

18 (2) The administrator shall establish a contract bidding process
19 that:

20 (a) Encourages competition among insuring entities;

21 (b) Maintains an equitable relationship between premiums charged
22 for similar benefits and between risk pools including premiums charged
23 for retired state and school district employees under the separate risk
24 pools established by RCW 41.05.022 and 41.05.080 such that insuring
25 entities may not avoid risk when establishing the premium rates for
26 retirees eligible for medicare;

27 (c) Is timely to the state budgetary process; and

28 (d) Sets conditions for awarding contracts to any insuring entity.

29 (3) The administrator shall establish a requirement for review of
30 utilization and financial data from participating insuring entities on
31 a quarterly basis.

32 (4) The administrator shall centralize the enrollment files for all
33 employee and retired or disabled school employee health plans offered
34 under chapter 41.05 RCW and develop enrollment demographics on a plan-
35 specific basis.

36 (5) All claims data shall be the property of the state. The

1 administrator may require of any insuring entity that submits a bid to
2 contract for coverage all information deemed necessary including:

3 (a) Subscriber or member demographic and claims data necessary for
4 risk assessment and adjustment calculations in order to fulfill the
5 administrator's duties as set forth in this chapter; and

6 (b) Subscriber or member demographic and claims data necessary to
7 implement performance measures or financial incentives related to
8 performance under subsection (7) of this section.

9 (6) All contracts with insuring entities for the provision of
10 health care benefits shall provide that the beneficiaries of such
11 benefit plans may use on an equal participation basis the services of
12 practitioners licensed pursuant to chapters 18.22, 18.25, 18.32, 18.53,
13 18.57, 18.71, 18.74, 18.83, and 18.79 RCW, as it applies to registered
14 nurses and advanced registered nurse practitioners. However, nothing
15 in this subsection may preclude the administrator from establishing
16 appropriate utilization controls approved pursuant to RCW 41.05.065(2)
17 (a), (b), and (d).

18 (7) The administrator shall, in collaboration with other state
19 agencies that administer state purchased health care programs, private
20 health care purchasers, health care facilities, providers, and
21 carriers:

22 (a) Use evidence-based medicine principles to develop common
23 performance measures and implement financial incentives in contracts
24 with insuring entities, health care facilities, and providers that:

25 (i) Reward improvements in health outcomes for individuals with
26 chronic diseases, increased utilization of appropriate preventive
27 health services, and reductions in medical errors; and

28 (ii) Increase, through appropriate incentives to insuring entities,
29 health care facilities, and providers, the adoption and use of
30 information technology that contributes to improved health outcomes,
31 better coordination of care, and decreased medical errors;

32 (b) Through state health purchasing, reimbursement, or pilot
33 strategies, promote and increase the adoption of health information
34 technology systems, including electronic medical records, by hospitals
35 as defined in RCW 70.41.020(4), integrated delivery systems, and
36 providers that:

37 (i) Facilitate diagnosis or treatment;

38 (ii) Reduce unnecessary duplication of medical tests;

- 1 (iii) Promote efficient electronic physician order entry;
2 (iv) Increase access to health information for consumers and their
3 providers; and
4 (v) Improve health outcomes;
5 (c) Coordinate a strategy for the adoption of health information
6 technology systems using the final health information technology report
7 and recommendations developed under chapter 261, Laws of 2005.

8 (8) The administrator may permit the Washington state health
9 insurance pool to contract to utilize any network maintained by the
10 authority or any network under contract with the authority.

11 **Sec. 35.** RCW 70.47.020 and 2005 c 188 s 2 are each amended to read
12 as follows:

13 As used in this chapter:

14 (1) "Washington basic health plan" or "plan" means the system of
15 enrollment and payment for basic health care services, administered by
16 the plan administrator through participating managed health care
17 systems, created by this chapter.

18 (2) "Administrator" means the Washington basic health plan
19 administrator, who also holds the position of administrator of the
20 Washington state health care authority.

21 (3) "Health coverage tax credit program" means the program created
22 by the Trade Act of 2002 (P.L. 107-210) that provides a federal tax
23 credit that subsidizes private health insurance coverage for displaced
24 workers certified to receive certain trade adjustment assistance
25 benefits and for individuals receiving benefits from the pension
26 benefit guaranty corporation.

27 (4) "Health coverage tax credit eligible enrollee" means individual
28 workers and their qualified family members who lose their jobs due to
29 the effects of international trade and are eligible for certain trade
30 adjustment assistance benefits; or are eligible for benefits under the
31 alternative trade adjustment assistance program; or are people who
32 receive benefits from the pension benefit guaranty corporation and are
33 at least fifty-five years old.

34 (5) "Managed health care system" means: (a) Any health care
35 organization, including health care providers, insurers, health care
36 service contractors, health maintenance organizations, or any
37 combination thereof, that provides directly or by contract basic health

1 care services, as defined by the administrator and rendered by duly
2 licensed providers, to a defined patient population enrolled in the
3 plan and in the managed health care system; or (b) a self-funded or
4 self-insured method of providing insurance coverage to subsidized
5 enrollees provided under RCW 41.05.140 and subject to the limitations
6 under RCW 70.47.100(7).

7 (6) "Subsidized enrollee" means:

8 (a) An individual, or an individual plus the individual's spouse or
9 dependent children:

10 ~~((a))~~ (i) Who is not eligible for medicare;

11 ~~((b))~~ (ii) Who is not confined or residing in a government-
12 operated institution, unless he or she meets eligibility criteria
13 adopted by the administrator;

14 ~~((c))~~ (iii) Who is not a full-time student who has received a
15 temporary visa to study in the United States;

16 ~~((d))~~ (iv) Who resides in an area of the state served by a
17 managed health care system participating in the plan;

18 ~~((e))~~ (v) Whose gross family income at the time of enrollment
19 does not exceed two hundred percent of the federal poverty level as
20 adjusted for family size and determined annually by the federal
21 department of health and human services; and

22 ~~((f))~~ (vi) Who chooses to obtain basic health care coverage from
23 a particular managed health care system in return for periodic payments
24 to the plan~~((g))~~;

25 (b) An individual who meets the requirements in (a)(i) through (iv)
26 and (vi) of this subsection and who is a foster parent licensed under
27 chapter 74.15 RCW and whose gross family income at the time of
28 enrollment does not exceed three hundred percent of the federal poverty
29 level as adjusted for family size and determined annually by the
30 federal department of health and human services; and

31 (c) To the extent that state funds are specifically appropriated
32 for this purpose, with a corresponding federal match, (~~"subsidized~~
33 enrollee—also means)) an individual, or an individual's spouse or
34 dependent children, who meets the requirements in (a)(i) through
35 ~~((d))~~ (iv) and ~~((f))~~ (vi) of this subsection and whose gross family
36 income at the time of enrollment is more than two hundred percent, but
37 less than two hundred fifty-one percent, of the federal poverty level

1 as adjusted for family size and determined annually by the federal
2 department of health and human services.

3 (7) "Nonsubsidized enrollee" means an individual, or an individual
4 plus the individual's spouse or dependent children: (a) Who is not
5 eligible for medicare; (b) who is not confined or residing in a
6 government-operated institution, unless he or she meets eligibility
7 criteria adopted by the administrator; (c) who is accepted for
8 enrollment by the administrator as provided in RCW 48.43.018, either
9 because the potential enrollee cannot be required to complete the
10 standard health questionnaire under RCW 48.43.018, or, based upon the
11 results of the standard health questionnaire, the potential enrollee
12 would not qualify for coverage under the Washington state health
13 insurance pool; (d) who resides in an area of the state served by a
14 managed health care system participating in the plan; ~~((+d))~~ (e) who
15 chooses to obtain basic health care coverage from a particular managed
16 health care system; and ~~((+e))~~ (f) who pays or on whose behalf is paid
17 the full costs for participation in the plan, without any subsidy from
18 the plan.

19 (8) "Subsidy" means the difference between the amount of periodic
20 payment the administrator makes to a managed health care system on
21 behalf of a subsidized enrollee plus the administrative cost to the
22 plan of providing the plan to that subsidized enrollee, and the amount
23 determined to be the subsidized enrollee's responsibility under RCW
24 70.47.060(2).

25 (9) "Premium" means a periodic payment, ~~((based upon gross family~~
26 ~~income))~~ which an individual, their employer or another financial
27 sponsor makes to the plan as consideration for enrollment in the plan
28 as a subsidized enrollee, a nonsubsidized enrollee, or a health
29 coverage tax credit eligible enrollee.

30 (10) "Rate" means the amount, negotiated by the administrator with
31 and paid to a participating managed health care system, that is based
32 upon the enrollment of subsidized, nonsubsidized, and health coverage
33 tax credit eligible enrollees in the plan and in that system.

34 **Sec. 36.** RCW 70.47.060 and 2006 c 343 s 9 are each amended to read
35 as follows:

36 The administrator has the following powers and duties:

1 (1) To design and from time to time revise a schedule of covered
2 basic health care services, including physician services, inpatient and
3 outpatient hospital services, prescription drugs and medications, and
4 other services that may be necessary for basic health care. In
5 addition, the administrator may, to the extent that funds are
6 available, offer as basic health plan services chemical dependency
7 services, mental health services and organ transplant services;
8 however, no one service or any combination of these three services
9 shall increase the actuarial value of the basic health plan benefits by
10 more than five percent excluding inflation, as determined by the office
11 of financial management. All subsidized and nonsubsidized enrollees in
12 any participating managed health care system under the Washington basic
13 health plan shall be entitled to receive covered basic health care
14 services in return for premium payments to the plan. The schedule of
15 services shall emphasize proven preventive and primary health care and
16 shall include all services necessary for prenatal, postnatal, and well-
17 child care. However, with respect to coverage for subsidized enrollees
18 who are eligible to receive prenatal and postnatal services through the
19 medical assistance program under chapter 74.09 RCW, the administrator
20 shall not contract for such services except to the extent that such
21 services are necessary over not more than a one-month period in order
22 to maintain continuity of care after diagnosis of pregnancy by the
23 managed care provider. The schedule of services shall also include a
24 separate schedule of basic health care services for children, eighteen
25 years of age and younger, for those subsidized or nonsubsidized
26 enrollees who choose to secure basic coverage through the plan only for
27 their dependent children. In designing and revising the schedule of
28 services, the administrator shall consider the guidelines for assessing
29 health services under the mandated benefits act of 1984, RCW 48.47.030,
30 and such other factors as the administrator deems appropriate.

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

1 subsection (11) of this section and to the share of the cost of the
2 plan due from subsidized enrollees entering the plan as employees
3 pursuant to subsection (12) of this section.

4 (b) To determine the periodic premiums due the administrator from
5 subsidized enrollees under RCW 70.47.020(6)(b). Premiums due for
6 foster parents with gross family income up to two hundred percent of
7 the federal poverty level shall be set at the minimum premium amount
8 charged to enrollees with income below sixty-five percent of the
9 federal poverty level. Premiums due for foster parents with gross
10 family income between two hundred percent and three hundred percent of
11 the federal poverty level shall not exceed one hundred dollars per
12 month.

13 (c) To determine the periodic premiums due the administrator from
14 nonsubsidized enrollees. Premiums due from nonsubsidized enrollees
15 shall be in an amount equal to the cost charged by the managed health
16 care system provider to the state for the plan plus the administrative
17 cost of providing the plan to those enrollees and the premium tax under
18 RCW 48.14.0201.

19 ~~((+e))~~ (d) To determine the periodic premiums due the
20 administrator from health coverage tax credit eligible enrollees.
21 Premiums due from health coverage tax credit eligible enrollees must be
22 in an amount equal to the cost charged by the managed health care
23 system provider to the state for the plan, plus the administrative cost
24 of providing the plan to those enrollees and the premium tax under RCW
25 48.14.0201. The administrator will consider the impact of eligibility
26 determination by the appropriate federal agency designated by the Trade
27 Act of 2002 (P.L. 107-210) as well as the premium collection and
28 remittance activities by the United States internal revenue service
29 when determining the administrative cost charged for health coverage
30 tax credit eligible enrollees.

31 ~~((+d))~~ (e) An employer or other financial sponsor may, with the
32 prior approval of the administrator, pay the premium, rate, or any
33 other amount on behalf of a subsidized or nonsubsidized enrollee, by
34 arrangement with the enrollee and through a mechanism acceptable to the
35 administrator. The administrator shall establish a mechanism for
36 receiving premium payments from the United States internal revenue
37 service for health coverage tax credit eligible enrollees.

1 (~~(e)~~) (f) To develop, as an offering by every health carrier
2 providing coverage identical to the basic health plan, as configured on
3 January 1, 2001, a basic health plan model plan with uniformity in
4 enrollee cost-sharing requirements.

5 (3) To evaluate, with the cooperation of participating managed
6 health care system providers, the impact on the basic health plan of
7 enrolling health coverage tax credit eligible enrollees. The
8 administrator shall issue to the appropriate committees of the
9 legislature preliminary evaluations on June 1, 2005, and January 1,
10 2006, and a final evaluation by June 1, 2006. The evaluation shall
11 address the number of persons enrolled, the duration of their
12 enrollment, their utilization of covered services relative to other
13 basic health plan enrollees, and the extent to which their enrollment
14 contributed to any change in the cost of the basic health plan.

15 (4) To end the participation of health coverage tax credit eligible
16 enrollees in the basic health plan if the federal government reduces or
17 terminates premium payments on their behalf through the United States
18 internal revenue service.

19 (5) To design and implement a structure of enrollee cost-sharing
20 due a managed health care system from subsidized, nonsubsidized, and
21 health coverage tax credit eligible enrollees. The structure shall
22 discourage inappropriate enrollee utilization of health care services,
23 and may utilize copayments, deductibles, and other cost-sharing
24 mechanisms, but shall not be so costly to enrollees as to constitute a
25 barrier to appropriate utilization of necessary health care services.

26 (6) To limit enrollment of persons who qualify for subsidies so as
27 to prevent an overexpenditure of appropriations for such purposes.
28 Whenever the administrator finds that there is danger of such an
29 overexpenditure, the administrator shall close enrollment until the
30 administrator finds the danger no longer exists. Such a closure does
31 not apply to health coverage tax credit eligible enrollees who receive
32 a premium subsidy from the United States internal revenue service as
33 long as the enrollees qualify for the health coverage tax credit
34 program.

35 (7) To limit the payment of subsidies to subsidized enrollees, as
36 defined in RCW 70.47.020. The level of subsidy provided to persons who
37 qualify may be based on the lowest cost plans, as defined by the
38 administrator.

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

5 (9) To solicit and accept applications from managed health care
6 systems, as defined in this chapter, for inclusion as eligible basic
7 health care providers under the plan for subsidized enrollees,
8 nonsubsidized enrollees, or health coverage tax credit eligible
9 enrollees. The administrator shall endeavor to assure that covered
10 basic health care services are available to any enrollee of the plan
11 from among a selection of two or more participating managed health care
12 systems. In adopting any rules or procedures applicable to managed
13 health care systems and in its dealings with such systems, the
14 administrator shall consider and make suitable allowance for the need
15 for health care services and the differences in local availability of
16 health care resources, along with other resources, within and among the
17 several areas of the state. Contracts with participating managed
18 health care systems shall ensure that basic health plan enrollees who
19 become eligible for medical assistance may, at their option, continue
20 to receive services from their existing providers within the managed
21 health care system if such providers have entered into provider
22 agreements with the department of social and health services.

23 (10) To receive periodic premiums from or on behalf of subsidized,
24 nonsubsidized, and health coverage tax credit eligible enrollees,
25 deposit them in the basic health plan operating account, keep records
26 of enrollee status, and authorize periodic payments to managed health
27 care systems on the basis of the number of enrollees participating in
28 the respective managed health care systems.

29 (11) To accept applications from individuals residing in areas
30 served by the plan, on behalf of themselves and their spouses and
31 dependent children, for enrollment in the Washington basic health plan
32 as subsidized, nonsubsidized, or health coverage tax credit eligible
33 enrollees, to give priority to members of the Washington national guard
34 and reserves who served in Operation Enduring Freedom, Operation Iraqi
35 Freedom, or Operation Noble Eagle, and their spouses and dependents,
36 for enrollment in the Washington basic health plan, to establish
37 appropriate minimum-enrollment periods for enrollees as may be
38 necessary, and to determine, upon application and on a reasonable

1 schedule defined by the authority, or at the request of any enrollee,
2 eligibility due to current gross family income for sliding scale
3 premiums. Funds received by a family as part of participation in the
4 adoption support program authorized under RCW 26.33.320 and 74.13.100
5 through 74.13.145 shall not be counted toward a family's current gross
6 family income for the purposes of this chapter. When an enrollee fails
7 to report income or income changes accurately, the administrator shall
8 have the authority either to bill the enrollee for the amounts overpaid
9 by the state or to impose civil penalties of up to two hundred percent
10 of the amount of subsidy overpaid due to the enrollee incorrectly
11 reporting income. The administrator shall adopt rules to define the
12 appropriate application of these sanctions and the processes to
13 implement the sanctions provided in this subsection, within available
14 resources. No subsidy may be paid with respect to any enrollee whose
15 current gross family income exceeds twice the federal poverty level or,
16 subject to RCW 70.47.110, who is a recipient of medical assistance or
17 medical care services under chapter 74.09 RCW. If a number of
18 enrollees drop their enrollment for no apparent good cause, the
19 administrator may establish appropriate rules or requirements that are
20 applicable to such individuals before they will be allowed to reenroll
21 in the plan.

22 (12) To accept applications from business owners on behalf of
23 themselves and their employees, spouses, and dependent children, as
24 subsidized or nonsubsidized enrollees, who reside in an area served by
25 the plan. The administrator may require all or the substantial
26 majority of the eligible employees of such businesses to enroll in the
27 plan and establish those procedures necessary to facilitate the orderly
28 enrollment of groups in the plan and into a managed health care system.
29 The administrator may require that a business owner pay at least an
30 amount equal to what the employee pays after the state pays its portion
31 of the subsidized premium cost of the plan on behalf of each employee
32 enrolled in the plan. Enrollment is limited to those not eligible for
33 medicare who wish to enroll in the plan and choose to obtain the basic
34 health care coverage and services from a managed care system
35 participating in the plan. The administrator shall adjust the amount
36 determined to be due on behalf of or from all such enrollees whenever
37 the amount negotiated by the administrator with the participating

1 managed health care system or systems is modified or the administrative
2 cost of providing the plan to such enrollees changes.

3 (13) To determine the rate to be paid to each participating managed
4 health care system in return for the provision of covered basic health
5 care services to enrollees in the system. Although the schedule of
6 covered basic health care services will be the same or actuarially
7 equivalent for similar enrollees, the rates negotiated with
8 participating managed health care systems may vary among the systems.
9 In negotiating rates with participating systems, the administrator
10 shall consider the characteristics of the populations served by the
11 respective systems, economic circumstances of the local area, the need
12 to conserve the resources of the basic health plan trust account, and
13 other factors the administrator finds relevant.

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

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

32 (16) To develop a program of proven preventive health measures and
33 to integrate it into the plan wherever possible and consistent with
34 this chapter.

35 (17) To provide, consistent with available funding, assistance for
36 rural residents, underserved populations, and persons of color.

37 (18) In consultation with appropriate state and local government

1 agencies, to establish criteria defining eligibility for persons
2 confined or residing in government-operated institutions.

3 (19) To administer the premium discounts provided under RCW
4 48.41.200(3)(a) (i) and (ii) pursuant to a contract with the Washington
5 state health insurance pool.

6 (20) To give priority in enrollment to persons who disenrolled from
7 the program in order to enroll in medicaid, and subsequently became
8 ineligible for medicaid coverage.

9 **Sec. 37.** RCW 48.43.018 and 2004 c 244 s 3 are each amended to read
10 as follows:

11 (1) Except as provided in (a) through (e) of this subsection, a
12 health carrier may require any person applying for an individual health
13 benefit plan and the health care authority shall require any person
14 applying for nonsubsidized enrollment in the basic health plan to
15 complete the standard health questionnaire designated under chapter
16 48.41 RCW.

17 (a) If a person is seeking an individual health benefit plan or
18 enrollment in the basic health plan as a nonsubsidized enrollee due to
19 his or her change of residence from one geographic area in Washington
20 state to another geographic area in Washington state where his or her
21 current health plan is not offered, completion of the standard health
22 questionnaire shall not be a condition of coverage if application for
23 coverage is made within ninety days of relocation.

24 (b) If a person is seeking an individual health benefit plan or
25 enrollment in the basic health plan as a nonsubsidized enrollee:

26 (i) Because a health care provider with whom he or she has an
27 established care relationship and from whom he or she has received
28 treatment within the past twelve months is no longer part of the
29 carrier's provider network under his or her existing Washington
30 individual health benefit plan; and

31 (ii) His or her health care provider is part of another carrier's
32 or a basic health plan managed care system's provider network; and

33 (iii) Application for a health benefit plan under that carrier's
34 provider network individual coverage or for basic health plan
35 nonsubsidized enrollment is made within ninety days of his or her
36 provider leaving the previous carrier's provider network; then

1 completion of the standard health questionnaire shall not be a
2 condition of coverage.

3 (c) If a person is seeking an individual health benefit plan or
4 enrollment in the basic health plan as a nonsubsidized enrollee due to
5 his or her having exhausted continuation coverage provided under 29
6 U.S.C. Sec. 1161 et seq., completion of the standard health
7 questionnaire shall not be a condition of coverage if application for
8 coverage is made within ninety days of exhaustion of continuation
9 coverage. A health carrier or the health care authority as
10 administrator of basic health plan nonsubsidized coverage shall accept
11 an application without a standard health questionnaire from a person
12 currently covered by such continuation coverage if application is made
13 within ninety days prior to the date the continuation coverage would be
14 exhausted and the effective date of the individual coverage applied for
15 is the date the continuation coverage would be exhausted, or within
16 ninety days thereafter.

17 (d) If a person is seeking an individual health benefit plan or
18 enrollment in the basic health plan as a nonsubsidized enrollee due to
19 his or her receiving notice that his or her coverage under a conversion
20 contract is discontinued, completion of the standard health
21 questionnaire shall not be a condition of coverage if application for
22 coverage is made within ninety days of discontinuation of eligibility
23 under the conversion contract. A health carrier or the health care
24 authority as administrator of basic health plan nonsubsidized coverage
25 shall accept an application without a standard health questionnaire
26 from a person currently covered by such conversion contract if
27 application is made within ninety days prior to the date eligibility
28 under the conversion contract would be discontinued and the effective
29 date of the individual coverage applied for is the date eligibility
30 under the conversion contract would be discontinued, or within ninety
31 days thereafter.

32 (e) If a person is seeking an individual health benefit plan (~~and,~~
33 ~~but for the number of persons employed by his or her employer, would~~
34 ~~have qualified for~~) or enrollment in the basic health plan as a
35 nonsubsidized enrollee following disenrollment from a health plan that
36 is exempt from continuation coverage provided under 29 U.S.C. Sec. 1161
37 et seq., completion of the standard health questionnaire shall not be
38 a condition of coverage if: (i) (~~Application for coverage is made~~

1 ~~within ninety days of a qualifying event as defined in 29 U.S.C. Sec.~~
2 ~~1163; and (ii))~~ The person had at least twenty-four months of
3 continuous group coverage including church plans immediately prior to
4 ~~((the qualifying event. A health carrier shall accept an application~~
5 ~~without a standard health questionnaire from a person with at least~~
6 ~~twenty four months of continuous group coverage if))~~ disenrollment;
7 (ii) application is made no more than ninety days prior to the date of
8 ~~((a qualifying event))~~ disenrollment; and (iii) the effective date of
9 the individual coverage applied for is the date of ~~((the qualifying~~
10 ~~event))~~ disenrollment, or within ninety days thereafter.

11 (f) If a person is seeking an individual health benefit plan,
12 completion of the standard health questionnaire shall not be a
13 condition of coverage if: (i) The person had at least twenty-four
14 months of continuous basic health plan coverage under chapter 70.47 RCW
15 immediately prior to disenrollment; and (ii) application for coverage
16 is made within ninety days of disenrollment from the basic health plan.
17 A health carrier shall accept an application without a standard health
18 questionnaire from a person with at least twenty-four months of
19 continuous basic health plan coverage if application is made no more
20 than ninety days prior to the date of disenrollment and the effective
21 date of the individual coverage applied for is the date of
22 disenrollment, or within ninety days thereafter.

23 (2) If, based upon the results of the standard health
24 questionnaire, the person qualifies for coverage under the Washington
25 state health insurance pool, the following shall apply:

26 (a) The carrier may decide not to accept the person's application
27 for enrollment in its individual health benefit plan and the health
28 care authority, as administrator of basic health plan nonsubsidized
29 coverage, shall not accept the person's application for enrollment as
30 a nonsubsidized enrollee; and

31 (b) Within fifteen business days of receipt of a completed
32 application, the carrier or the health care authority as administrator
33 of basic health plan nonsubsidized coverage shall provide written
34 notice of the decision not to accept the person's application for
35 enrollment to both the person and the administrator of the Washington
36 state health insurance pool. The notice to the person shall state that
37 the person is eligible for health insurance provided by the Washington
38 state health insurance pool, and shall include information about the

1 Washington state health insurance pool and an application for such
2 coverage. If the carrier or the health care authority as administrator
3 of basic health plan nonsubsidized coverage does not provide or
4 postmark such notice within fifteen business days, the application is
5 deemed approved.

6 (3) If the person applying for an individual health benefit plan:
7 (a) Does not qualify for coverage under the Washington state health
8 insurance pool based upon the results of the standard health
9 questionnaire; (b) does qualify for coverage under the Washington state
10 health insurance pool based upon the results of the standard health
11 questionnaire and the carrier elects to accept the person for
12 enrollment; or (c) is not required to complete the standard health
13 questionnaire designated under this chapter under subsection (1)(a) or
14 (b) of this section, the carrier or the health care authority as
15 administrator of basic health plan nonsubsidized coverage, whichever
16 entity administered the standard health questionnaire, shall accept the
17 person for enrollment if he or she resides within the carrier's or the
18 basic health plan's service area and provide or assure the provision of
19 all covered services regardless of age, sex, family structure,
20 ethnicity, race, health condition, geographic location, employment
21 status, socioeconomic status, other condition or situation, or the
22 provisions of RCW 49.60.174(2). The commissioner may grant a temporary
23 exemption from this subsection if, upon application by a health
24 carrier, the commissioner finds that the clinical, financial, or
25 administrative capacity to serve existing enrollees will be impaired if
26 a health carrier is required to continue enrollment of additional
27 eligible individuals.

28 **Sec. 38.** RCW 43.70.670 and 2003 c 274 s 2 are each amended to read
29 as follows:

30 (1) "Human immunodeficiency virus insurance program," as used in
31 this section, means a program that provides health insurance coverage
32 for individuals with human immunodeficiency virus, as defined in RCW
33 70.24.017(7), who are not eligible for medical assistance programs from
34 the department of social and health services as defined in RCW
35 74.09.010(8) and meet eligibility requirements established by the
36 department of health.

1 (2) The department of health may pay for health insurance coverage
2 on behalf of persons with human immunodeficiency virus, who meet
3 department eligibility requirements, and who are eligible for
4 "continuation coverage" as provided by the federal consolidated omnibus
5 budget reconciliation act of 1985, group health insurance policies, or
6 individual policies. (~~The number of insurance policies supported by
7 this program in the Washington state health insurance pool as defined
8 in RCW 48.41.030(18) shall not grow beyond the July 1, 2003, level.~~)

9 **PREVENTION AND HEALTH PROMOTION**

10 NEW SECTION. **Sec. 39.** (1) The Washington state health care
11 authority, the department of social and health services, the department
12 of labor and industries, and the department of health shall, by
13 September 1, 2007, develop a five-year plan to integrate disease and
14 accident prevention and health promotion into state purchased health
15 programs that they administer by:

16 (a) Structuring benefits and reimbursements to promote healthy
17 choices and disease and accident prevention;

18 (b) Encouraging enrollees in state health programs to complete a
19 health assessment, and providing appropriate follow up;

20 (c) Reimbursing for cost-effective prevention activities; and

21 (d) Developing prevention and health promotion contracting
22 standards for state programs that contract with health carriers.

23 (2) The plan shall: (a) Identify any existing barriers and
24 opportunities to support implementation, including needed changes to
25 state or federal law; (b) identify the goals the plan is intended to
26 achieve and how progress towards those goals will be measured and
27 reported; and (c) be submitted to the governor and the legislature upon
28 completion.

29 **Sec. 40.** RCW 41.05.540 and 2005 c 360 s 8 are each amended to read
30 as follows:

31 (1) The health care authority, in coordination with (~~the
32 department of personnel,~~) the department of health, health plans
33 participating in public employees' benefits board programs, and the
34 University of Washington's center for health promotion, (~~may create a~~

1 ~~worksite health promotion program to develop and implement initiatives~~
2 ~~designed to increase physical activity and promote improved self-care~~
3 ~~and engagement in health care decision-making among state employees.~~

4 ~~(2) The health care authority shall report to the governor and the~~
5 ~~legislature by December 1, 2006, on progress in implementing, and~~
6 ~~evaluating the results of, the worksite health promotion program))~~
7 shall establish and maintain a state employee health program focused on
8 reducing the health risks and improving the health status of state
9 employees, dependents, and retirees enrolled in the public employees'
10 benefits board. The program shall use public and private sector best
11 practices to achieve goals of measurable health outcomes, measurable
12 productivity improvements, positive impact on the cost of medical care,
13 and positive return on investment. The program shall establish
14 standards for health promotion and disease prevention activities, and
15 develop a mechanism to update standards as evidence-based research
16 brings new information and best practices forward.

17 (2) The state employee health program shall:

18 (a) Provide technical assistance and other services as needed to
19 wellness staff in all state agencies and institutions of higher
20 education;

21 (b) Develop effective communication tools and ongoing training for
22 wellness staff;

23 (c) Contract with outside vendors for evaluation of program goals;

24 (d) Strongly encourage the widespread completion of online health
25 assessment tools for all state employees, dependents, and retirees.
26 The health assessment tool must be voluntary and confidential. Health
27 assessment data and claims data shall be used to:

28 (i) Engage state agencies and institutions of higher education in
29 providing evidence-based programs targeted at reducing identified
30 health risks;

31 (ii) Guide contracting with third-party vendors to implement
32 behavior change tools for targeted high-risk populations; and

33 (iii) Guide the benefit structure for state employees, dependents,
34 and retirees to include covered services and medications known to
35 manage and reduce health risks.

36 (3) The health care authority shall report to the legislature in
37 December 2008 and December 2010 on outcome goals for the employee
38 health program.

1 NEW SECTION. **Sec. 41.** A new section is added to chapter 41.05 RCW
2 to read as follows:

3 (1) The health care authority through the state employee health
4 program shall implement a state employee health demonstration project.
5 The agencies selected must: (a) Show a high rate of health risk
6 assessment completion; (b) document an infrastructure capable of
7 implementing employee health programs using current and emerging best
8 practices; (c) show evidence of senior management support; and (d)
9 together employ a total of no more than eight thousand employees who
10 are enrolled in health plans of the public employees' benefits board.
11 Demonstration project agencies shall operate employee health programs
12 for their employees in collaboration with the state employee health
13 program.

14 (2) Agency demonstration project employee health programs:

15 (a) Shall include but are not limited to the following key
16 elements: Outreach to all staff with efforts made to reach the largest
17 percentage of employees possible; awareness-building information that
18 promotes health; motivational opportunities that encourage employees to
19 improve their health; behavior change opportunities that demonstrate
20 and support behavior change; and tools to improve employee health care
21 decisions;

22 (b) Must have wellness staff with direct accountability to agency
23 senior management;

24 (c) Shall initiate and maintain employee health programs using
25 current and emerging best practices in the field of health promotion;

26 (d) May offer employees such incentives as cash for completing
27 health risk assessments, free preventive screenings, training in
28 behavior change tools, improved nutritional standards on agency
29 campuses, bike racks, walking maps, on-site weight reduction programs,
30 and regular communication to promote personal health awareness.

31 (3) The state employee health program shall evaluate each of the
32 four programs separately and compare outcomes for each of them with the
33 entire state employee population to assess effectiveness of the
34 programs. Specifically, the program shall measure at least the
35 following outcomes in the demonstration population: The reduction in
36 the percent of the population that is overweight or obese, the
37 reduction in risk factors related to diabetes, the reduction in risk
38 factors related to absenteeism, the reduction in tobacco consumption,

1 the reduction in high blood pressure and high cholesterol, and the
2 increase in appropriate use of preventive health services. The state
3 employee health program shall report to the legislature in December
4 2008 and December 2010 on the demonstration project.

5 (4) This section expires June 30, 2011.

6 **PRESCRIPTION MONITORING PROGRAM**

7 NEW SECTION. **Sec. 42.** The definitions in this section apply
8 throughout this chapter unless the context clearly requires otherwise.

9 (1) "Controlled substance" has the meaning provided in RCW
10 69.50.101.

11 (2) "Department" means the department of health.

12 (3) "Patient" means the person or animal who is the ultimate user
13 of a drug for whom a prescription is issued or for whom a drug is
14 dispensed.

15 (4) "Dispenser" means a practitioner or pharmacy that delivers a
16 Schedule II, III, IV, or V controlled substance to the ultimate user,
17 but does not include:

18 (a) A practitioner or other authorized person who administers, as
19 defined in RCW 69.41.010, a controlled substance; or

20 (b) A licensed wholesale distributor or manufacturer, as defined in
21 chapter 18.64 RCW, of a controlled substance.

22 NEW SECTION. **Sec. 43.** (1) When sufficient funding is provided for
23 such purpose through federal or private grants, or is appropriated by
24 the legislature, the department shall establish and maintain a
25 prescription monitoring program to monitor the prescribing and
26 dispensing of all Schedules II, III, IV, and V controlled substances
27 and any additional drugs identified by the board of pharmacy as
28 demonstrating a potential for abuse by all professionals licensed to
29 prescribe or dispense such substances in this state. The program shall
30 be designed to improve health care quality and effectiveness by
31 reducing abuse of controlled substances, reducing duplicative
32 prescribing and over-prescribing of controlled substances, and
33 improving controlled substance prescribing practices with the intent of
34 eventually establishing an electronic database available in real time

1 to dispensers and prescribers of control substances. As much as
2 possible, the department should establish a common database with other
3 states.

4 (2) Except as provided in subsection (4) of this section, each
5 dispenser shall submit to the department by electronic means
6 information regarding each prescription dispensed for a drug included
7 under subsection (1) of this section. Drug prescriptions for more than
8 immediate one day use should be reported. The information submitted
9 for each prescription shall include, but not be limited to:

- 10 (a) Patient identifier;
- 11 (b) Drug dispensed;
- 12 (c) Date of dispensing;
- 13 (d) Quantity dispensed;
- 14 (e) Prescriber; and
- 15 (f) Dispenser.

16 (3) Each dispenser shall submit the information in accordance with
17 transmission methods established by the department.

18 (4) The data submission requirements of this section do not apply
19 to:

20 (a) Medications provided to patients receiving inpatient services
21 provided at hospitals licensed under chapter 70.41 RCW; or patients of
22 such hospitals receiving services at the clinics, day surgery areas, or
23 other settings within the hospital's license where the medications are
24 administered in single doses; or

25 (b) Pharmacies operated by the department of corrections for the
26 purpose of providing medications to offenders in department of
27 corrections institutions who are receiving pharmaceutical services from
28 a department of corrections pharmacy, except that the department of
29 corrections must submit data related to each offender's current
30 prescriptions for controlled substances upon the offender's release
31 from a department of corrections institution.

32 (5) The department shall seek federal grants to support the
33 activities described in this act. The department may not require a
34 practitioner or a pharmacist to pay a fee or tax specifically dedicated
35 to the operation of the system.

36 NEW SECTION. **Sec. 44.** To the extent that funding is provided for
37 such purpose through federal or private grants, or is appropriated by

1 the legislature, the health care authority shall study the feasibility
2 of enhancing the prescription monitoring program established in section
3 43 of this act in order to improve the quality of state purchased
4 health services by reducing legend drug abuse, reducing duplicative and
5 overprescribing of legend drugs, and improving legend drug prescribing
6 practices. The study shall address the steps necessary to expand the
7 program to allow those who prescribe or dispense prescription drugs to
8 perform a web-based inquiry and obtain real time information regarding
9 the legend drug utilization history of persons for whom they are
10 providing medical or pharmaceutical care when such persons are
11 receiving health services through state purchased health care programs.

12 NEW SECTION. **Sec. 45.** (1) Prescription information submitted to
13 the department shall be confidential, in compliance with chapter 70.02
14 RCW and federal health care information privacy requirements and not
15 subject to disclosure, except as provided in subsections (3) and (4) of
16 this section.

17 (2) The department shall maintain procedures to ensure that the
18 privacy and confidentiality of patients and patient information
19 collected, recorded, transmitted, and maintained is not disclosed to
20 persons except as in subsections (3) and (4) of this section.

21 (3) The department may provide data in the prescription monitoring
22 program to the following persons:

23 (a) Persons authorized to prescribe or dispense controlled
24 substances, for the purpose of providing medical or pharmaceutical care
25 for their patients;

26 (b) An individual who requests the individual's own prescription
27 monitoring information;

28 (c) Health professional licensing, certification, or regulatory
29 agency or entity;

30 (d) Appropriate local, state, and federal law enforcement or
31 prosecutorial officials who are engaged in a bona fide specific
32 investigation involving a designated person;

33 (e) Authorized practitioners of the department of social and health
34 services regarding medicaid program recipients;

35 (f) The director or director's designee within the department of
36 labor and industries regarding workers' compensation claimants;

1 (g) The director or the director's designee within the department
2 of corrections regarding offenders committed to the department of
3 corrections;

4 (h) Other entities under grand jury subpoena or court order; and

5 (i) Personnel of the department for purposes of administration and
6 enforcement of this chapter or chapter 69.50 RCW.

7 (4) The department may provide data to public or private entities
8 for statistical, research, or educational purposes after removing
9 information that could be used to identify individual patients,
10 dispensers, prescribers, and persons who received prescriptions from
11 dispensers.

12 (5) A dispenser or practitioner acting in good faith is immune from
13 any civil, criminal, or administrative liability that might otherwise
14 be incurred or imposed for requesting, receiving, or using information
15 from the program.

16 NEW SECTION. **Sec. 46.** The department may contract with another
17 agency of this state or with a private vendor, as necessary, to ensure
18 the effective operation of the prescription monitoring program. Any
19 contractor is bound to comply with the provisions regarding
20 confidentiality of prescription information in section 45 of this act
21 and is subject to the penalties specified in section 48 of this act for
22 unlawful acts.

23 NEW SECTION. **Sec. 47.** The department shall adopt rules to
24 implement this chapter.

25 NEW SECTION. **Sec. 48.** (1) A dispenser who knowingly fails to
26 submit prescription monitoring information to the department as
27 required by this chapter or knowingly submits incorrect prescription
28 information is subject to disciplinary action under chapter 18.130 RCW.

29 (2) A person authorized to have prescription monitoring information
30 under this chapter who knowingly discloses such information in
31 violation of this chapter is subject to civil penalty.

32 (3) A person authorized to have prescription monitoring information
33 under this chapter who uses such information in a manner or for a
34 purpose in violation of this chapter is subject to civil penalty.

1 (4) In accordance with chapter 70.02 RCW and federal health care
2 information privacy requirements, any physician or pharmacist
3 authorized to access a patient's prescription monitoring may discuss or
4 release that information to other health care providers involved with
5 the patient in order to provide safe and appropriate care coordination.

6 **Sec. 49.** RCW 42.56.360 and 2006 c 209 s 9 and 2006 c 8 s 112 are
7 each reenacted and amended to read as follows:

8 (1) The following health care information is exempt from disclosure
9 under this chapter:

10 (a) Information obtained by the board of pharmacy as provided in
11 RCW 69.45.090;

12 (b) Information obtained by the board of pharmacy or the department
13 of health and its representatives as provided in RCW 69.41.044,
14 69.41.280, and 18.64.420;

15 (c) Information and documents created specifically for, and
16 collected and maintained by a quality improvement committee under RCW
17 43.70.510 or 70.41.200, or by a peer review committee under RCW
18 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640
19 or 18.20.390, and notifications or reports of adverse events or
20 incidents made under RCW 70.56.020 or 70.56.040, regardless of which
21 agency is in possession of the information and documents;

22 (d)(i) Proprietary financial and commercial information that the
23 submitting entity, with review by the department of health,
24 specifically identifies at the time it is submitted and that is
25 provided to or obtained by the department of health in connection with
26 an application for, or the supervision of, an antitrust exemption
27 sought by the submitting entity under RCW 43.72.310;

28 (ii) If a request for such information is received, the submitting
29 entity must be notified of the request. Within ten business days of
30 receipt of the notice, the submitting entity shall provide a written
31 statement of the continuing need for confidentiality, which shall be
32 provided to the requester. Upon receipt of such notice, the department
33 of health shall continue to treat information designated under this
34 subsection (1)(d) as exempt from disclosure;

35 (iii) If the requester initiates an action to compel disclosure
36 under this chapter, the submitting entity must be joined as a party to
37 demonstrate the continuing need for confidentiality;

1 (e) Records of the entity obtained in an action under RCW 18.71.300
2 through 18.71.340;

3 (f) Except for published statistical compilations and reports
4 relating to the infant mortality review studies that do not identify
5 individual cases and sources of information, any records or documents
6 obtained, prepared, or maintained by the local health department for
7 the purposes of an infant mortality review conducted by the department
8 of health under RCW 70.05.170; (~~and~~)

9 (g) Complaints filed under chapter 18.130 RCW after July 27, 1997,
10 to the extent provided in RCW 18.130.095(1); and

11 (h) Information obtained by the department of health under chapter
12 70.-- RCW (sections 42 through 48 of this act).

13 (2) Chapter 70.02 RCW applies to public inspection and copying of
14 health care information of patients.

15 STRATEGIC HEALTH PLANNING

16 NEW SECTION. **Sec. 50.** The definitions in this section apply
17 throughout this chapter unless the context clearly requires otherwise.

18 (1) "Health care provider" means an individual who holds a license
19 issued by a disciplining authority identified in RCW 18.130.040 and who
20 practices his or her profession in a health care facility or provides
21 a health service.

22 (2) "Health facility" or "facility" means hospices licensed under
23 chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural
24 health care facilities as defined in RCW 70.175.020, psychiatric
25 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
26 under chapter 18.51 RCW, community mental health centers licensed under
27 chapter 71.05 or 71.24 RCW, kidney disease treatment centers,
28 ambulatory diagnostic, treatment, or surgical facilities, drug and
29 alcohol treatment facilities licensed under chapter 70.96A RCW, and
30 home health agencies licensed under chapter 70.127 RCW, and includes
31 such facilities if owned and operated by a political subdivision,
32 including a public hospital district, or instrumentality of the state
33 and such other facilities as required by federal law and implementing
34 regulations.

35 (3) "Health service" or "service" means that service, including

1 primary care service, offered or provided by health care facilities and
2 health care providers relating to the prevention, cure, or treatment of
3 illness, injury, or disease.

4 (4) "Health service area" means a geographic region appropriate for
5 effective health planning that includes a broad range of health
6 services.

7 (5) "Office" means the office of financial management.

8 (6) "Strategy" means the statewide health resources strategy.

9 NEW SECTION. **Sec. 51.** (1) The office shall serve as a
10 coordinating body for public and private efforts to improve quality in
11 health care, promote cost-effectiveness in health care, and plan health
12 facility and health service availability. In addition, the office
13 shall facilitate access to health care data collected by public and
14 private organizations as needed to conduct its planning
15 responsibilities.

16 (2) The office shall:

17 (a) Conduct strategic health planning activities related to the
18 preparation of the strategy, as specified in this chapter;

19 (b) Develop a computerized system for accessing, analyzing, and
20 disseminating data relevant to strategic health planning
21 responsibilities. The office may contract with an organization to
22 create the computerized system capable of meeting the needs of the
23 office;

24 (c) Maintain access to deidentified data collected and stored by
25 any public and private organizations as necessary to support its
26 planning responsibilities, including state-purchased health care
27 program data, hospital discharge data, and private efforts to collect
28 utilization and claims-related data. The office is authorized to enter
29 into any data sharing agreements and contractual arrangements necessary
30 to obtain data or to distribute data. Among the sources of
31 deidentified data that the office may access are any databases
32 established pursuant to the recommendations of the health information
33 infrastructure advisory board established by chapter 261, Laws of 2005.
34 The office may store limited data sets as necessary to support its
35 activities. Unless specifically authorized, the office shall not
36 collect data directly from the records of health care providers and

1 health care facilities, but shall make use of databases that have
2 already collected such information; and

3 (d) Conduct research and analysis or arrange for research and
4 analysis projects to be conducted by public or private organizations to
5 further the purposes of the strategy.

6 (3) The office shall establish a technical advisory committee to
7 assist in the development of the strategy. Members of the committee
8 shall include health economists, health planners, representatives of
9 government and nongovernment health care purchasers, representatives of
10 state agencies that use or regulate entities with an interest in health
11 planning, representatives of acute care facilities, representatives of
12 long-term care facilities, representatives of community-based long-term
13 care providers, representatives of health care providers, a
14 representative of one or more federally recognized Indian tribes, and
15 representatives of health care consumers. The committee shall include
16 members with experience in the provision of health services to rural
17 communities.

18 NEW SECTION. **Sec. 52.** (1) The office, in consultation with the
19 technical advisory committee established under section 51 of this act,
20 shall develop a statewide health resources strategy. The strategy
21 shall establish statewide health planning policies and goals related to
22 the availability of health care facilities and services, quality of
23 care, and cost of care. The strategy shall identify needs according to
24 geographic regions suitable for comprehensive health planning as
25 designated by the office.

26 (2) The development of the strategy shall consider the following
27 general goals and principles:

28 (a) That excess capacity of health services and facilities place
29 considerable economic burden on the public who pay for the construction
30 and operation of these facilities as patients, health insurance
31 purchasers, carriers, and taxpayers; and

32 (b) That the development and ongoing maintenance of current and
33 accurate health care information and statistics related to cost and
34 quality of health care, as well as projections of need for health
35 facilities and services, are essential to effective strategic health
36 planning.

1 (3) The strategy, with public input by health service areas, shall
2 include:

3 (a) A health system assessment and objectives component that:

4 (i) Describes state and regional population demographics, health
5 status indicators, and trends in health status and health care needs;
6 and

7 (ii) Identifies key policy objectives for the state health system
8 related to access to care, health outcomes, quality, and cost-
9 effectiveness;

10 (b) A health care facilities and services plan that shall assess
11 the demand for health care facilities and services to inform state
12 health planning efforts and direct certificate of need determinations,
13 for those facilities and services subject to certificate of need as
14 provided in chapter 70.38 RCW. The plan shall include:

15 (i) An inventory of each geographic region's existing health care
16 facilities and services;

17 (ii) Projections of need for each category of health care facility
18 and service, including those subject to certificate of need;

19 (iii) Policies to guide the addition of new or expanded health care
20 facilities and services to promote the use of quality, evidence-based,
21 cost-effective health care delivery options, including any
22 recommendations for criteria, standards, and methods relevant to the
23 certificate of need review process; and

24 (iv) An assessment of the availability of health care providers,
25 public health resources, transportation infrastructure, and other
26 considerations necessary to support the needed health care facilities
27 and services in each region;

28 (c) A health care data resource plan that identifies data elements
29 necessary to properly conduct planning activities and to review
30 certificate of need applications, including data related to inpatient
31 and outpatient utilization and outcomes information, and financial and
32 utilization information related to charity care, quality, and cost.
33 The plan shall inventory existing data resources, both public and
34 private, that store and disclose information relevant to the health
35 planning process, including information necessary to conduct
36 certificate of need activities pursuant to chapter 70.38 RCW. The plan
37 shall identify any deficiencies in the inventory of existing data
38 resources and the data necessary to conduct comprehensive health

1 planning activities. The plan may recommend that the office be
2 authorized to access existing data sources and conduct appropriate
3 analyses of such data or that other agencies expand their data
4 collection activities as statutory authority permits. The plan may
5 identify any computing infrastructure deficiencies that impede the
6 proper storage, transmission, and analysis of health planning data.
7 The plan shall provide recommendations for increasing the availability
8 of data related to health planning to provide greater community
9 involvement in the health planning process and consistency in data used
10 for certificate of need applications and determinations;

11 (d) An assessment of emerging trends in health care delivery and
12 technology as they relate to access to health care facilities and
13 services, quality of care, and costs of care. The assessment shall
14 recommend any changes to the scope of health care facilities and
15 services covered by the certificate of need program that may be
16 warranted by these emerging trends. In addition, the assessment may
17 recommend any changes to criteria used by the department to review
18 certificate of need applications, as necessary;

19 (e) A rural health resource plan to assess the availability of
20 health resources in rural areas of the state, assess the unmet needs of
21 these communities, and evaluate how federal and state reimbursement
22 policies can be modified, if necessary, to more efficiently and
23 effectively meet the health care needs of rural communities. The plan
24 shall consider the unique health care needs of rural communities, the
25 adequacy of the rural health workforce, and transportation needs for
26 accessing appropriate care.

27 (4) The office shall submit the initial strategy to the governor
28 and the appropriate committees of the senate and house of
29 representatives by January 1, 2010. Every two years the office shall
30 submit an updated strategy. The health care facilities and services
31 plan as it pertains to a distinct geographic planning region may be
32 updated by individual categories on a rotating, biannual schedule.

33 (5) The office shall hold at least one public hearing and allow
34 opportunity to submit written comments prior to the issuance of the
35 initial strategy or an updated strategy. A public hearing shall be
36 held prior to issuing a draft of an updated health care facilities and
37 services plan, and another public hearing shall be held before final
38 adoption of an updated health care facilities and services plan. Any

1 hearing related to updating a health care facilities and services plan
2 for a specific planning region shall be held in that region with
3 sufficient notice to the public and an opportunity to comment.

4 NEW SECTION. **Sec. 53.** The office shall submit the strategy to the
5 department of health to direct its activities related to the
6 certificate of need review program under chapter 70.38 RCW. As the
7 health care facilities and services plan is updated for any specific
8 geographic planning region, the office shall submit that plan to the
9 department of health to direct its activities related to the
10 certificate of need review program under chapter 70.38 RCW. The office
11 shall not issue determinations of the merits of specific project
12 proposals submitted by applicants for certificates of need.

13 NEW SECTION. **Sec. 54.** (1) The office may respond to requests for
14 data and other information from its computerized system for special
15 studies and analysis consistent with requirements for confidentiality
16 of patient, provider, and facility-specific records. The office may
17 require requestors to pay any or all of the reasonable costs associated
18 with such requests that might be approved.

19 (2) Data elements related to the identification of individual
20 patient's, provider's, and facility's care outcomes are confidential,
21 are exempt from RCW 42.56.030 through 42.56.570 and 42.17.350 through
22 42.17.450, and are not subject to discovery by subpoena or admissible
23 as evidence.

24 **Sec. 55.** RCW 70.38.015 and 1989 1st ex.s. c 9 s 601 are each
25 amended to read as follows:

26 It is declared to be the public policy of this state:

27 (1) That strategic health planning ((~~to~~)) efforts must be supported
28 by appropriately tailored regulatory activities that can effectuate the
29 goals and principles of the statewide health resources strategy
30 developed pursuant to chapter 43.-- RCW (sections 50 through 54 of this
31 act). The implementation of the strategy can promote, maintain, and
32 assure the health of all citizens in the state, ((~~to~~)) provide
33 accessible health services, health manpower, health facilities, and
34 other resources while controlling ((~~excessive~~)) increases in costs, and
35 ((~~to~~)) recognize prevention as a high priority in health programs((~~is~~

1 essential to the health, safety, and welfare of the people of the
2 state. Health planning should be responsive to changing health and
3 social needs and conditions)). Involvement in health planning from
4 both consumers and providers throughout the state should be encouraged;

5 (2) ~~((That the development of health services and resources,~~
6 ~~including the construction, modernization, and conversion of health~~
7 ~~facilities, should be accomplished in a planned, orderly fashion,~~
8 ~~consistent with identified priorities and without unnecessary~~
9 ~~duplication or fragmentation)) That the certificate of need program is
10 a component of a health planning regulatory process that is consistent
11 with the statewide health resources strategy and public policy goals
12 that are clearly articulated and regularly updated;~~

13 (3) That the development and maintenance of adequate health care
14 information, statistics and projections of need for health facilities
15 and services is essential to effective health planning and resources
16 development;

17 (4) That the development of nonregulatory approaches to health care
18 cost containment should be considered, including the strengthening of
19 price competition; and

20 (5) That health planning should be concerned with public health and
21 health care financing, access, and quality, recognizing their close
22 interrelationship and emphasizing cost control of health services,
23 including cost-effectiveness and cost-benefit analysis.

24 NEW SECTION. Sec. 56. (1) For the purposes of this section and
25 RCW 70.38.015 and 70.38.135, "statewide health resource strategy" or
26 "strategy" means the statewide health resource strategy developed by
27 the office of financial management pursuant to chapter 43.-- RCW
28 (sections 50 through 54 of this act).

29 (2) Effective January 1, 2010, for those facilities and services
30 covered by the certificate of need programs, certificate of need
31 determinations must be consistent with the statewide health resources
32 strategy developed pursuant to section 52 of this act, including any
33 health planning policies and goals identified in the statewide health
34 resources strategy in effect at the time of application. The
35 department may waive specific terms of the strategy if the applicant
36 demonstrates that consistency with those terms will create an undue

1 burden on the population that a particular project would serve, or in
2 emergency circumstances which pose a threat to public health.

3 **Sec. 57.** RCW 70.38.135 and 1989 1st ex.s. c 9 s 607 are each
4 amended to read as follows:

5 The secretary shall have authority to:

6 (1) Provide when needed temporary or intermittent services of
7 experts or consultants or organizations thereof, by contract, when such
8 services are to be performed on a part time or fee-for-service basis;

9 (2) Make or cause to be made such on-site surveys of health care or
10 medical facilities as may be necessary for the administration of the
11 certificate of need program;

12 (3) Upon review of recommendations, if any, from the board of
13 health or the office of financial management as contained in the
14 Washington health resources strategy;

15 (a) Promulgate rules under which health care facilities providers
16 doing business within the state shall submit to the department such
17 data related to health and health care as the department finds
18 necessary to the performance of its functions under this chapter;

19 (b) Promulgate rules pertaining to the maintenance and operation of
20 medical facilities which receive federal assistance under the
21 provisions of Title XVI;

22 (c) Promulgate rules in implementation of the provisions of this
23 chapter, including the establishment of procedures for public hearings
24 for predecisions and post-decisions on applications for certificate of
25 need;

26 (d) Promulgate rules providing circumstances and procedures of
27 expedited certificate of need review if there has not been a
28 significant change in existing health facilities of the same type or in
29 the need for such health facilities and services;

30 (4) Grant allocated state funds to qualified entities, as defined
31 by the department, to fund not more than seventy-five percent of the
32 costs of regional planning activities, excluding costs related to
33 review of applications for certificates of need, provided for in this
34 chapter or approved by the department; and

35 (5) Contract with and provide reasonable reimbursement for
36 qualified entities to assist in determinations of certificates of need.

1 HEALTH INSURANCE PARTNERSHIP

2 Sec. 58. RCW 70.47A.030 and 2006 c 255 s 3 are each amended to
3 read as follows:

4 (1) To the extent funding is appropriated in the operating budget
5 for this purpose, the ((small-employer)) health insurance partnership
6 ((program)) is established. The administrator shall be responsible for
7 the implementation and operation of the ((small-employer)) health
8 insurance partnership ((program)), directly or by contract. The
9 administrator shall offer premium subsidies to eligible ((employees))
10 partnership participants under RCW 70.47A.040.

11 (2) Consistent with policies adopted by the board under section 59
12 of this act, the administrator shall, directly or by contract:

13 (a) Establish and administer procedures for enrolling small
14 employers in the partnership, including publicizing the existence of
15 the partnership and disseminating information on enrollment, and
16 establishing rules related to minimum participation of employees in
17 small groups purchasing health insurance through the partnership.
18 Opportunities to publicize the program for outreach and education of
19 small employers on the value of insurance shall explore the use of
20 online employer guides. As a condition of participating in the
21 partnership, a small employer must agree to establish a cafeteria plan
22 under section 125 of the federal internal revenue code that will enable
23 employees to use pretax dollars to pay their share of their health
24 benefit plan premium. The partnership shall provide technical
25 assistance to small employers for this purpose;

26 (b) Establish and administer procedures for health benefit plan
27 enrollment by employees of small employers during open enrollment
28 periods and outside of open enrollment periods upon the occurrence of
29 any qualifying event specified in the federal health insurance
30 portability and accountability act of 1996 or applicable state law.
31 Neither the employer nor the partnership shall limit an employee's
32 choice of coverage from among all the health benefit plans offered;

33 (c) Establish and manage a system for the partnership to be
34 designated as the sponsor or administrator of a participating small
35 employer health benefit plan and to undertake the obligations required
36 of a plan administrator under federal law;

37 (d) Establish and manage a system of collecting and transmitting to
38 the applicable carriers all premium payments or contributions made by

1 or on behalf of partnership participants, including employer
2 contributions, automatic payroll deductions for partnership
3 participants, premium subsidy payments, and contributions from
4 philanthropies;

5 (e) Establish and manage a system for determining eligibility for
6 and making premium subsidy payments under this act;

7 (f) Establish a mechanism to apply a surcharge to all health
8 benefit plans, which shall be used only to pay for administrative and
9 operational expenses of the partnership. The surcharge must be applied
10 uniformly to all health benefit plans offered through the partnership
11 and must be included in the premium for each health benefit plan.
12 Surcharges may not be used to pay any premium assistance payments under
13 this chapter;

14 (g) Design a schedule of premium subsidies that is based upon gross
15 family income, giving appropriate consideration to family size and the
16 ages of all family members based on a benchmark health benefit plan
17 designated by the board. The amount of an eligible partnership
18 participant's premium subsidy shall be determined by applying a sliding
19 scale subsidy schedule with the percentage of premium similar to that
20 developed for subsidized basic health plan enrollees under RCW
21 70.47.060. The subsidy shall be applied to the employee's premium
22 obligation for his or her health benefit plan, so that employees
23 benefit financially from any employer contribution to the cost of their
24 coverage through the partnership.

25 (3) The administrator may enter into interdepartmental agreements
26 with the office of the insurance commissioner, the department of social
27 and health services, and any other state agencies necessary to
28 implement this chapter.

29 ****NEW SECTION. Sec. 59. A new section is added to chapter 70.47A***
30 ***RCW to read as follows:***

31 ***(1) The health insurance partnership board is hereby established.***
32 ***The governor shall appoint a nine-member board composed as follows:***

33 ***(a) Two representatives of small employers;***
34 ***(b) Two representatives of employees of small employers, one of***
35 ***whom shall represent low-wage employees;***

36 ***(c) Four employee health plan benefits specialists; and***

37 ***(d) The administrator.***

1 purposes of sections 60 through 65 of this act, distributions to local
2 health jurisdictions shall deliver the following outcomes:

3 (a) Create a disease response system capable of responding at all
4 times;

5 (b) Stop the increase in, and reduce, sexually transmitted disease
6 rates;

7 (c) Reduce vaccine preventable diseases;

8 (d) Build capacity to quickly contain disease outbreaks;

9 (e) Decrease childhood and adult obesity and types I and II
10 diabetes rates, and resulting kidney failure and dialysis;

11 (f) Increase childhood immunization rates;

12 (g) Improve birth outcomes and decrease child abuse;

13 (h) Reduce animal-to-human disease rates; and

14 (i) Monitor and protect drinking water across jurisdictional
15 boundaries.

16 (3) Benchmarks for these outcomes shall be drawn from the national
17 healthy people 2010 goals, other reliable data sets, and any subsequent
18 national goals.

19 NEW SECTION. **Sec. 61.** A new section is added to chapter 43.70 RCW
20 to read as follows:

21 The definitions in this section apply throughout sections 60
22 through 65 of this act unless the context clearly requires otherwise.

23 (1) "Core public health functions of statewide significance" or
24 "public health functions" means health services that:

25 (a) Address: Communicable disease prevention and response;
26 preparation for, and response to, public health emergencies caused by
27 pandemic disease, earthquake, flood, or terrorism; prevention and
28 management of chronic diseases and disabilities; promotion of healthy
29 families and the development of children; assessment of local health
30 conditions, risks, and trends, and evaluation of the effectiveness of
31 intervention efforts; and environmental health concerns;

32 (b) Promote uniformity in the public health activities conducted by
33 all local health jurisdictions in the public health system, increase
34 the overall strength of the public health system, or apply to broad
35 public health efforts; and

36 (c) If left neglected or inadequately addressed, are reasonably

1 likely to have a significant adverse impact on counties beyond the
2 borders of the local health jurisdiction.

3 (2) "Local health jurisdiction" or "jurisdiction" means a county
4 board of health organized under chapter 70.05 RCW, a health district
5 organized under chapter 70.46 RCW, or a combined city and county health
6 department organized under chapter 70.08 RCW.

7 NEW SECTION. **Sec. 62.** A new section is added to chapter 43.70 RCW
8 to read as follows:

9 (1) The department shall accomplish the tasks included in
10 subsection (2) of this section by utilizing the expertise of varied
11 interests, as provided in this subsection.

12 (a) In addition to the perspectives of local health jurisdictions,
13 the state board of health, the Washington health foundation, and
14 department staff that are currently engaged in development of the
15 public health services improvement plan under RCW 43.70.520, the
16 secretary shall actively engage:

17 (i) Individuals or entities with expertise in the development of
18 performance measures, accountability and systems management, such as
19 the University of Washington school of public health and community
20 medicine, and experts in the development of evidence-based medical
21 guidelines or public health practice guidelines; and

22 (ii) Individuals or entities who will be impacted by performance
23 measures developed under this section and have relevant expertise, such
24 as community clinics, public health nurses, large employers, tribal
25 health providers, family planning providers, and physicians.

26 (b) In developing the performance measures, consideration shall be
27 given to levels of performance necessary to promote uniformity in core
28 public health functions of statewide significance among all local
29 health jurisdictions, best scientific evidence, national standards of
30 performance, and innovations in public health practice. The
31 performance measures shall be developed to meet the goals and outcomes
32 in section 60 of this act. The office of the state auditor shall
33 provide advice and consultation to the committee to assist in the
34 development of effective performance measures and health status
35 indicators.

36 (c) On or before November 1, 2007, the experts assembled under this
37 section shall provide recommendations to the secretary related to the

1 activities and services that qualify as core public health functions of
2 statewide significance and performance measures. The secretary shall
3 provide written justification for any departure from the
4 recommendations.

5 (2) By January 1, 2008, the department shall:

6 (a) Adopt a prioritized list of activities and services performed
7 by local health jurisdictions that qualify as core public health
8 functions of statewide significance as defined in section 61 of this
9 act; and

10 (b) Adopt appropriate performance measures with the intent of
11 improving health status indicators applicable to the core public health
12 functions of statewide significance that local health jurisdictions
13 must provide.

14 (3) The secretary may revise the list of activities and the
15 performance measures in future years as appropriate. Prior to
16 modifying either the list or the performance measures, the secretary
17 must provide a written explanation of the rationale for such changes.

18 (4) The department and the local health jurisdictions shall abide
19 by the prioritized list of activities and services and the performance
20 measures developed pursuant to this section.

21 (5) The department, in consultation with representatives of county
22 governments, shall provide local jurisdictions with financial
23 incentives to encourage and increase local investments in core public
24 health functions. The local jurisdictions shall not supplant existing
25 local funding with such state-incented resources.

26 NEW SECTION. **Sec. 63.** A new section is added to chapter 43.70 RCW
27 to read as follows:

28 Beginning November 15, 2009, the department shall report to the
29 legislature and the governor annually on the distribution of funds to
30 local health jurisdictions under sections 60 through 65 of this act and
31 the use of those funds. The initial report must discuss the
32 performance measures adopted by the secretary and any impact the
33 funding in this act has had on local health jurisdiction performance
34 and health status indicators. Future reports shall evaluate trends in
35 performance over time and the effects of expenditures on performance
36 over time.

1 **Sec. 64.** RCW 43.70.520 and 1993 c 492 s 467 are each amended to
2 read as follows:

3 (1) The legislature finds that the public health functions of
4 community assessment, policy development, and assurance of service
5 delivery are essential elements in achieving the objectives of health
6 reform in Washington state. The legislature further finds that the
7 population-based services provided by state and local health
8 departments are cost-effective and are a critical strategy for the
9 long-term containment of health care costs. The legislature further
10 finds that the public health system in the state lacks the capacity to
11 fulfill these functions consistent with the needs of a reformed health
12 care system. The legislature further finds that public health nurses
13 and nursing services are an essential part of our public health system,
14 delivering evidence-based care and providing core services including
15 prevention of illness, injury, or disability; the promotion of health;
16 and maintenance of the health of populations.

17 (2) The department of health shall develop, in consultation with
18 local health departments and districts, the state board of health, the
19 health services commission, area Indian health service, and other state
20 agencies, health services providers, and citizens concerned about
21 public health, a public health services improvement plan. The plan
22 shall provide a detailed accounting of deficits in the core functions
23 of assessment, policy development, assurance of the current public
24 health system, how additional public health funding would be used, and
25 describe the benefits expected from expanded expenditures.

26 (3) The plan shall include:

27 (a) Definition of minimum standards for public health protection
28 through assessment, policy development, and assurances:

29 (i) Enumeration of communities not meeting those standards;

30 (ii) A budget and staffing plan for bringing all communities up to
31 minimum standards;

32 (iii) An analysis of the costs and benefits expected from adopting
33 minimum public health standards for assessment, policy development, and
34 assurances;

35 (b) Recommended strategies and a schedule for improving public
36 health programs throughout the state, including:

37 (i) Strategies for transferring personal health care services from

1 the public health system, into the uniform benefits package where
2 feasible; and

3 ~~(ii) ((Timing of increased funding for public health services~~
4 ~~linked to specific objectives for improving public health))~~ Linking
5 funding for public health services to performance measures that relate
6 to achieving improved health outcomes; and

7 (c) A recommended level of dedicated funding for public health
8 services to be expressed in terms of a percentage of total health
9 service expenditures in the state or a set per person amount; such
10 recommendation shall also include methods to ensure that such funding
11 does not supplant existing federal, state, and local funds received by
12 local health departments, and methods of distributing funds among local
13 health departments.

14 (4) The department shall coordinate this planning process with the
15 study activities required in section 258, chapter 492, Laws of 1993.

16 (5) By March 1, 1994, the department shall provide initial
17 recommendations of the public health services improvement plan to the
18 legislature regarding minimum public health standards, and public
19 health programs needed to address urgent needs, such as those cited in
20 subsection (7) of this section.

21 (6) By December 1, 1994, the department shall present the public
22 health services improvement plan to the legislature, with specific
23 recommendations for each element of the plan to be implemented over the
24 period from 1995 through 1997.

25 (7) Thereafter, the department shall update the public health
26 services improvement plan for presentation to the legislature prior to
27 the beginning of a new biennium.

28 (8) Among the specific population-based public health activities to
29 be considered in the public health services improvement plan are:
30 Health data assessment and chronic and infectious disease surveillance;
31 rapid response to outbreaks of communicable disease; efforts to prevent
32 and control specific communicable diseases, such as tuberculosis and
33 acquired immune deficiency syndrome; health education to promote
34 healthy behaviors and to reduce the prevalence of chronic disease, such
35 as those linked to the use of tobacco; access to primary care in
36 coordination with existing community and migrant health clinics and
37 other not for profit health care organizations; programs to ensure
38 children are born as healthy as possible and they receive immunizations

1 and adequate nutrition; efforts to prevent intentional and
2 unintentional injury; programs to ensure the safety of drinking water
3 and food supplies; poison control; trauma services; and other
4 activities that have the potential to improve the health of the
5 population or special populations and reduce the need for or cost of
6 health services.

7 NEW SECTION. **Sec. 65.** A new section is added to chapter 43.70 RCW
8 to read as follows:

9 (1) Each local health jurisdiction shall submit to the secretary
10 such data as the secretary determines is necessary to allow the
11 secretary to assess whether the local health jurisdiction has used the
12 funds in a manner consistent with achieving the performance measures in
13 section 62 of this act.

14 (2) If the secretary determines that the data submitted
15 demonstrates that the local health jurisdiction is not spending the
16 funds in a manner consistent with achieving the performance measures,
17 the secretary shall:

18 (a) Provide a report to the governor identifying the local health
19 jurisdiction and the specific items that the secretary identified as
20 inconsistent with achieving the performance measures; and

21 (b) Require that the local health jurisdiction submit a plan of
22 correction to the secretary within sixty days of receiving notice from
23 the secretary, which explains the measures that the jurisdiction will
24 take to resume spending funds in a manner consistent with achieving the
25 performance measures. The secretary shall provide technical assistance
26 to the local health jurisdiction to support the jurisdiction in
27 successfully completing the activities included in the plan of
28 correction.

29 (3) Upon a determination by the secretary that a local health
30 jurisdiction that had previously been identified as not spending the
31 funds in a manner consistent with achieving the performance measures
32 has resumed consistency, the secretary shall notify the governor that
33 the jurisdiction has returned to consistent status.

34 (4) Any local health jurisdiction that has not resumed spending
35 funds in a manner consistent with achieving the performance measures
36 within one year of the secretary reporting the jurisdiction to the
37 governor shall be precluded from receiving any funds appropriated for

1 the purposes of sections 60 through 65 of this act. Funds may resume
2 once the local health jurisdiction has demonstrated to the satisfaction
3 of the secretary that it has returned to consistent status.

4 **Sec. 66.** RCW 70.48.130 and 1993 c 409 s 1 are each amended to read
5 as follows:

6 It is the intent of the legislature that all jail inmates receive
7 appropriate and cost-effective emergency and necessary medical care.
8 Governing units, the department of social and health services, and
9 medical care providers shall cooperate to achieve the best rates
10 consistent with adequate care.

11 Payment for emergency or necessary health care shall be by the
12 governing unit, except that the department of social and health
13 services shall directly reimburse the provider pursuant to chapter
14 74.09 RCW, in accordance with the rates and benefits established by the
15 department, if the confined person is eligible under the department's
16 medical care programs as authorized under chapter 74.09 RCW. After
17 payment by the department, the financial responsibility for any
18 remaining balance, including unpaid client liabilities that are a
19 condition of eligibility or participation under chapter 74.09 RCW,
20 shall be borne by the medical care provider and the governing unit as
21 may be mutually agreed upon between the medical care provider and the
22 governing unit. In the absence of mutual agreement between the medical
23 care provider and the governing unit, the financial responsibility for
24 any remaining balance shall be borne equally between the medical care
25 provider and the governing unit. Total payments from all sources to
26 providers for care rendered to confined persons eligible under chapter
27 74.09 RCW shall not exceed the amounts that would be paid by the
28 department for similar services provided under Title XIX medicaid,
29 unless additional resources are obtained from the confined person.

30 As part of the screening process upon booking or preparation of an
31 inmate into jail, general information concerning the inmate's ability
32 to pay for medical care shall be identified, including insurance or
33 other medical benefits or resources to which an inmate is entitled.
34 This information shall be made available to the department, the
35 governing unit, and any provider of health care services.

36 The governing unit or provider may obtain reimbursement from the
37 confined person for the cost of health care services not provided under

1 chapter 74.09 RCW, including reimbursement from any insurance program
2 or from other medical benefit programs available to the confined
3 person. Nothing in this chapter precludes civil or criminal remedies
4 to recover the costs of medical care provided jail inmates or paid for
5 on behalf of inmates by the governing unit. As part of a judgment and
6 sentence, the courts are authorized to order defendants to repay all or
7 part of the medical costs incurred by the governing unit or provider
8 during confinement.

9 To the extent that a confined person is unable to be financially
10 responsible for medical care and is ineligible for the department's
11 medical care programs under chapter 74.09 RCW, or for coverage from
12 private sources, and in the absence of an interlocal agreement or other
13 contracts to the contrary, the governing unit may obtain reimbursement
14 for the cost of such medical services from the unit of government
15 (~~whose law enforcement officers~~) that initiated the charges on which
16 the person is being held in the jail: PROVIDED, That reimbursement for
17 the cost of such services shall be by the state for state prisoners
18 being held in a jail who are accused of either escaping from a state
19 facility or of committing an offense in a state facility.

20 There shall be no right of reimbursement to the governing unit from
21 units of government (~~whose law enforcement officers~~) that initiated
22 the charges for which a person is being held in the jail for care
23 provided after the charges are disposed of by sentencing or otherwise,
24 unless by intergovernmental agreement pursuant to chapter 39.34 RCW.

25 Under no circumstance shall necessary medical services be denied or
26 delayed because of disputes over the cost of medical care or a
27 determination of financial responsibility for payment of the costs of
28 medical care provided to confined persons.

29 Nothing in this section shall limit any existing right of any
30 party, governing unit, or unit of government against the person
31 receiving the care for the cost of the care provided.

32 NEW SECTION. **Sec. 67.** The following acts or parts of acts are
33 each repealed:

34 (1) RCW 70.38.919 (Effective date--State health plan--1989 1st
35 ex.s. c 9) and 1989 1st ex.s. c 9 s 610; and

36 (2) 2006 c 255 s 10 (uncodified).

1 NEW SECTION. **Sec. 76.** Section 66 of this act expires June 30,
2 2009.

Passed by the Senate April 21, 2007.

Passed by the House April 20, 2007.

Approved by the Governor May 2, 2007, with the exception of
certain items that were vetoed.

Filed in Office of Secretary of State May 3, 2007.

Note: Governor's explanation of partial veto is as follows:

"I am returning, without my approval as to Sections 59 and 74,
Engrossed Second Substitute Senate Bill 5930 entitled:

"AN ACT Relating to providing high quality, affordable health
care to Washingtonians based on the recommendations of the blue
ribbon commission on health care costs and access."

I am pleased to support Engrossed Second Substitute Senate Bill 5930,
an act relating to providing high quality, affordable health care to
Washingtonians based on the recommendations of the Blue Ribbon
Commission on Health Care Costs and Access.

Section 59 of this bill establishes a nine-member board charged with
designing and managing the Washington Health Insurance Partnership
(WHP). This section duplicates a comparable board established under
Engrossed Second Substitute House Bill 1569, which passed during the
2007 legislative session. Section 74 of this bill of is an emergency
clause, and would allow certain sections of the bill to become
effective on July 1. Section 74 is not essential to the proper and
timely implementation of the bill.

For these reasons, I have vetoed Sections 59 and 74 of Engrossed
Second Substitute Senate Bill 5930.

With the exception of Sections 59 and 74, Engrossed Second Substitute
Senate Bill 5930 is approved."