
SENATE BILL 5420

State of Washington 53rd Legislature 1993 Regular Session

By Senators Moyer, Wojahn, Oke, Deccio, Prince and Talmadge

Read first time 01/27/93. Referred to Committee on Health & Human Services.

1 AN ACT Relating to health care reform; amending RCW 48.21.010,
2 48.21.050, 48.30.300, 48.44.220, 48.46.370, 70.47.010, 70.47.020,
3 70.47.030, 70.47.060, 70.47.080, 70.47.120, 70.170.010, 70.170.020,
4 70.170.030, 70.170.040, 70.170.050, 70.170.080, 70.170.100, 70.170.110,
5 18.130.160, 18.130.190, 70.41.200, 82.24.020, and 82.26.020; adding new
6 sections to Title 48 RCW; adding a new section to chapter 70.170 RCW;
7 adding a new section to chapter 70.41 RCW; adding a new section to
8 chapter 71.12 RCW; adding a new section to chapter 18.68 RCW; adding
9 new sections to chapter 7.70 RCW; adding a new section to chapter
10 18.130 RCW; adding a new section to Title 70 RCW; adding a new section
11 to chapter 48.22 RCW; adding new chapters to Title 48 RCW; creating new
12 sections; repealing RCW 7.70.080; prescribing penalties; making an
13 appropriation; and providing an effective date.

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

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1 **PART I - INTENT**

2 NEW SECTION. **Sec. 101.** LEGISLATIVE INTENT. The legislature
3 declares that:

4 (1) Insurance reform is essential to assure that an affordable
5 basic health care coverage is available to all residents.

6 Individuals should be able to change their employment without fear
7 of losing access to health insurance coverage.

8 (2) The basic health plan must be expanded to all parts of the
9 state and to assure access to citizens unable to afford insurance, the
10 number of subsidized individuals in the plan must be increased.

11 (3) Health providers must be aware of the costs of treatments and
12 prescription medications.

13 (4) General principles of ethical practice must be developed for
14 the appropriate medical practice at the beginning and end of life.

15 **PART II - VOLUNTARY FORMATION OF STATE-WIDE HEALTH**
16 **INSURANCE PURCHASING POOL**

17 NEW SECTION. **Sec. 201.** A new section is added to Title 48 RCW to
18 read as follows:

19 DEFINITION OF A BASIC HEALTH CARE BENEFIT PACKAGE. Carriers
20 regulated under chapters 48.20, 48.21, 48.44, and 48.46 RCW may
21 collectively design a basic health care benefit package. The health
22 services in the benefit package shall not be less than those provided
23 through the basic health plan under chapter 70.47 RCW. Each carrier
24 shall submit a schedule of premiums for the basic benefit package to
25 the commissioner. The insurance commissioner shall review each
26 carrier's schedule of premiums to determine whether they are reasonable
27 in relation to the basic benefit package. Only when the commissioner
28 determines that rates are reasonable shall the carriers offer the basic
29 benefit package.

30 NEW SECTION. **Sec. 202.** HEALTH INSURANCE REFORMS. Basic benefit
31 plans authorized under section 201 of this act should be offered
32 subject to the following provisions:

1 (1) Should not deny, exclude, or limit benefits for a covered
2 individual for losses incurred more than six months following the
3 effective date of the eligible individual's coverage due to a
4 preexisting condition.

5 (2) Should not modify, decrease, exclude, or restrict benefits
6 through riders, conditions, restrictions, endorsements, or otherwise,
7 on the basis of sex, age, or health status or health condition of the
8 eligible individual.

9 (3) Should not modify, decrease, or restrict coverage through
10 riders, conditions, restrictions, endorsements, or otherwise, on the
11 basis of category of business trade, employment skill, or vocation or
12 profession of the eligible individual.

13 (4) Should guarantee renewability of coverage except for nonpayment
14 of premium unless the insurer has obtained the prior written approval
15 of the commissioner who may, at his or her discretion, permit
16 nonrenewal when renewal would impair the carrier's ability to perform
17 its contractual duties.

18 (5) Entities offering health benefit plans should assume the full
19 financial risk of providing the health benefit plan to all enrollees or
20 participate in risk distribution methods authorized under section 203
21 of this act.

22 NEW SECTION. **Sec. 203.** A new section is added to Title 48 RCW to
23 read as follows:

24 **MEDICAL RISK DISTRIBUTION.** The insurance commissioner shall
25 establish methods to assure the fair distribution of high medical risk
26 enrollees among carriers subject to section 201 of this act or fair
27 financial compensation for basic benefit plans that have a
28 disproportionately large number of high medical risk enrollees. This
29 shall be done in a manner to assure that costs associated with
30 providing services to high medical risk enrollees is fairly distributed
31 among the regulated carriers.

32 **PART III - INSURANCE COMMISSIONER AUTHORITY**

33 NEW SECTION. **Sec. 301.** A new section is added to Title 48 RCW to
34 read as follows:

35 If the insurance commissioner determines that less than ninety-five
36 percent of the regulated carriers in the state have not complied with

1 sections 201 through 203 of this act by July 1, 1994, the commissioner
2 shall exercise duties and responsibilities under sections 401 through
3 409 and 601 through 605 of this act.

4 **PART IV - MANAGED HEALTH CARE**

5 NEW SECTION. **Sec. 401.** DEFINITIONS. In this chapter, unless the
6 context clearly indicates otherwise:

7 (1) "Basic benefit package" means the uniform, appropriate,
8 confidentially provided, and affordable set of personal health services
9 to be made available to enrollees by certified health plans.

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

14 (3) "Certified health plans" means health benefit plans offered as
15 managed care plans and certified by the commissioner to provide the
16 basic benefit package.

17 (4) "Eligible individual" means a resident of the state of
18 Washington who is eligible to receive the basic benefit package.

19 (5) "Employee" means a resident who is actively employed with an
20 employer, or is a proprietor, partner, or corporate officer of the
21 employer of the state of Washington, is paid on a regular, periodic
22 basis through the employer's payroll system, regularly works on a full-
23 time basis and has a normal work week of twenty or more hours, and is
24 expected to continue in this employment capacity.

25 (6) "Enrollee" means a resident who receives the basic benefit
26 package from a certified health plan for himself or herself and for his
27 or her dependents.

28 (7) "Health benefit plan" means a hospital or medical policy,
29 health care service contract, health maintenance organization
30 subscriber contract, or plan provided by another benefit arrangement.
31 The term does not include accident only, credit, dental only, vision
32 only, medicare supplements, or disability income insurance coverage
33 issued as a supplement to liability insurance, workers' compensation or
34 similar insurance, or automobile medical payment insurance.

35 (8) "Individual point of service cost sharing" means moneys paid to
36 a certified health plan by an enrollee for basic benefit package health

1 care services at the time of delivery of such services in an amount not
2 to exceed limits established by the commissioner.

3 (9) "Insurance commissioner" or "commissioner" means the insurance
4 commissioner as defined in Title 48 RCW.

5 (10) "Managed health care" means an integrated system of insurance
6 and delivery system functions using a defined network of health care
7 providers that provide the basic benefit package in a cost-effective
8 manner and on a prepaid capitated basis to a defined patient population
9 according to provisions established under this chapter.

10 (11) "Premium" means the level of payment a certified health plan
11 receives from an enrollee or sponsor on behalf of an enrollee for
12 expenses, including administration, operation, and capital for
13 providing the basic benefit package to enrollees.

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

21 (13) "Resident" means an individual who lives in the state of
22 Washington and who has not come to the state for the purpose of
23 obtaining health services.

24 (14) "Small employer" means a person, firm, corporation,
25 partnership, or association actively engaged in business, that, on at
26 least fifty percent of its working days during the preceding calendar
27 quarter, employed no more than one hundred employees, the majority of
28 whom are residents.

29 (15) "Sponsor" means an employer, the state, or other persons or
30 entities, other than the enrollee, who pays to the pool on behalf of
31 the enrollee premiums in return for provision of the basic benefit
32 package to the enrollee.

33 (16) "State-wide health insurance purchasing pool" or "pool" means
34 a state-wide health insurance purchasing agent that obtains the basic
35 benefit package for employers and individuals on a prepaid capitated
36 basis from a certified health plan through a system of competitive
37 bidding under terms established in this chapter.

1 NEW SECTION. **Sec. 402.** STATE-WIDE HEALTH INSURANCE PURCHASING
2 POOL--MEMBERSHIP. Subject to the exercise of authority in section 301
3 of this act, the insurance commissioner shall create the state-wide
4 health insurance purchasing pool.

5 NEW SECTION. **Sec. 403.** STATE-WIDE HEALTH INSURANCE PURCHASING
6 POOL--POWERS AND DUTIES. (1) The duties of the insurance commissioner
7 include:

8 (a) To define and update the basic benefit package as provided for
9 in this chapter;

10 (b) To enforce the premium growth rate targets for the basic
11 benefit package established under this chapter;

12 (c) To certify health benefit plans to provide the basic benefit
13 package.

14 (2) The insurance commissioner shall have the following duties for
15 certified health plans offered through the pool:

16 (a) To set the maximum amount of individual premium payments and
17 individual point of service cost-sharing, which includes, deductibles,
18 coinsurance, and copayments to be paid by enrollees for basic benefit
19 package services. This includes:

20 (i) Setting the maximum premium amount sponsors may pay on behalf
21 of enrollees and dependents for the basic benefit package. The amount
22 shall be established at no less than fifty percent and no more than
23 ninety percent of the lowest bid premium received from a certified
24 health plan among those certified health plans available to an
25 enrollee. The enrollee shall be responsible for payment amounts in
26 excess of these amounts;

27 (ii) Determining individual point of service cost-sharing for
28 enrollees, required cost-sharing shall be structured to discourage
29 inappropriate enrollee utilization of health care services, but shall
30 not be so costly to enrollees as to constitute a barrier to appropriate
31 utilization of necessary health care services;

32 (b) To determine the methods by which certified health plans pay
33 providers to deliver the basic health benefit package services;

34 (c) To establish payment methods for reimbursing providers in
35 certified health plans in a manner to encourage cost-effective delivery
36 of health care services;

37 (d) To assess the need for, and if necessary, establish methods to
38 assure fair distribution of high medical risk enrollees among certified

1 health plans or fair financial compensation for certified health plans
2 that have a disproportionately large number of high medical risk
3 enrollees. This shall be done in a manner to ensure that costs
4 associated with providing services to high medical risk enrollees is
5 fairly distributed among the certified health plans in the pool;

6 (e) To establish rules of participation for employers and enrollees
7 who obtain basic benefit package services through the pool. The method
8 used shall reflect actual risk to the certified health plan;

9 (f) To establish a schedule of uniform premium rate adjustments to
10 be used by each certified health plan sold through the pool. The
11 schedule shall allow certified health plans to adjust premium rates
12 based upon the age and gender of individual enrollees and for the cost
13 of providing the basic benefit package within major geographic areas
14 within the state;

15 (g) To establish an administrative fee as part of premiums charged
16 for the basic benefit package to support the pool activities required
17 under this chapter;

18 (h) To conduct an annual open enrollment for the purpose of
19 offering certified health plans to enrollees;

20 (i) To monitor the performance of the certified health plans and to
21 make recommendations to the governor and the legislature for needed
22 statutory changes to improve the delivery and the quality of the basic
23 benefit package;

24 (j) To form technical advisory committees from time to time for the
25 purpose of receiving advice from technical experts and other interest
26 groups on issues within the purview of the insurance commissioner;

27 (k) To determine, in consultation with the health care data,
28 quality assurance, and cost control council under chapter 70.170 RCW,
29 whether new high cost medical technologies and experimental procedures
30 are cost-effective and efficacious and shall be included as
31 reimbursable services as part of the basic benefit package;

32 (l) To establish an outcome-based accountability and reporting
33 system and a system of continuous quality improvement to monitor the
34 appropriate utilization and quality of health care services provided by
35 certified health plans; and

36 (m) To contract for consultation and actuarial services necessary
37 to perform duties provided under this chapter.

1 NEW SECTION. **Sec. 404.** BASIC BENEFIT PACKAGE DESIGN. (1) The
2 commissioner, through a public process, shall design and update the
3 basic benefit package. The basic benefit package shall be the minimum
4 set of personal health services that must be provided by health benefit
5 plans subject to this chapter. The initial basic benefit package shall
6 be adopted by March 1, 1994. Services shall be selected and included
7 in the basic benefit package based upon an assessment of the cost-
8 effectiveness of such services in the maintenance of the health of the
9 public. The best available scientific evidence and cost utilization
10 studies shall be used in the assessment.

11 (2) The legislature intends that the basic benefit package be
12 sufficient to meet the needs of state residents. The categories of
13 coverage shall, at least, include the following:

14 (a) Personal health services, including inpatient and outpatient
15 services;

16 (b) Wellness and disease and injury prevention services;

17 (c) Diagnosis and assessment, and selection of treatment and care;

18 (d) Clinical preventive services;

19 (e) Emergency health services;

20 (f) Reproductive and maternity services;

21 (g) Clinical management and provision of treatment; and

22 (h) Therapeutic drugs, biologicals, supplies, and equipment.

23 (3) The commissioner shall determine which services will be
24 excluded.

25 NEW SECTION. **Sec. 405.** APPLICABILITY. Subject to the exercise of
26 authority in section 301 of this act:

27 (1) Effective July 1, 1994, every carrier offering health benefit
28 plans to individuals and small employers shall also offer the basic
29 benefit package as a certified health plan and shall offer such
30 certified health plans through the pool in every area of the state
31 where they provide health insurance benefits to any small employer or
32 individual. Nothing in this subsection shall prevent a carrier from
33 offering health benefit plans to individuals or small employers outside
34 the pool, provided the benefits meet the requirements of chapter 48.--
35 RCW (sections 501 through 506 of this act).

36 (2) Effective January 1, 1996, every carrier offering health
37 benefit plans to individuals or employers that includes any of the
38 services in the basic benefit package shall: (a) Be certified under

1 this chapter to provide all of the basic benefit package services and
2 meet other requirements established in this chapter, or (b) meet the
3 requirements of chapter 48.-- RCW (sections 501 through 506 of this
4 act).

5 (3)(a) Effective July 1, 2000, every health benefit plan offered to
6 residents of the state of Washington that includes any of the services
7 in the basic benefit package, shall: (i) Be certified under this
8 chapter to provide all the basic benefit services and meet other
9 requirements of this chapter, or (ii) meet the requirements of chapter
10 48.-- RCW (sections 501 through 506 of this act).

11 (b) Prior to the effective date established under this subsection,
12 the commissioner shall negotiate with the United States congress for a
13 statutory exemption from provisions of the federal employer retirement
14 income security act that would prohibit the state from implementing
15 this subsection.

16 (4) Nothing in this section prohibits an individual or employer
17 from voluntarily obtaining the basic benefit package through the pool
18 on a date earlier than required under this section, provided such
19 individuals and employers meet participation requirements set forth
20 under this chapter. The pool shall permit voluntary enrollment only to
21 the extent that the pool has the capacity to provide certified health
22 plans to such employers.

23 (5) Nothing in this chapter shall prohibit a carrier or other
24 entity offering the basic benefit plan from offering supplemental
25 plans.

26 NEW SECTION. Sec. 406. CERTIFIED HEALTH PLANS. The basic benefit
27 package shall be provided through certified health plans. The
28 commissioner shall begin certification of health plans by July 1, 1994.
29 To be certified, a health benefit plan shall meet the following
30 requirements:

31 (1) Provide or assure the provision of health care services in the
32 basic benefit package.

33 (2) With respect to carriers, offer the basic benefit package
34 services in every geographic area of the state where the carrier
35 provides any type of health benefit plan.

36 (3) Comply with data requirements of the commissioner and the
37 health data, quality assurance, and cost control council established
38 under chapter 70.170 RCW.

1 (4) Comply with rules of participation under this chapter or
2 provisions of chapter 48.-- RCW (sections 501 through 506 of this act).

3 NEW SECTION. **Sec. 407.** MANAGED COMPETITION--RULES OF
4 PARTICIPATION. All certified health plans offered through the pool
5 shall abide by the provisions in this section. A certified health plan
6 shall:

7 (1) Not deny, exclude, or limit benefits for a covered individual
8 for expenses incurred more than six months following the effective date
9 of the eligible individual's coverage due to a preexisting condition.

10 (2) Not modify, decrease, exclude, or restrict benefits through
11 riders, conditions, restrictions, endorsements, or otherwise, on the
12 basis of sex, age, or health status or health condition of the eligible
13 individual.

14 (3) Not modify, decrease, or restrict coverage through riders,
15 conditions, restrictions, endorsements, or otherwise, on the basis of
16 category of business trade, employment skill, or vocation or profession
17 of the eligible individual.

18 (4) Assume financial risk of providing the basic benefit to all
19 enrolled individuals subject to any medical risk sharing arrangements
20 that may be authorized under this chapter.

21 (5) Determine and adjust annual premium rates based on the
22 experience of the state as a community, except that adjustments in the
23 premium rates may be made, following the schedule established by the
24 commissioner, for age and gender of individual enrollees and for the
25 cost of providing the basic benefit package within major geographic
26 areas within the state. No coverage may be denied to an enrollee
27 during the contract enrollment period provided that premium payments
28 are made and other conditions of participation are met in accordance
29 with this chapter.

30 (6) Provide the basic health package in a manner to promote the use
31 of cost-effective managed health care delivery.

32 (7) Participate in an open enrollment period each year at a time
33 established by the commissioner.

34 (8) Offer incentives to encourage providers to offer high quality,
35 cost-effective health care services.

36 (9) Participate in an insurance commissioner-adopted uniform
37 outcome-based accountability and reporting system to allow the

1 commissioner, employers, and other individuals to compare the price and
2 best value of certified health plans.

3 (10) Provide such data as is requested by the commissioner and the
4 health data, quality assurance, and cost control council under chapter
5 70.170 RCW that is necessary to implement the provisions of this
6 chapter.

7 NEW SECTION. **Sec. 408.** POOL COMPETITIVE BIDDING PROCESS WITH
8 MANAGED HEALTH CARE PROVIDERS. Subject to the exercise of authority in
9 section 301 of this act:

10 (1) By January 1, 1994, the commissioner shall adopt rules for
11 accepting competitive bids from certified health plans to offer the
12 basic benefit package through the pool. The rules shall assure that
13 certified health plans compete based upon the best price, service,
14 quality, and value of providing the basic benefit package to enrollees.

15 (2) Beginning July 1, 1994, and on that date each year thereafter,
16 the commissioner shall accept the bids from certified health plans and
17 make such plans available to pool enrollees according to the provisions
18 of this chapter.

19 NEW SECTION. **Sec. 409.** HEALTH CARE INSURANCE PREMIUM GROWTH RATE
20 TARGETS. To assure the cost of health care services in the state
21 remains affordable, the commissioner shall establish health insurance
22 premium growth rate targets. The purpose of this section shall be to
23 establish the maximum state-wide premium growth rate targets for
24 insured health care services provided on a capitated bases and to
25 initiate activities to limit the growth of spending should the targets
26 be exceeded. The targets shall be established as follows:

27 (1)(a) For the basic benefit package health care services purchased
28 through the pool, the initial base premium shall be established by the
29 commissioner. In establishing the initial base premium, the
30 commissioner shall conduct an analysis of the 1993 cost experience of
31 health benefit plans offering health care benefits similar to the basic
32 benefit package to groups in the state of Washington whose enrollment
33 size is similar to what the commissioner anticipates for the pool. The
34 commissioner may also consider other factors in establishing the
35 initial base premium such as, but not limited to, the expected use of
36 managed care systems required under this chapter and the expected
37 administrative savings resulting from implementation of the other

1 provisions of chapter . . . , Laws of 1993 (this act). Annual premium
2 growth rate targets established thereafter shall be at ten percent for
3 1995, nine percent for 1998, and seven percent for 2000. After 2000,
4 the premium growth rate target shall increase at a rate no more than is
5 generally consistent with the rate of growth in the state's gross
6 domestic product adjusted for increased demand for services as the
7 result of the aging of the general population.

8 (b) The commissioner shall monitor premium growth rate increases
9 and shall inform certified health plans if such increases exceed
10 targets. If premium rate increases exceed the target rates established
11 under this subsection after 1998, the commissioner shall require that
12 certified health plans reduce premium rate increases to no more than
13 the target rate. In addition, the commissioner may reduce premium rate
14 increases by an additional one percent below the target rate for a
15 period of one year.

16 (2)(a) For health benefit plans subject to section 405(2) of this
17 act the commissioner shall establish an initial premium base using the
18 1995 average premium rate of plans subject to subsection (1)(a) of this
19 section. The premium growth rate targets thereafter shall be
20 established at ten percent for 1998, nine percent for 2000, and seven
21 percent for 2002. After 2002, the premium growth rate target shall
22 grow at a rate no more than is generally consistent with the rate of
23 growth in the state's gross domestic product adjusted for increased
24 demand for services as the result of the aging of the general
25 population.

26 (b) The commissioner shall monitor premium rate increases and shall
27 inform certified health plans if such increases exceed targets. If
28 premium rate increases exceed the target rates established under this
29 subsection after 2000, the commissioner shall require that certified
30 health plans reduce premium rate increases to no more than the target
31 rate. In addition, the commissioner may reduce premium rate increases
32 by an additional one percent below the target rate for a period of one
33 year.

34 (3)(a) For health benefit plans subject to section 405(3) of this
35 act the commissioner shall establish an initial premium base using the
36 1999 average premium rate of plans subject to subsection (1)(a) of this
37 section. The premium growth rate targets thereafter shall be
38 established at ten percent for 2002, nine percent for 2004, and seven
39 percent for 2006. After 2006, the premium growth rate target shall

1 grow at a rate no more than is generally consistent with the rate of
2 growth in the state's gross domestic product adjusted for increased
3 demand for services as the result of the aging of the general
4 population.

5 (b) The commissioner shall monitor premium rate increases and shall
6 inform certified health plans if such increases exceed targets. If
7 premium rate increases exceed the target rates established under this
8 subsection after 2004, the commissioner shall require that certified
9 health plans reduce premium rate increases to no more than the target
10 rate. In addition, the commissioner may reduce premium rate increases
11 by an additional one percent below the target rate for a period of one
12 year.

13 (4) The annual premium growth targets established in subsections
14 (1) through (3) of this section may be annually adjusted by the
15 commissioner to an amount equal to the United States consumer price
16 index if the growth in the consumer price index exceeds the premium
17 growth rate targets established under subsections (1) through (3) of
18 this section.

19 (5) The commissioner shall annually report to the governor and to
20 the fiscal and health policy committees of the legislature concerning
21 compliance with the targets and commissioner activities undertaken to
22 assure compliance when targets have been exceeded.

23 NEW SECTION. **Sec. 410.** Sections 401 through 409 of this act shall
24 constitute a new chapter in Title 48 RCW.

25 **PART V - INSURANCE REFORM**

26 NEW SECTION. **Sec. 501.** SHORT TITLE. This chapter shall be known
27 and cited as the employer and individual health coverage act.

28 NEW SECTION. **Sec. 502.** DEFINITIONS. As used in this chapter:

29 (1) "Basic benefit package" means the uniform, appropriate,
30 confidentially provided, and affordable set of personal health services
31 designed by the commissioner and to be made available to enrollees by
32 certified health plans.

33 (2) "Carrier" means an entity that provides a health insurance
34 benefit plan to employers and individuals in Washington state as an
35 insurance company, health services contractor, or health maintenance

1 organization, and is regulated by the state of Washington under chapter
2 48.20, 48.21, 48.44, or 48.46 RCW.

3 (3) "Certified health plans" means health insurance plans offered
4 by carriers and certified by the commissioner to provide the basic
5 benefit package.

6 (4) "Eligible individual" means (a) an individual person who elects
7 to purchase a health benefit plan for himself or herself and his or her
8 dependents, or (b) an active employee, proprietor, partner, or
9 corporate officer of an employer group who elects to purchase a health
10 benefit plan for himself or herself and his or her dependents where the
11 eligible individual resides, is paid on a regular, periodic basis
12 through the group's payroll system, regularly works on a full-time
13 basis and has a normal work week of twenty or more hours, and is
14 expected to continue in this employment capacity.

15 (5) "Employer" means a person, firm, corporation, partnership, or
16 association that is actively engaged in business that, on at least
17 fifty percent of its working days during the preceding calendar
18 quarter, employed eligible individuals, the majority of whom were
19 employed within Washington state.

20 (6) "Enrollee" means an eligible individual who receives the basic
21 benefit package from a carrier.

22 (7) "Health benefit plan" means a hospital or medical policy,
23 health care service contract, health maintenance organization
24 subscriber contract, or plan provided by any other benefit arrangement.
25 The term does not include accident only, credit, dental only, vision
26 only, medicare supplement, or disability income insurance coverage
27 issued as a supplement to liability insurance, workers' compensation or
28 similar insurance, or automobile medical payment insurance.

29 (8) "Insurance commissioner" or "commissioner" means the state
30 health insurance purchasing pool board as established under chapter
31 48.-- RCW (sections 401 through 409 of this act).

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

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

3 NEW SECTION. **Sec. 503.** SCOPE AND APPLICABILITY. Subject to the
4 exercise of authority in section 301 of this act, except for health
5 benefit plans offered under chapter 48.-- RCW (sections 401 through 409
6 of this act), the provisions of this chapter shall apply to all health
7 insurance benefits offered to individuals and employers in Washington
8 state by state-regulated insurance companies under chapter 48.20 or
9 48.21 RCW, health services contractors under chapter 48.44 RCW, or
10 health maintenance organizations under chapter 48.46 RCW.

11 NEW SECTION. **Sec. 504.** GENERAL REQUIRED PRACTICES IN THE EMPLOYER
12 AND INDIVIDUAL HEALTH BENEFIT PLAN MARKET. Health benefit plans
13 subject to the provisions of this chapter:

14 (1) Shall not deny, exclude, or limit benefits for a covered
15 individual for losses incurred more than six months following the
16 effective date of the eligible individual's coverage due to a
17 preexisting condition.

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

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

26 (4) Entities offering health benefit plans shall:

27 (a) Assume the full financial risk of providing the health benefit
28 plan to all enrollees;

29 (b) Determine and adjust annual premium rates based on a community
30 basis using the entire state as the community pool;

31 (c) Not refuse to renew coverage except for nonpayment of premiums;

32 (d) Require that employers:

33 (i) Enroll at least eighty percent of individuals in the employer's
34 group;

35 (ii) Pay between fifty and ninety percent of premiums on behalf of
36 employees enrolled in the health benefit plan; and

1 (iii) Require point of service cost-sharing as established by the
2 pool under chapter 48.-- RCW (sections 401 through 409 of this act);

3 (e) Adjust premium rates for a rating period based upon the average
4 of actual or expected variation in claims costs or actual or expected
5 variation in the health status of the state community pool;

6 (f) Comply with premium growth rate targets prescribed under
7 chapter 48.-- RCW (sections 401 through 409 of this act);

8 (g) Provide data as required by the health data, quality assurance,
9 and cost control council under chapter 70.170 RCW; and

10 (h) Guarantee renewability of coverage except for nonpayment of
11 premium unless the insurer has obtained the prior written approval of
12 the commissioner who may, at his or her discretion, permit nonrenewal
13 when renewal would impair the carrier's ability to perform its
14 contractual duties.

15 NEW SECTION. **Sec. 505.** CERTIFICATION OF HEALTH BENEFIT PLANS
16 REQUIRED. Subject to section 301 of this act:

17 (1) Effective January 1, 1996, all health benefit plans subject to
18 the provisions of this chapter must be certified by the commissioner to
19 offer the entire set of health services in the basic benefit package if
20 the plans offer any health services included in the basic benefit
21 package.

22 (2) The commissioner shall certify that the carrier provides the
23 entire basic benefit package through managed care providers, abides by
24 enrollee cost-sharing requirements prescribed in chapter 48.-- RCW
25 (sections 401 through 409 of this act), and has paid a certification
26 fee as established in rule by the commissioner.

27 (3) Nothing in this chapter shall prohibit carriers from offering
28 supplemental plans that include services not provided in the basic
29 benefit package.

30 NEW SECTION. **Sec. 506.** DUTIES OF THE INSURANCE COMMISSIONER. The
31 commissioner shall adopt rules to implement sections 501 through 504 of
32 this act.

33 NEW SECTION. **Sec. 507.** CODIFICATION DIRECTIONS. Sections 501
34 through 506 of this act shall constitute a new chapter in Title 48 RCW.

1 the individuals insured than would be permitted by the standard
2 provisions required for individual disability insurance policies.

3 **Sec. 603.** RCW 48.30.300 and 1975-'76 2nd ex.s. c 119 s 7 are each
4 amended to read as follows:

5 No person or entity engaged in the business of insurance in this
6 state shall refuse to issue any contract of insurance or cancel or
7 decline to renew such contract because of the sex or marital status, or
8 the presence of any sensory, mental, or physical handicap of the
9 insured or prospective insured. The amount of benefits payable, or any
10 term, rate, condition, or type of coverage shall not be restricted,
11 modified, excluded, increased or reduced on the basis of the sex or
12 marital status, or be restricted, modified, excluded or reduced on the
13 basis of the presence of any sensory, mental, or physical handicap of
14 the insured or prospective insured. Except as provided for in chapter
15 48.-- RCW (sections 401 through 409 of this act), sections 201 through
16 203 of this act, and chapter 48.-- RCW (sections 501 through 506 of
17 this act), these provisions shall not prohibit fair discrimination on
18 the basis of sex, or marital status, or the presence of any sensory,
19 mental, or physical handicap when bona fide statistical differences in
20 risk or exposure have been substantiated.

21 **Sec. 604.** RCW 48.44.220 and 1983 c 154 s 4 are each amended to
22 read as follows:

23 No health care service contractor shall deny coverage to any person
24 solely on account of race, religion, national origin, or the presence
25 of any sensory, mental, or physical handicap. Except as provided for
26 in chapter 48.-- RCW (sections 401 through 409 of this act), sections
27 201 through 203 of this act, and chapter 48.-- RCW (sections 501
28 through 506 of this act), nothing in this section shall be construed as
29 limiting a health care service contractor's authority to deny or
30 otherwise limit coverage to a person when the person because of a
31 medical condition does not meet the essential eligibility requirements
32 established by the health care service contractor for purposes of
33 determining coverage for any person.

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

1 **Sec. 605.** RCW 48.46.370 and 1983 c 106 s 15 are each amended to
2 read as follows:

3 No health maintenance organization may deny coverage to a person
4 solely on account of the presence of any sensory, mental, or physical
5 handicap. Except as provided for in chapter 48.-- RCW (sections 401
6 through 409 of this act), sections 201 through 203 of this act, and
7 chapter 48.-- RCW (sections 501 through 506 of this act), nothing in
8 this section may be construed as limiting a health maintenance
9 organization's authority to deny or otherwise limit coverage to a
10 person when the person because of a medical condition does not meet the
11 essential eligibility requirements established by the health
12 maintenance organization for purposes of determining coverage for any
13 person.

14 **PART VII - BASIC HEALTH PLAN EXPANSION**

15 **Sec. 701.** RCW 70.47.010 and 1987 1st ex.s. c 5 s 3 are each
16 amended to read as follows:

17 (1) The legislature finds that:

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

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

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

31 (2) The purpose of this chapter is to provide or make available
32 necessary basic health care services in an appropriate setting to
33 working persons and others who lack coverage, at a cost to these
34 persons that does not create barriers to the utilization of necessary
35 health care services. To that end, this chapter establishes a program
36 to be made available to those residents under sixty-five years of age
37 not otherwise eligible for medicare with gross family income at or

1 below (~~two~~) three hundred percent of the federal poverty guidelines
2 who share in a portion of the cost or who pay the full cost of
3 receiving basic health care services from a managed health care system.

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

10 (~~The program authorized under this chapter is strictly limited~~
11 ~~in respect to the total number of individuals who may be allowed to~~
12 ~~participate and the specific areas within the state where it may be~~
13 ~~established. All such restrictions or limitations shall remain in full~~
14 ~~force and effect until quantifiable evidence based upon the actual~~
15 ~~operation of the program, including detailed cost benefit analysis, has~~
16 ~~been presented to the legislature and the legislature, by specific act~~
17 ~~at that time, may then modify such limitations~~)) (a) It is the purpose
18 of this chapter to acknowledge the initial success of this program that
19 has (i) assisted thousands of families in their search for affordable
20 health care; (ii) demonstrated that low-income uninsured families are
21 willing to pay for their own health care coverage to the extent of
22 their ability to pay; and (iii) proved that local health care providers
23 are willing to enter into a public-private partnership as they
24 configure their own professional and business relationships into a
25 managed care system.

26 (b) As a consequence, the legislature intends to make the program
27 available to individuals in the state with incomes below three hundred
28 percent of federal poverty guidelines who reside in communities where
29 the plan is operational, and who collectively or individually wish to
30 exercise the opportunity to purchase health care coverage through the
31 program if it is done at no cost to the state.

32 **Sec. 702.** RCW 70.47.020 and 1987 1st ex.s. c 5 s 4 are each
33 amended to read as follows:

34 As used in this chapter:

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

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

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

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

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

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

30 (~~(+6)~~) (7) "Premium" means a periodic payment, based upon gross
31 family income and determined under RCW 70.47.060(2), which an enrollee
32 makes to the plan as consideration for enrollment in the plan.

33 (~~(+7)~~) (8) "Rate" means the per capita amount, negotiated by the
34 administrator with and paid to a participating managed health care
35 system, that is based upon the enrollment of enrollees in the plan and
36 in that system.

37 **Sec. 703.** RCW 70.47.030 and 1992 c 232 s 907 are each amended to
38 read as follows:

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

12 (2) The basic health plan subscription account is created in the
13 custody of the state treasurer. All receipts from amounts due under
14 RCW 70.47.060 (11) shall be deposited into the account. Funds in the
15 account shall be used exclusively for the purposes of this chapter,
16 including payments to participating managed health care systems on
17 behalf of enrollees in the plan and payment of costs of administrating
18 the plan. The account is subject to allotment procedures under chapter
19 43.88 RCW, but no appropriation is required for expenditures.

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

26 **Sec. 704.** RCW 70.47.060 and 1992 c 232 s 908 are each amended to
27 read as follows:

28 The administrator has the following powers and duties:

29 (1) To design and from time to time revise a schedule of covered
30 basic health care services, including physician services, inpatient and
31 outpatient hospital services, and other services including prescription
32 drugs and medications that may be necessary for basic health care,
33 which enrollees in any participating managed health care system under
34 the Washington basic health plan shall be entitled to receive in return
35 for premium payments to the plan. The schedule of services shall
36 emphasize proven preventive and primary health care and shall include
37 all services necessary for prenatal, postnatal, and well-child care.
38 However, for the period ending June 30, 1993, with respect to coverage

1 for groups of subsidized enrollees, the administrator shall not
2 contract for prenatal or postnatal services that are provided under the
3 medical assistance program under chapter 74.09 RCW except to the extent
4 that such services are necessary over not more than a one-month period
5 in order to maintain continuity of care after diagnosis of pregnancy by
6 the managed care provider, or except to provide any such services
7 associated with pregnancies diagnosed by the managed care provider
8 before July 1, 1992. The schedule of services shall also include a
9 separate schedule of basic health care services for children, eighteen
10 years of age and younger, for those enrollees who choose to secure
11 basic coverage through the plan only for their dependent children. In
12 designing and revising the schedule of services, the administrator
13 shall consider the guidelines for assessing health services under the
14 mandated benefits act of 1984, RCW 48.42.080, and such other factors as
15 the administrator deems appropriate.

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

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

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

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

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

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

1 (c) Coinsurance rates that are established based on specific
2 service and procedure costs and the enrollee's ability to pay for the
3 care. However, coinsurance rates for families with incomes below one
4 hundred twenty percent of the federal poverty level shall be nominal.
5 No coinsurance shall be required for specific proven prevention
6 programs, such as prenatal care. The coinsurance rate levels shall not
7 have a measurable negative effect upon the enrollee's health status;
8 and

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

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

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

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

32 (b) To limit participation of nonsubsidized enrollees in the plan
33 to those whose family incomes at the time of enrollment does not exceed
34 three times the federal poverty level adjusted for family size and
35 determined annually by the federal department of health and human
36 services.

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

1 In the selection of any area of the state for the initial operation of
2 the plan, the administrator shall take into account the levels and
3 rates of unemployment in different areas of the state, the need to
4 provide basic health care coverage to a population reasonably
5 representative of the portion of the state's population that lacks such
6 coverage, and the need for geographic, demographic, and economic
7 diversity.

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

11 ~~(7))~~ (8) To solicit and accept applications from managed health
12 care systems, as defined in this chapter, for inclusion as eligible
13 basic health care providers under the plan. The administrator shall
14 endeavor to assure that covered basic health care services are
15 available to any enrollee of the plan from among a selection of two or
16 more participating managed health care systems. In adopting any rules
17 or procedures applicable to managed health care systems and in its
18 dealings with such systems, the administrator shall consider and make
19 suitable allowance for the need for health care services and the
20 differences in local availability of health care resources, along with
21 other resources, within and among the several areas of the state.

22 ~~((+8))~~ (9) To receive periodic premiums from enrollees, deposit
23 them in the basic health plan operating account, keep records of
24 enrollee status, and authorize periodic payments to managed health care
25 systems on the basis of the number of enrollees participating in the
26 respective managed health care systems.

27 ~~((+9))~~ (10) To accept applications from individuals residing in
28 areas served by the plan, on behalf of themselves and their spouses and
29 dependent children, for enrollment in the Washington basic health plan
30 as subsidized enrollees, to establish appropriate minimum-enrollment
31 periods for enrollees as may be necessary, and to determine, upon
32 application and at least annually thereafter, or at the request of any
33 enrollee, eligibility due to current gross family income for sliding
34 scale premiums. An enrollee who remains current in payment of the
35 sliding-scale premium, as determined under subsection (2) of this
36 section, and whose gross family income has risen above ~~((twice))~~ two
37 and one-half times the federal poverty level, may continue enrollment
38 as subsidized enrollees unless and until the enrollee's gross family
39 income has remained above ~~((twice))~~ two and one-half times the poverty

1 level for (~~six~~) eighteen consecutive months, by making payment at the
2 unsubsidized rate required for the managed health care system in which
3 he or she may be enrolled plus the administrative cost of providing the
4 plan to that enrollee. No subsidy may be paid with respect to any
5 enrollee whose current gross family income exceeds twice the federal
6 poverty level or, subject to RCW 70.47.110, who is a recipient of
7 medical assistance or medical care services under chapter 74.09 RCW.
8 If a number of enrollees drop their enrollment for no apparent good
9 cause, the administrator may establish appropriate rules or
10 requirements that are applicable to such individuals before they will
11 be allowed to re-enroll in the plan.

12 (~~(10)~~) (11) To accept applications from individuals residing in
13 areas serviced by the plan, on behalf of themselves and their spouses
14 and dependent children, under sixty-five years of age and not otherwise
15 eligible for medicare, whose gross family income at the time of
16 enrollment does not exceed three times the federal poverty level as
17 adjusted for family size and determined by the federal department of
18 health and human services, who wish to enroll in the plan at no cost to
19 the state and choose to obtain the basic health care coverage and
20 services from a managed care system participating in the plan. Any
21 such nonsubsidized enrollees must pay the amount negotiated by the
22 administrator with the participating managed health care system and the
23 administrative cost of providing the plan to such nonsubsidized
24 enrollees and shall not be eligible for any subsidy from the plan.

25 (12) To determine the rate to be paid to each participating managed
26 health care system in return for the provision of covered basic health
27 care services to enrollees in the system. Although the schedule of
28 covered basic health care services will be the same for similar
29 enrollees, the rates negotiated with participating managed health care
30 systems may vary among the systems. In negotiating rates with
31 participating systems, the administrator shall consider the
32 characteristics of the populations served by the respective systems,
33 economic circumstances of the local area, the need to conserve the
34 resources of the basic health plan trust account, and other factors the
35 administrator finds relevant. In determining the rate to be paid to a
36 contractor, the administrator shall strive to assure that the rate does
37 not result in adverse cost shifting to other private payers of health
38 care.

1 (~~(11)~~) (13) To monitor the provision of covered services to
2 enrollees by participating managed health care systems in order to
3 assure enrollee access to good quality basic health care, to require
4 periodic data reports concerning the utilization of health care
5 services rendered to enrollees in order to provide adequate information
6 for evaluation, and to inspect the books and records of participating
7 managed health care systems to assure compliance with the purposes of
8 this chapter. In requiring reports from participating managed health
9 care systems, including data on services rendered enrollees, the
10 administrator shall endeavor to minimize costs, both to the managed
11 health care systems and to the administrator. The administrator shall
12 coordinate any such reporting requirements with other state agencies,
13 such as the insurance commissioner and the department of health, to
14 minimize duplication of effort.

15 (~~(12)~~) (14) To monitor the access that state residents have to
16 adequate and necessary health care services, determine the extent of
17 any unmet needs for such services or lack of access that may exist from
18 time to time, and make such reports and recommendations to the
19 legislature as the administrator deems appropriate.

20 (~~(13)~~) (15) To evaluate the effects this chapter has on private
21 employer-based health care coverage and to take appropriate measures
22 consistent with state and federal statutes that will discourage the
23 reduction of such coverage in the state.

24 (~~(14)~~) (16) To develop a program of proven preventive health
25 measures and to integrate it into the plan wherever possible and
26 consistent with this chapter.

27 (~~(15)~~) (17) To provide, consistent with available resources,
28 technical assistance for rural health activities that endeavor to
29 develop needed health care services in rural parts of the state.

30 **Sec. 705.** RCW 70.47.080 and 1987 1st ex.s. c 5 s 10 are each
31 amended to read as follows:

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

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

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

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

21 **Sec. 706.** RCW 70.47.120 and 1987 1st ex.s. c 5 s 14 are each
22 amended to read as follows:

23 In addition to the powers and duties specified in RCW 70.47.040 and
24 70.47.060, the administrator has the power to enter into contracts for
25 the following functions and services:

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

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

35 (3) With public or private agencies, including health care service
36 contractors registered under RCW 48.44.015, and doing business in the
37 state, for marketing and administrative services in connection with
38 participation of managed health care systems, enrollment of enrollees,

1 billing and collection services to the administrator, and other
2 administrative functions ordinarily performed by health care service
3 contractors, other than insurance except that the administrator may
4 purchase or arrange for the purchase of reinsurance, or self-insure for
5 reinsurance, on behalf of its participating managed health care
6 systems. Any activities of a health care service contractor pursuant
7 to a contract with the administrator under this section shall be exempt
8 from the provisions and requirements of Title 48 RCW.

9

PART VIII - HEALTH DATA

10 **Sec. 801.** RCW 70.170.010 and 1989 1st ex.s. c 9 s 501 are each
11 amended to read as follows:

12 (1) The legislature finds and declares that there is a need for
13 health care information that helps the general public understand health
14 care issues and how they can be better consumers and that is useful to
15 purchasers, payers, and providers in making health care choices (~~and~~
16 ~~negotiating payments~~). The legislature further finds that there is a
17 need for a comprehensive health data system that will permit
18 purchasers, payers, consumers, and government to assess and monitor the
19 quality of health care services, monitor the costs of health care and
20 aid in making health care purchasing decisions. It is the purpose and
21 intent of this chapter to establish a (~~hospital~~) health care data
22 collection, storage, and retrieval system which supports these data
23 needs and which also provides public officials and others engaged in
24 the development of state health policy the information necessary for
25 the analysis of health care issues.

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

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

35 (4) The lack of reliable statistical information about the delivery
36 of charity care is a particular concern that should be addressed. It
37 is (~~the~~) a purpose and intent of this chapter to require hospitals to

1 provide, and report to the state, charity care to persons with acute
2 care needs, and to have a state agency both monitor and report on the
3 relative commitment of hospitals to the delivery of charity care
4 services, as well as the relative commitment of public and private
5 purchasers or payers to charity care funding.

6 **Sec. 802.** RCW 70.170.020 and 1989 1st ex.s. c 9 s 502 are each
7 amended to read as follows:

8 As used in this chapter:

9 (1) "Council" means the health care ~~((access))~~ data, quality
10 assurance, and cost control council created by this chapter.

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

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

15 (4) "Secretary" means secretary of health.

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

20 (6) "Sliding fee schedule" means a hospital-determined, publicly
21 available schedule of discounts to charges for persons deemed eligible
22 for charity care; such schedules shall be established after
23 consideration of guidelines developed by the department.

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

26 (8) "Health care" means all care, goods, technologies, or services
27 provided to persons by providers of care intended to ascertain,
28 improve, restore, or maintain the health and well-being of such
29 persons. It specifically includes but is not limited to, the care,
30 goods, technologies, or services of health care practitioners,
31 programs, facilities, or other health care entities regulated by Title
32 18 or 70 RCW.

33 (9) "Providers" means all health care practitioners, programs,
34 facilities, or other health care entities regulated under Title 18 or
35 70 RCW.

36 (10) "Health care payers" includes all state health care payment
37 programs; all disability insurers, health care service contractors, and
38 health maintenance organizations subject to the jurisdiction of the

1 insurance commissioner under Title 48 RCW; all providers, carriers, and
2 others subject to the provisions of chapter 48.-- RCW (sections 401
3 through 409 of this act), and all employers who provide health care
4 benefits to employees through self-insurance.

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

6 **Sec. 803.** RCW 70.170.030 and 1989 1st ex.s. c 9 s 503 are each
7 amended to read as follows:

8 (1) There is created the health care ((access)) data, quality
9 assurance, and cost control council within the department of health
10 consisting of the following: The director of the department of labor
11 and industries; the administrator of the health care authority; the
12 secretary of social and health services; the insurance commissioner;
13 the administrator of the basic health plan; a person representing the
14 governor on matters of health policy; the secretary of health; and
15 ((one member from the public at large to be selected by the governor
16 who shall represent individual consumers of health care. The public
17 member shall not have any fiduciary obligation to any health care
18 facility or any financial interest in the provision of health care
19 services)) six public members. Public members shall be appointed by
20 the governor. In selecting public members, the governor shall assure
21 that the council collectively has the technical expertise necessary to
22 fulfill the purposes of this chapter and also reflects the perspectives
23 of the users and reporters. Public members shall serve five-year
24 terms. The governor shall designate three of the initial appointees to
25 serve three-year terms in order to provide staggered terms. Thereafter
26 all public members shall serve five-year terms. All persons appointed
27 to fill vacancies shall be appointed in the same manner as the persons
28 they are replacing. Members employed by the state shall serve without
29 pay and participation in the council's work shall be deemed performance
30 of their employment. The public member shall be compensated in
31 accordance with RCW 43.03.240 and shall be reimbursed for related
32 travel expenses in accordance with RCW 43.03.050 and 43.03.060.

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

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

4 **Sec. 804.** RCW 70.170.040 and 1989 1st ex.s. c 9 s 504 are each
5 amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

36 ~~(ii) Determination of the effects, if any, of nonmonetary factors~~
37 ~~upon the availability of, and access to, appropriate and necessary~~

1 basic health services such as, but not limited to, prenatal and
2 obstetrical care; and

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

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

8 **Sec. 805.** RCW 70.170.050 and 1989 1st ex.s. c 9 s 505 are each
9 amended to read as follows:

10 The department shall have the authority to respond to requests ((of
11 others)) for data, special studies, or analysis. The department may
12 require ((such sponsors to pay)) payment of any or all of the
13 reasonable costs associated with such requests that might be approved,
14 but in no event may costs directly associated with any such special
15 study be charged against the funds generated by the assessment
16 authorized under RCW 70.170.080.

17 **Sec. 806.** RCW 70.170.080 and 1991 sp.s. c 13 s 71 are each amended
18 to read as follows:

19 The basic expenses for the ((hospital)) data collection and
20 reporting activities of this chapter shall be financed by an assessment
21 ((against hospitals)) upon reporters of no more than four one-
22 hundredths of one percent of ((each hospital's gross operating costs,
23 to be levied and collected from and after that date, upon which the
24 similar assessment levied under chapter 70.39 RCW is terminated, for
25 the provision of hospital services for its last fiscal year ending on
26 or before June 30th of the preceding calendar year)) the gross billed
27 amount for the service that is the subject matter of the data.
28 Budgetary requirements in excess of that limit must be financed by a
29 general fund appropriation by the legislature. All moneys collected
30 under this section shall be deposited by the state treasurer in the
31 ((hospital)) health data collection account which is hereby created in
32 the state treasury. This account is the successor to the hospital data
33 collection account, the balance of which shall be placed in the health
34 care data collection account. The department may also charge, receive,
35 and dispense funds or authorize any contractor or outside sponsor to
36 charge for and reimburse the costs associated with special studies as
37 specified in RCW 70.170.050.

1 Any amounts raised by the collection of assessments from hospitals
2 provided for in this section which are not required to meet
3 appropriations in the budget act for the current fiscal year shall be
4 available to the department in succeeding years.

5 **Sec. 807.** RCW 70.170.100 and 1990 c 269 s 12 are each amended to
6 read as follows:

7 (1) The department, in consultation with the council, is
8 responsible for the development, implementation, and custody of a
9 state-wide ((hospital)) health care data system. As part of the design
10 stage for development of the system, the ((department)) council shall
11 undertake a needs assessment of the types of, and format for,
12 ((hospital)) health care data needed by consumers, purchasers, health
13 care payers, ((hospitals)) providers, the Washington health insurance
14 purchasing pool, and state government as consistent with the intent of
15 this chapter and chapter 48.-- RCW (sections 401 through 409 of this
16 act). The ((department)) council shall ((identify)) recommend to the
17 department a set of ((hospital)) health care data elements and report
18 specifications which satisfy these needs. The ((council shall review
19 the design of the data system and may direct the department to))
20 department may contract with a private vendor ((for assistance in the
21 design of the data system)) in the state of Washington for work to be
22 performed under this section. The data elements, specifications, and
23 other ((design)) distinguishing features of this data system shall be
24 made available for public review and comment and shall be published,
25 with comments, as the department's ((first)) data plan by January 1,
26 ((1990)) 1994.

27 (2) ~~((Subsequent to the initial development of the data system as~~
28 ~~published as the department's first data plan, revisions to the data~~
29 ~~system shall be considered through the department's development of a~~
30 ~~biennial data plan, as proposed to, and funded by, the legislature~~
31 ~~through the biennial appropriations process. Costs of data activities~~
32 ~~outside of these data plans except for special studies shall be funded~~
33 ~~through legislative appropriations.~~

34 (3)) In designing the state-wide ((hospital)) health care data
35 system and any data plans, the council and the department shall
36 identify ((hospital)) health care data elements relating to ((both
37 hospital finances)) health care costs, public health services, the
38 quality of health care services, data needs necessary to implement

1 provisions of chapter 48.-- RCW (sections 401 through 409 of this act)
2 and ((the)) use of health care services by ((patients)) consumers.
3 Data elements ((relating to hospital finances)) shall be reported ((by
4 hospitals)) as the department directs by reporters in conformance with
5 a uniform ((system of)) reporting ((as specified by the department and
6 shall)) system established by the department, which shall be adopted by
7 all reporters. In the case of hospitals this includes data elements
8 identifying each hospital's revenues, expenses, contractual allowances,
9 charity care, bad debt, other income, total units of inpatient and
10 outpatient services, and other financial, service utilization, and
11 quality-related information reasonably necessary to fulfill the
12 purposes of this chapter, for hospital activities as a whole and, as
13 feasible and appropriate, for specified classes of hospital purchasers
14 and payers. Data elements relating to use of hospital services by
15 patients shall, at least initially, be the same as those currently
16 compiled by hospitals through inpatient discharge abstracts ((and
17 reported to the Washington state hospital commission)). The department
18 shall permit reporting by electronic transmission or hard copy as is
19 practical and economical to reporters.

20 ~~((+4))~~ (3) The state-wide ~~((hospital))~~ health care data system
21 shall be uniform in its identification of reporting requirements for
22 ~~((hospitals))~~ reporters across the state to the extent that such
23 uniformity is ~~((necessary))~~ useful to fulfill the purposes of this
24 chapter. Data reporting requirements may reflect differences ~~((in~~
25 ~~hospital size; urban or rural location; scope, type, and method of~~
26 ~~providing service; financial structure; or other pertinent~~
27 ~~distinguishing factors))~~ that involve pertinent distinguishing features
28 as recommended by the council and approved by the department in rule.
29 So far as ~~((possible))~~ is practical, the data system shall be
30 coordinated with any requirements of the trauma care data registry as
31 authorized in RCW 70.168.090, the federal department of health and
32 human services in its administration of the medicare program, ~~((and))~~
33 the state in its role of gathering public health statistics, or any
34 other payer program of consequence, so as to minimize any unduly
35 burdensome reporting requirements imposed on ~~((hospitals))~~ reporters.

36 ~~((+5))~~ (4) In identifying financial reporting requirements under
37 the state-wide ~~((hospital))~~ health care data system, the department may
38 require both annual reports and condensed quarterly reports, from
39 reporters so as to achieve both accuracy and timeliness in reporting,

1 but shall craft such requirements with due regard of the data reporting
2 burdens of reporters.

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

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

19 ~~(8)) (5) The ((hospital)) health care data collected ((and)),~~
20 ~~maintained, and studied by the department shall be available for~~
21 ~~retrieval, unless deemed confidential, in original or processed form to~~
22 ~~public and private requestors within a reasonable period of time after~~
23 ~~the date of request. The cost of retrieving data for state officials~~
24 ~~and agencies shall be funded through the state general appropriation.~~
25 ~~The cost of retrieving data for individuals and organizations engaged~~
26 ~~in research or private use of data shall be funded by a fee schedule~~
27 ~~developed by the department which reflects the direct cost of~~
28 ~~retrieving the data or study in the requested form.~~

29 (6) All persons subject to this chapter, including all state
30 agencies, shall comply with requirements established by rule in the
31 acquisition of data. The department shall each December 1 of even-
32 numbered years report to the senate and house of representatives policy
33 committees on health care on the status of the data system, the level
34 of participation by payer and provider groups, and recommended
35 statutory changes necessary to meet the objectives established in this
36 chapter.

37 (7) The department shall establish in rule confidentiality
38 standards to safeguard the information collected under this chapter
39 from inappropriate use or release.

1 **Sec. 808.** RCW 70.170.110 and 1989 1st ex.s. c 9 s 511 are each
2 amended to read as follows:

3 The department shall provide, or may contract with a private
4 ~~((entity to provide, hospital analyses and reports))~~ vendor in the
5 state of Washington to provide any studies or reports it chooses to
6 conduct consistent with the purposes of this chapter. ~~((Prior to~~
7 ~~release, the department shall provide affected hospitals with an~~
8 ~~opportunity to review and comment on reports which identify individual~~
9 ~~hospital data with respect to accuracy and completeness, and otherwise~~
10 ~~shall focus on aggregate reports of hospital performance.))~~ The
11 department may perform such studies or any other studies consistent
12 with the purposes of this chapter. These reports ~~((shall))~~ may
13 include:

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

19 (2) Reports for use by classes of purchasers, health care payers,
20 and providers as specified for content and format in the state-wide
21 data system and data plan; ~~((and))~~

22 (3) Reports on relevant ~~((hospital))~~ health care policy ~~((issues))~~
23 including the distribution of hospital charity care obligations among
24 hospitals; absolute and relative rankings of Washington and other
25 states, regions, and the nation with respect to expenses, net revenues,
26 and other key indicators; ~~((hospital))~~ provider efficiencies; and the
27 effect of medicare, medicaid, and other public health care programs on
28 rates paid by other purchasers of ~~((hospital))~~ health care;

29 (4) Any other studies deemed useful to assist the public in
30 understanding the prudent and cost-effective use of the health care
31 delivery system;

32 (5) Study and report each December 1 to the health policy and
33 fiscal committees of the legislature and the governor on the number of
34 uninsured residents in the state. The report shall provide enough
35 detail to permit the legislature and the governor to monitor the
36 effectiveness of the state's efforts to increase the availability of
37 health insurance to state residents and to identify significant
38 populations or groups who remain uninsured; and

1 (6) Any other studies necessary to fulfill the legislative intent
2 of this chapter and the provisions of chapter 48.-- RCW (sections 401
3 through 409 of this act).

4 NEW SECTION. Sec. 809. A new section is added to chapter 70.170
5 RCW to read as follows:

6 COUNCIL STUDY. The council shall examine local, state, and federal
7 regulations that apply to hospitals and shall report to the health care
8 policy committees of the legislature by July 1, 1994, on the following:

9 (1) An inventory of health and safety regulations that apply to
10 hospitals;

11 (2) A description of the costs to local, state, and federal
12 agencies for operating the regulatory programs;

13 (3) An estimate of the costs to hospitals to comply with the
14 regulations;

15 (4) A description of whether regulatory functions are duplicated
16 among different regulatory programs;

17 (5) An analysis of the effectiveness of regulatory programs in
18 meeting their safety and health objectives;

19 (6) Recommendations on elimination or consolidation of unnecessary
20 or duplicative regulatory activities that would not result in a
21 reduction in the health and safety objectives.

22 **PART IX - DISCLOSURE OF HOSPITAL AND PHARMACY CHARGES**

23 NEW SECTION. Sec. 901. A new section is added to chapter 70.41
24 RCW to read as follows:

25 (1) The legislature finds that the spiraling costs of health care
26 continue to surmount efforts to contain them, increasing at
27 approximately twice the inflationary rate. The causes of this
28 phenomenon are complex. By making physicians and other health care
29 providers with hospital admitting privileges more aware of the cost
30 consequences of health care services for consumers, these providers may
31 be inclined to exercise more restraint in providing only the most
32 relevant and cost-beneficial hospital services, with a potential for
33 reducing the utilization of those services. The requirement of the
34 hospital to inform physicians and other health care providers of the
35 charges of the health care services that they order may have a positive
36 effect on containing health costs. Further, the option of the

1 physician or other health care provider to inform the patient of these
2 charges may strengthen the necessary dialogue in the provider-patient
3 relationship that tends to be diminished by intervening third-party
4 payors.

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

13 NEW SECTION. **Sec. 902.** A new section is added to chapter 71.12
14 RCW to read as follows:

15 (1) The legislature finds that the spiraling costs of health care
16 continue to surmount efforts to contain them, increasing at
17 approximately twice the inflationary rate. The causes of this
18 phenomenon are complex. By making physicians and other health care
19 providers with hospital admitting privileges more aware of the cost
20 consequences of health care services for consumers, these providers may
21 be inclined to exercise more restraint in providing only the most
22 relevant and cost-beneficial hospital services, with a potential for
23 reducing the utilization of those services. The requirement of the
24 hospital to inform physicians and other health care providers of the
25 charges of the health care services that they order may have a positive
26 effect on containing health costs. Further, the option of the
27 physician or other health care provider to inform the patient of these
28 charges may strengthen the necessary dialogue in the provider-patient
29 relationship that tends to be diminished by intervening third-party
30 payors.

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

1 NEW SECTION. **Sec. 903.** The legislature finds that the spiraling
2 costs of health care continue to surmount efforts to contain them,
3 increasing at approximately twice the inflationary rate. One of the
4 fastest growing segments of the health care expenditure involves
5 prescription medications. The prescription drug market is extremely
6 cost competitive. The causes of these phenomena are complex. By
7 making physicians and other health care providers with prescriptive
8 authority more aware of the cost consequences of health care treatments
9 for consumers, these providers may be inclined to exercise more
10 restraint in providing only the most relevant and cost-beneficial drug
11 and medication treatments. The requirement of the pharmacy to inform
12 physicians and other health care providers of the charges of
13 prescription drugs and medications that they order may have a positive
14 effect on containing health costs. Further, the option of the
15 physician or other health care provider to inform the patient of these
16 charges may strengthen the necessary dialogue in the provider-patient
17 relationship that tends to be diminished by intervening third-party
18 payers.

19 NEW SECTION. **Sec. 904.** A new section is added to chapter 18.68
20 RCW to read as follows:

21 The registered or licensed pharmacist under this chapter shall
22 establish and maintain a procedure for disclosing to physicians and
23 other health care providers with prescriptive authority information
24 detailed by prescriber, of the cost and dispensation of all
25 prescriptive medications prescribed by him or her across his or her
26 patients. These charges shall be easily read and provided to the
27 physician or other health care provider on a monthly basis by the
28 pharmacy. The physician or other health care provider may inform the
29 patient of these charges.

30 NEW SECTION. **Sec. 905.** The department of health shall report to
31 the legislature by December 31, 1993, with recommendations on any
32 necessary revisions to sections 901 through 904 of this act, including
33 their continued necessity and the appropriateness of their repeal.

34 NEW SECTION. **Sec. 906.** Sections 901 through 904 of this act shall
35 take effect July 1, 1994.

1 **PART X - COMMISSION ON THE BEGINNING OF LIFE**
2 **AND THE END OF LIFE**

3 NEW SECTION. **Sec. 1001.** There is established a commission on the
4 beginning and end of life. The commission shall consist of five
5 members appointed by the governor. The commission shall be a
6 multidisciplinary professional group of physicians, nurses, lay-
7 members, and ethicists.

8 Consistent with funds appropriated specifically for this purpose,
9 the commission may hire staff or contract for professional assistance.
10 State agencies may provide staff support upon request of the
11 commission. The commission may establish ad hoc technical advisory
12 committees as necessary.

13 To conduct its business, the commission shall have access to all
14 health data available by statute to the secretary of health. The
15 commission shall provide the commission with requested health data or
16 other relevant information maintained by the department of health in a
17 timely and easy-to-comprehend manner.

18 The members of the commission shall receive no compensation for
19 their service, except that travel expenses shall be reimbursed, from
20 whatever funds are made available to the commission, pursuant to RCW
21 43.03.050 and 43.03.060.

22 By November 1, 1994, the commission shall examine the beginning of
23 life and the end of life from the standpoint of appropriate medical and
24 health care practice. The objective of the commission shall be the
25 development of general principles of ethical practice dedicated to the
26 preservation of comfort without unreasonable life prolongation in the
27 presence of an untreatable condition. These guidelines shall be for
28 use by health care providers and institutions. The commission shall
29 report to the governor, the insurance commissioner, and the legislature
30 on their recommendations. The commission shall cease to exist on
31 December 1, 1994.

32 NEW SECTION. **Sec. 1002.** The sum of seventy-five thousand dollars,
33 or as much thereof as may be necessary, is appropriated for the
34 biennium ending June 30, 1995, from the general fund to the commission
35 on the beginning and end of life for the purposes of section 1001 of
36 this act.

PART XI - MALPRACTICE

1

2 NEW SECTION. **Sec. 1101.** A new section is added to chapter 7.70
3 RCW to read as follows:

4 NONECONOMIC DAMAGES--JOINT AND SEVERAL LIABILITY--LEGISLATIVE
5 INTENT. The legislature finds that in *Sofie v. Fibreboard Corp.*, 112
6 Wn.2d 636 (1989), the Washington state supreme court struck down the
7 limit on noneconomic damages enacted by the legislature in 1986,
8 because the court found that the statutory limitation on noneconomic
9 damages interfered with the jury's province to determine damages, and
10 thus violated a plaintiff's constitutionally protected right to trial
11 by jury.

12 The legislature further finds that reforms in existing law for
13 actions involving fault are necessary and proper to avoid catastrophic
14 economic consequences for state and local governmental entities as well
15 as private individuals and businesses.

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

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

25 NEW SECTION. **Sec. 1102.** A new section is added to chapter 7.70
26 RCW to read as follows:

27 JOINT AND SEVERAL LIABILITY RESTRICTIONS. (1) For the purposes of
28 this section, the term "economic damages" means objectively verifiable
29 monetary losses, including medical expenses, loss of earnings, burial
30 costs, cost of obtaining substitute domestic services, loss of
31 employment, and loss of business or employment opportunities.
32 "Economic damages" does not include subjective, nonmonetary losses such
33 as pain and suffering, mental anguish, emotional distress, disability
34 and disfigurement, inconvenience, injury to reputation, humiliation,
35 destruction of the parent-child relationship, the nature and extent of
36 an injury, loss of consortium, society, companionship, support, love,

1 affection, care, services, guidance, training, instruction, and
2 protection.

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

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

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

24 (3) If a defendant is jointly and severally liable under one of the
25 exceptions listed in subsection (2)(a) or (b) of this section, such
26 defendant's rights to contribution against another jointly and
27 severally liable defendant, and the effect of settlement by either such
28 defendant, shall be determined under RCW 4.22.040, 4.22.050, and
29 4.22.060.

30 NEW SECTION. **Sec. 1103.** A new section is added to chapter 18.130
31 RCW to read as follows:

32 **MALPRACTICE INSURANCE COVERAGE MANDATE.** Except to the extent that
33 liability insurance is not available, every licensed health care
34 practitioner whose services are included in the uniform benefits
35 package, as determined by section 403 of this act, and whose scope of
36 practice includes independent practice, shall, as a condition of
37 licensure and relicensure, be required to provide evidence of a minimum

1 level of malpractice insurance coverage. On or before January 1, 1994,
2 the department shall designate by rule:

3 (1) Those health professions whose scope of practice includes
4 independent practice;

5 (2) For each health profession whose scope of practice includes
6 independent practice, whether malpractice insurance is available; and

7 (3) If such insurance is available, the appropriate minimum level
8 of mandated coverage.

9 NEW SECTION. **Sec. 1104.** A new section is added to Title 70 RCW to
10 read as follows:

11 RISK MANAGEMENT TRAINING WITHIN HEALTH FACILITIES. Effective July
12 1, 1994, each health care provider, facility, or health maintenance
13 organization that self-insures for liability risks related to medical
14 malpractice and employs physicians or other independent health care
15 practitioners in Washington state shall condition each physician's and
16 practitioner's liability coverage by that entity upon that physician's
17 or practitioner's participation in risk management training offered by
18 the provider, facility, or health maintenance organization to its
19 employees. The risk management training shall provide information
20 related to avoiding adverse health outcomes resulting from substandard
21 practice and minimizing damages associated with those adverse health
22 outcomes that occur. For purposes of this section, "independent health
23 care practitioner" means those health care practitioner licensing
24 classifications designated by the department of health in rule under
25 section 605 of this act.

26 NEW SECTION. **Sec. 1105.** A new section is added to chapter 48.22
27 RCW to read as follows:

28 RISK MANAGEMENT TRAINING OF INDEPENDENT HEALTH CARE PRACTITIONERS.
29 Effective July 1, 1994, a casualty insurer's issuance of a new medical
30 malpractice policy or renewal of an existing medical malpractice
31 policy, to a physician or other independent health care practitioner,
32 shall be conditioned upon that practitioner's participation in, and
33 completion of, health care liability risk management training offered
34 by the insurer. The risk management training shall provide information
35 related to avoiding adverse health outcomes resulting from substandard
36 practice and minimizing damages associated with those adverse health

1 outcomes that occur. For purposes of this section, "independent health
2 care practitioners" means those health care practitioner licensing
3 classifications designated by the department of health in rule pursuant
4 to section 605 of this act.

5 **Sec. 1106.** RCW 18.130.160 and 1986 c 259 s 8 are each amended to
6 read as follows:

7 FINDING OF UNPROFESSIONAL CONDUCT--ORDERS--SANCTIONS--STAY--COSTS.
8 Upon a finding that a license holder or applicant has committed
9 unprofessional conduct or is unable to practice with reasonable skill
10 and safety due to a physical or mental condition, the disciplining
11 authority may issue an order providing for one or any combination of
12 the following:

13 (1) Revocation of the license;

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

15 (3) Restriction or limitation of the practice;

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

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

20 (6) Censure or reprimand;

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

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

26 (9) Denial of the license request;

27 (10) Corrective action;

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

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

1 **Sec. 1107.** RCW 18.130.190 and 1991 c 3 s 271 are each amended to
2 read as follows:

3 PRACTICE WITHOUT LICENSE--INVESTIGATION OF COMPLAINTS--TEMPORARY
4 CEASE AND DESIST ORDERS--INJUNCTIONS--PENALTY. (1) The secretary shall
5 investigate complaints concerning practice by unlicensed persons of a
6 profession or business for which a license is required by the chapters
7 specified in RCW 18.130.040. In the investigation of the complaints,
8 the secretary shall have the same authority as provided the secretary
9 under RCW 18.130.050. The secretary shall issue a cease and desist
10 order to a person after notice and hearing and upon a determination
11 that the person has violated this subsection. If the secretary makes
12 a written finding of fact that the public interest will be irreparably
13 harmed by delay in issuing an order, the secretary may issue a
14 temporary cease and desist order. The cease and desist order shall not
15 relieve the person so practicing or operating a business without a
16 license from criminal prosecution therefor, but the remedy of a cease
17 and desist order shall be in addition to any criminal liability. The
18 cease and desist order is conclusive proof of unlicensed practice and
19 may be enforced under RCW 7.21.060. This method of enforcement of the
20 cease and desist order may be used in addition to, or as an alternative
21 to, any provisions for enforcement of agency orders set out in chapter
22 34.05 RCW.

23 (2) The attorney general, a county prosecuting attorney, the
24 secretary, a board, or any person may in accordance with the laws of
25 this state governing injunctions, maintain an action in the name of
26 this state to enjoin any person practicing a profession or business for
27 which a license is required by the chapters specified in RCW 18.130.040
28 without a license from engaging in such practice or operating such
29 business until the required license is secured. However, the
30 injunction shall not relieve the person so practicing or operating a
31 business without a license from criminal prosecution therefor, but the
32 remedy by injunction shall be in addition to any criminal liability.

33 (3) Unlicensed practice of a profession or operating a business for
34 which a license is required by the chapters specified in RCW
35 18.130.040, unless otherwise exempted by law, constitutes a gross
36 misdemeanor. All fees, fines, forfeitures, and penalties collected or
37 assessed by a court because of a violation of this section shall be
38 remitted to the health professions account.

1 (4) In addition to the remedies provided in this section, the
2 secretary is authorized to impose a civil penalty of up to five
3 thousand dollars on any person engaged, without a license, in a
4 profession or business for which a license is required by the chapters
5 specified in RCW 18.130.040. The imposition of such civil penalty
6 shall occur only subsequent to a hearing in conformance with the
7 provisions of chapter 34.05 RCW in any case in which the secretary
8 finds that there has been a failure or refusal to comply with the
9 provisions of any chapters specified in RCW 18.130.040.

10 **Sec. 1108.** RCW 70.41.200 and 1991 c 3 s 336 are each amended to
11 read as follows:

12 MEDICAL MALPRACTICE PREVENTION PROGRAM--QUALITY ASSURANCE
13 COMMITTEE--SANCTION AND GRIEVANCE PROCEDURES--INFORMATION COLLECTION
14 AND REPORTING. (1) Every hospital shall maintain a coordinated program
15 for the identification and prevention of medical malpractice. The
16 program shall include at least the following:

17 (a) The establishment of a quality assurance committee with the
18 responsibility to review the services rendered in the hospital in order
19 to improve the quality of medical care of patients and to prevent
20 medical malpractice. The committee shall oversee and coordinate the
21 medical malpractice prevention program and shall insure that
22 information gathered pursuant to the program is used to review and to
23 revise hospital policies and procedures. At least one member of the
24 committee shall be a member of the governing board of the hospital who
25 is not otherwise affiliated with the hospital in an employment or
26 contractual capacity;

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

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

34 (d) A procedure, including but not limited to, mediation, for the
35 prompt resolution of grievances by patients or their representatives
36 related to accidents, injuries, treatment, and other events that may
37 result in claims of medical malpractice;

1 (e) The maintenance and continuous collection of information
2 concerning the hospital's experience with negative health care outcomes
3 and incidents injurious to patients, patient grievances, professional
4 liability premiums, settlements, awards, costs incurred by the hospital
5 for patient injury prevention, and safety improvement activities;

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

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

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

17 (2) Any person who, in substantial good faith, provides information
18 to further the purposes of the medical malpractice prevention program,
19 or who, in substantial good faith, participates on the quality
20 assurance committee, or who, in substantial good faith, assists in a
21 broader scope of quality assurance by health care service providers
22 shall not be subject to an action for civil damages or other relief as
23 a result of such activity.

24 (3) Information and documents, including complaints and incident
25 reports, created, collected, and maintained about health care providers
26 arising out of the matters that are under review or have been evaluated
27 by a review committee conducting quality assurance reviews or that are
28 related to general quality assurance activities are not subject to
29 discovery or introduction into evidence in any civil action, and no
30 person who was in attendance at a meeting of such committee or board or
31 quality assurance activities shall be permitted or required to testify
32 in any civil action as to the content of such proceedings or
33 activities. This subsection does not preclude: (a) In any civil
34 action, the testimony of any person concerning the facts which form the
35 basis for the institution of such proceedings of which the person had
36 personal knowledge acquired independently of such proceedings; (b) in
37 any civil action by a health care provider regarding the restriction or
38 revocation of that individual's clinical or staff privileges,
39 introduction into evidence information collected and maintained by

1 quality assurance committees regarding such health care provider; (c)
2 in any civil action, disclosure of the fact that staff privileges were
3 terminated or restricted, including the specific restrictions imposed,
4 if any; or (d) in any civil action, discovery and introduction into
5 evidence of the patient's medical records required by regulation of the
6 department of health to be made regarding the care and treatment
7 received.

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

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

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

22 NEW SECTION. **Sec. 1109.** A new section is added to chapter 7.70
23 RCW to read as follows:

24 (1) With respect to a health care liability action or claim, the
25 total amount of damages received by an individual under such action or
26 claim shall be reduced, in accordance with subsection (2) of this
27 section, by any other payment that has been, or will be, made to an
28 individual to compensate such individual for the injury that was the
29 subject of such action or claim.

30 (2) The amount by which an award of damages to an individual for an
31 injury shall be reduced under subsection (1) of this section shall be:

32 (a) The total amount of any payments, other than such award, that
33 have been made or that will be made to such individual to compensate
34 such individual for the injury that was the subject of the action or
35 claim; minus

36 (b) The amount paid by such individual, or by the spouse, parent,
37 or legal guardian of such individual, to secure the payments described
38 in (a) of this subsection.

1 distribution of all tobacco products in this state at the rate of
2 forty-five percent of the wholesale sales price of such tobacco
3 products. Such tax shall be imposed at the time the distributor (a)
4 brings, or causes to be brought, into this state from without the state
5 tobacco products for sale, (b) makes, manufactures, or fabricates
6 tobacco products in this state for sale in this state, or (c) ships or
7 transports tobacco products to retailers in this state, to be sold by
8 those retailers.

9 (2) An additional tax is imposed equal to the rate specified in RCW
10 82.02.030 multiplied by the tax payable under subsection (1) of this
11 section.

12 (3) An additional tax is imposed equal to 381.80 percent of the
13 wholesale sales price of tobacco products.

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

16 **PART XIII - MISCELLANEOUS**

17 NEW SECTION. Sec. 1301. The department of health shall study and
18 report by December 31, 1993, the following:

19 (1) The development of a regulatory system for quality assurance
20 plans throughout the medical community.

21 (2) The inclusion of communication techniques, cost control,
22 liability insurance, and the health care liability system in continuing
23 education programs.

24 (3) The inclusion of provider credentialing, the use of contracted
25 providers, and quality assurance activities in health plan
26 certification standards.

27 (4) Development and use, in consultation with providers, of
28 practice guidelines.

29 NEW SECTION. Sec. 1302. The health care authority shall study the
30 following, and report to the legislature by December 31, 1994:

31 (1) The development of a universal, uniform, comprehensive, and
32 publicly accessible health care liability data system;

33 (2) The facilitation of programs that educate the public about how
34 best to use health services, and promote realistic and reasonable
35 consumer expectations of the health system.

1 NEW SECTION. **Sec. 1303.** The administrator for the courts shall
2 study and report to the legislature by December 31, 1994, the
3 development of an informal, voluntary system to facilitate prefiling
4 review of malpractice claims by one or more medical or health services
5 experts chosen from a pool maintained by each of the health care
6 practitioner or provider associations.

7 NEW SECTION. **Sec. 1304.** CAPTIONS. Captions and part headings as
8 used in this act constitute no part of the law.

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