SECOND ENGROSSED SUBSTITUTE HOUSE BILL 2590

State of Washington 52nd Legislature 1992 Regular Session

By House Committee on Health Care (originally sponsored by Representatives Braddock, Winsley, Wang, Brekke, G. Cole, H. Myers, Wineberry, Locke, Paris, Jones, Franklin, Ogden, R. Fisher, Pruitt, Prentice, O'Brien, Nelson, Jacobsen, Belcher, Spanel, J. Kohl and Anderson; by request of Governor Gardner)

Read first time 02/07/92.

AN ACT Relating to health care; amending RCW 70.47.010, 70.47.020, 70.47.040, 70.47.080, and 70.47.120; reenacting and amending RCW 70.47.030 and 70.47.060; adding a new section to chapter 70.170 RCW; adding new sections to Title 48 RCW; adding new sections to chapter 48.21 RCW; adding new sections to chapter 48.44 RCW; adding new sections to chapter 48.46 RCW; adding a new section to chapter 70.47 RCW; adding a new chapter to Title 70 RCW; creating new sections; repealing RCW 43.131.355 and 43.131.356; providing effective dates; providing an expiration date; and declaring an emergency.

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

WASHINGTON HEALTH SERVICES ACT

NEW SECTION. **Sec. 1.** FINDINGS, INTENT, AND PRINCIPLES. (1) The legislature finds that:

(a) Despite the significant strides Washington state has made in addressing the lack of access to health services and rising health service costs, major system deficiencies still exist. The number of persons without access or with increasingly limited access to health services continues to grow at an alarming rate, as health service costs continue to rise well above the rate of inflation;

(b) Problems relating to health service access, assurance of quality of care, and cost control are likely to have a detrimental effect on the state's ability to be competitive in the international economy. Further, growing health service costs and the inability to purchase insurance have had a particularly harmful effect on small businesses, families, and individuals;

(c) There are significant administrative inefficiencies in the structure of the current health system, which has numerous payers and administrators, involving excess paperwork and consuming much of a health provider's time on nonclinical matters; and that a more unified financing and administrative structure would reduce overall administrative costs and increase the amount of time a health service provider would have available for patient care; and

(d) Future reforms must be systemic, addressing total community as well as individual needs, and encompassing all major components of health service delivery and finance. Reforms must also result in appropriate health service coverage for all state residents, promote quality of care, and include effective cost controls.

(2) To address the problems set forth in subsection (1) of this section, it is the intent of the legislature to implement the following principles by means of this chapter:

(a) The fundamental purpose of the health system should be to maintain or improve the health of all Washington residents at a reasonable cost;

(b) Because the responsibility for a healthy society lies primarily with its citizenry, enlightened citizens should play a key role in the development and oversight of their health services system;

(c) Appropriate health services should be available within an integrated system to all residents of Washington state regardless of health condition, age, sex, marital status, ethnicity, race, geographic location, employment, or economic status;

(d) The financial burden for providing needed health services should be equitably shared by government, employers, individuals, and families;

(e) Citizens should have the freedom to choose their health service provider, with incentives to participate in cost-effective well-managed health service settings;

(f) Health service providers should receive fair compensation for their services in a timely and uncomplicated manner;

(g) Health service providers should have the freedom to choose their practice settings with incentives to participate in cost-effective well-managed health service settings and to practice in areas where there are shortages of providers;

(h) Health promotion and illness and injury prevention programs should be a major part of a health services system;

(i) A state health services budget, reflecting the cost of providing health services through certified health plans and established in a public and deliberative manner, is essential to controlling health costs;

(j) An efficient health services administrative structure is essential to reduce costs and streamline service delivery;

(k) Quality of care should be promoted through identification of the most effective health services, with the assistance of health service providers, health scientists, health economists, health policy

experts and consumers, through implementation of acceptable standards for the education, credentialing, and disciplining of health service providers and the operation of health facilities, and through a process of continued quality improvement and total quality management;

(l) The health services system should be sensitive to cultural differences and recognize the need for access services in eliminating significant barriers to health services and give special consideration to the special needs of racial and ethnic minorities and underserved or inappropriately serviced populations;

(m) There should be explicit policy addressing critical issues related to medical ethics and acceptable use of health service rationing, which should be developed in an open manner reflecting community and societal values; and

(n) The problems of medical malpractice and health care liability have a substantial effect upon the efficacy and cost-effectiveness of a health services system and should be addressed in health services reform policy.

NEW SECTION. **Sec. 2.** DEFINITIONS. In this chapter, unless the context otherwise requires:

(1) "Access services" means services that are not necessarily provided by a provider or facility but are deemed by the commission as critical for the efficient and effective delivery of health services.

(2) "Certified health plan" or "plan" means a disability group insurer regulated under chapter 48.21 or 48.22 RCW, a health care service contractor as defined in RCW 48.44.010, a health maintenance organization as defined in RCW 48.46.020, an entity as identified in section 5(15) of this act, or two or more of such entities that contract with the commission to administer or provide the uniform benefits package consistent with the requirements set forth in sections

5, 6, and 8 of this act. The Washington health care authority created under chapter 41.05 RCW shall be designated as a certified health plan when deemed appropriate by the commission.

(3) "Chair" means the presiding officer and the chief administrative officer of the commission.

(4) "Commission" means the Washington health services commission.

(5) "Continuous quality improvement and total quality management" means a continuous process to improve the quality of health services while reducing the costs of such services, as set forth in section 24 of this act.

(6) "Employer" means an employer as defined in RCW 50.04.080; a corporate officer; a partner in a partnership; a sole proprietor; and an individual who is an employee for whom an assessment is not collected or who earns self-employment or partnership income that is essentially equivalent to wages as defined in RCW 50.04.320.

(7) "Enrollee" means any person who is a Washington resident enrolled in a certified health plan.

(8) "Enrollee point of service cost-sharing" means fees paid to certified health plans by enrollees at the time of receiving uniform benefits package services.

(9) "Enrollee premium sharing" means that portion of the premium, as determined in section 14 of this act, that is paid by enrollees or their family members.

(10) "Federal poverty level" means the federal poverty guidelines determined annually by the United States department of health and human services or successor agency.

(11) "Health service facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes

licensed under chapter 18.51 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment or surgical facilities licensed under chapter 70.41 RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations, but does not include Christian Science sanatoriums operated, listed, or certified by the First Church of Christ Scientist, Boston, Massachusetts.

(12) "Health service provider" or "provider" means either:

(a) Any licensed, certified, or registered health professional regulated under chapter 18.130 RCW who the commission identifies as appropriate to provide health services;

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

(c) An entity, whether or not incorporated, facility, or institution employing one or more persons described in (a) of this subsection, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his or her employment.

(13) "Improper queuing" means a delay in the delivery of health services, the results of which could be detrimental to the health of an enrollee.

(14) "Maximum enrollee financial participation" means the income-related total annual payments that may be required of an enrollee per family member, including both premium sharing and point of service cost-sharing.

(15) "Premium" means the level of payment a certified health plan receives for all expenses, including administration, operation, and

capital, determined on an annual basis by the commission, for providing the uniform benefits package to an individual, either adult or child, or a family.

(16) "Technology" means drugs, devices, equipment, and medical or surgical procedures used in the delivery of health services, and the organizational or supportive systems within which such services are provided. It also means sophisticated and complicated machinery developed as a result of ongoing research in the basic biological and physical sciences, clinical medicine, electronics and computer sciences, as well as the growing body of specialized professionals, medical equipment, procedures, and chemical formulations used for both diagnostic and therapeutic purposes.

(17) "Uniform benefits package" means the subset of appropriate and effective health services, as defined by the commission pursuant to section 8 of this act, that must be offered to all Washington residents through certified health plans.

(18) "Washington resident" means a person who has established permanent residence in the state of Washington and who has not moved to Washington for the primary purpose of securing health insurance under this chapter. The confinement of a person in a nursing home, hospital, or other medical institution in the state shall not by itself be sufficient to qualify such person as a resident.

(19) "Washington state health service supplier certification" means a process established pursuant to section 24 of this act whereby health service providers and health service facilities become certified to provide the uniform benefits package.

NEW SECTION. **Sec. 3.** CREATION OF COMMISSION--MEMBERSHIP--TERMS OF OFFICE--VACANCIES--SALARIES. (1) The Washington health services commission is created with the responsibility of exercising strategies

to control rapidly increasing health services expenditures and ensure universal access. The regulatory practices of the commission shall be limited to strategies that will reduce administrative waste, limit inefficient use of capital and technology, reduce defensive medical practices, structure payment mechanisms that provide incentives for efficient delivery of appropriate services, and define the uniform benefits package and the price that may be charged to provide that package to citizens of the state. The rate of increase in the price of the uniform benefits package is limited by this act. Implementation of these cost control strategies is necessary to meet the goal of universal access.

The commission's regulatory efforts shall include regulation that aids market forces as an effective means of cost containment. Increasing the use of managed care systems to provide health services, and emphasizing preventive and primary care shall guide the commission's regulatory activities.

(2) There is created an agency of state government to be known as the Washington health services commission. The commission shall consist of seven members appointed by the governor with the consent of the senate. One member shall be designated by the governor as chair and shall serve at the pleasure of the governor. The other six members shall serve five-year terms. In making such appointments the governor shall give consideration to the geographical exigencies, and the interests of consumers, purchasers, and ethnic groups. One member shall have experience as a health service provider, and one member shall have experience in health service administration. Of the initial members, two shall be appointed to a term of three years, two shall be appointed to a term of four years, and two shall be appointed to a term of five years. Thereafter, members shall be appointed to five-year

terms. Vacancies shall be filled by appointment for the remainder of the unexpired term of the position being vacated.

(3) Members of the commission shall have no pecuniary interest in any business subject to regulation by the commission and shall be subject to chapter 42.18 RCW, the executive branch conflict of interest act.

(4) Members of the commission shall occupy their positions on a full-time basis and are exempt from the provisions of chapter 41.06 RCW. Members shall be paid a salary to be fixed by the governor in accordance with RCW 43.03.040. A majority of the members of the commission constitutes a quorum for the conduct of business.

NEW SECTION. **Sec. 4.** POWERS AND DUTIES OF THE CHAIR. The chair shall be the chief administrative officer and the appointing authority of the commission and has the following powers and duties:

(1) Direct and supervise the commission's administrative and technical activities in accordance with the provisions of this chapter and rules and policies adopted by the commission;

(2) Employ personnel of the commission, not to exceed twenty-five full-time employees, in accordance with chapter 41.06 RCW, and prescribe their duties. With the approval of a majority of the commission, the chair may appoint persons to administer any entity established pursuant to subsection (8) of this section, and up to seven additional full-time employees, all of whom shall be exempt from the provisions of chapter 41.06 RCW;

(3) Enter into contracts on behalf of the commission;

(4) Accept and expend gifts, donations, grants, and other funds received by the commission;

(5) Delegate administrative functions of the commission to employees of the commission as the chair deems necessary to ensure efficient administration;

(6) Subject to approval of the commission, appoint advisory committees and undertake studies, research, and analysis necessary to support activities of the commission;

(7) Preside at meetings of the commission;

(8) Consistent with policies and rules established by the commission, establish such administrative divisions, offices, or programs as are necessary to carry out the purposes of this chapter; and

(9) Perform such other administrative and technical duties as are consistent with this chapter and the rules and policies of the commission.

NEW SECTION. **Sec. 5.** POWERS AND DUTIES OF THE COMMISSION. The activities of the commission shall be limited to the following powers and duties:

(1) Establish a total state health services budget, as provided in section 13 of this act.

(2) Adopt necessary rules in accordance with chapter 34.05 RCW to carry out the purposes of this chapter, provided that an initial set of draft rules addressing, at a minimum, the uniform benefits package, limits on maximum enrollee financial participation, methods for developing the state health services budget, standards for health plan certification, procedures for monitoring and enforcing health plans certification standards, and standards for certified health plan and commission grievance procedures, must be submitted to the legislature by December 1, 1993.

(3) Establish the uniform benefits package, as provided in section 8 of this act, which shall be offered to enrollees of a certified health plan. The uniform benefits package shall be provided at the premium specified in subsection (4) of this section.

(4) Establish for each year, a premium that a certified health plan may receive from the Washington health services trust fund to provide the uniform benefits package to enrollees. The premium shall be determined by the commission, after conducting an analysis of the cost experience of the state employee health benefit plans for 1992 and assuming cost savings that may result from: Reductions in cost shifting; managed health care approaches; cost savings as a result of the uniform benefits package design process pursuant to section 8(2) of this act; the continuous quality improvement and total quality management process set forth in section 24 of this act, and other cost reduction strategies set forth herein. Thereafter, the commission shall, as soon as possible, limit the rate of increase to no more than the rate of increase in the United States consumer price index. In no event shall the rate of increase in the premium be increased by more than the amount of actual growth in the cost of the uniform benefits package between 1991 and 1992, as determined by the commission, minus two percentage points per year for each succeeding year until the annual rate of increase is no greater than the growth in the United States consumer price index.

(5) Evaluate and monitor the extent to which racial and ethnic minorities have access to and receive health services within the state.

(6) Monitor the actual growth in total annual health services expenditures in the state.

(7) Establish a maximum annual budget for major capital expenditures that are included within the premium. A major capital expenditure is defined as any single expenditure for capital

acquisitions, including medical technological equipment, as defined by the commission, costing more than one million dollars. Periodically the commission shall prioritize the proposed projects based on standards of cost-effectiveness and access. The commission shall then approve those projects in rank order that are within the limits of the capital budget.

(8) After consultation with certified health plans, health service providers, purchasers, and consumers of health services, adopt practice guidelines in specific practice areas, for providers participating in any certified health plan. Such practice guidelines shall be used to promote appropriate use of technology, services, drugs, and supplies, and for cost containment and quality assurance.

(9) Develop guidelines to certified health plans for utilization management, use of technology and methods of payment, such as diagnosis related groupings and a resource-based relative value scale. Such guidelines shall be designed to promote improved management of health services, and improved efficiency and effectiveness within the health services delivery system.

(10) For services provided under the uniform benefits package, adopt standards for a single billing and claims payment procedure. Such standards shall ensure that these procedures are performed in a simplified, streamlined, and economical manner for all parties concerned. Except to the extent provided in section 7 of this act, nothing in this subsection authorizes the commission to require any specific claim or payment level or method.

(11) Adopt standards for personal health systems data and information systems as provided in section 17 of this act.

(12) Adopt standards that prevent conflict of interest by health service providers as provided in section 10 of this act.

(13) Certify certified health plans to provide the uniform benefits package.

(14) Contract with certified health plans to provide the uniform benefits package.

(15) When deemed necessary to ensure the availability of the uniform benefits package in a timely manner, contract directly with a local health department, a community/migrant health center, or any other private, nonprofit community-based health services agency for all or any part of the uniform benefits package.

(16) Ensure that no certified health plan may charge any additional fees or balance bill for services included in the uniform benefits package.

(17) Establish standards for certified health plan grievance and complaint procedures whereby an enrollee may file a complaint or grievance regarding any aspect of the plan and such grievance is addressed expeditiously.

(18) As of July 1, 1994, prohibit any disability group insurer, health care service contractor, or health maintenance organization from independently insuring, contracting for, or providing those health services provided through the uniform benefits package.

(19) In developing the uniform benefits package and other standards pursuant to this section, consider the likelihood of the establishment of a national health services plan by the federal government and its implications.

(20) Monitor certified health plans for compliance with standards established pursuant to this section.

(21) Establish standards for enrollment and prohibit discrimination based upon age, sex, family structure, ethnicity, race, health condition, geographic location, employment, or economic status in enrollment by certified health plans.

To the extent that the exercise of any of the powers and duties specified in this section may be inconsistent with the powers and duties of other state agencies, offices, or commissions, the authority of the commission shall supersede that of such other state agency, office, or commission, except in matters of health data pursuant to section 18 of this act, where the department of health shall have primary responsibility.

NEW SECTION. **Sec. 6.** CERTIFIED HEALTH PLANS--REQUIREMENTS FOR APPROVAL. The uniform benefits package established pursuant to section 8 of this act shall be provided through certified health plans. To participate, a plan must meet at least the following requirements:

(1) Provide or assure the provision of services in the uniform benefits package within a defined geographic area.

(2) Bear full financial risk and responsibility for the uniform benefits package provided to enrollees.

(3) Comply with commission standards regarding health data and certified health plan evaluation.

(4) Comply with all other standards established by the commission pursuant to section 5 of this act.

NEW SECTION. **Sec. 7.** COMMISSION CERTIFICATION ENFORCEMENT AUTHORITY. (1) Upon a determination by the commission that a certified health plan is failing, or is at imminent risk of failing, to meet its obligations to its enrollees or the state during a current certification or contractual period, the commission may intervene and assume those functions that are demonstrably necessary to protect the interests of the plan's enrollees and the state. Such actions may include, but are not limited to:

(a) Approval of provider or facility payment methods or levels;

(b) Approval of utilization management procedures or mechanisms to control the use of technology; and

(c) Administration of functions demonstrably related to the failure, or imminent risk of failure, of the certified health plan to meet its certification or contractual obligations.

(2) The assumption of any certified health plan function by the commission pursuant to this section shall not absolve such certified health plan from any of the financial obligations undertaken by it through its certification or contracts with enrollees.

(3) Actions taken by the commission pursuant to this section shall be limited in duration to the balance of time remaining in the current certification period of the certified health plan. At or before the expiration of such time period, the commission shall make a determination regarding renewal of the plan's certification. If the commission determines that the plan's certification should not be renewed, the commission shall make every effort to ensure that the plan's current enrollees experience as minimal a disruption as possible in their receipt of health services, and in their established relationships with health service providers. It shall, as soon as possible, contract with another certified health plan to assume these responsibilities.

NEW SECTION. **Sec. 8.** UNIFORM BENEFITS PACKAGE DESIGN. (1) The commission shall define the uniform benefits package, which shall include those health services, based on the best available scientific health information, deemed to be effective and necessary on a societal basis for the maintenance of the health of the residents of the state, giving consideration to the state health services budget established pursuant to section 13 of this act.

(a) The legislature intends that the uniform benefits package be sufficiently comprehensive to meet the needs of state residents. As guidance in developing the package, the commission shall include no significant reductions in the categories of coverage included in the state employees health benefits plans, and shall include access services as defined herein. However, the specific schedule of services shall be established through the process set forth in subsection (2) of this section. The categories of coverage shall, at least, include the following:

(i) Personal health services, including inpatient and outpatient services for physical, mental, and developmental illnesses and disabilities including:

(A) Diagnosis and assessment, and selection of treatment and care;

(B) Clinical preventive services;

(C) Emergency health services;

(D) Reproductive and maternity services;

(E) Clinical management and provision of treatment; and

(F) Therapeutic drugs, biologicals, supplies, and equipment.

(ii) Access services.

(b) The commission, through a public process, also shall determine which services will be excluded. These exclusions shall include at least the following:

(i) Cosmetic surgery except where deemed necessary for normal functioning or restorative purposes;

(ii) Examinations associated with life insurance applications or legal proceedings; and

(iii) Infertility services.

(c) The commission shall establish limits on maximum enrollee financial participation, related to enrollee gross family income.

(d) The commission shall evaluate the inclusion or exclusion of dental services in the uniform benefits package, and make such inclusions as are deemed appropriate.

(e) The uniform benefits package may include other services determined by the commission to be effective, necessary, and consistent with the principles set forth in section 1 of this act.

(2) The commission shall establish procedures to determine the specific schedule of health services to be included in the uniform benefits package categories of coverage. To assist the commission in this task, it may periodically establish health service review panels for specified periods of time to review existing information on need, efficacy, and cost-effectiveness of specific services and treatments. These panels shall consider the services outcome data provided under section 17 of this act. These panels also shall take into consideration available practice guidelines and appropriate use of expensive technology. Their review activities shall be consistent with the health service rationing policy set forth in section 20 of this act.

(3) In establishing the uniform benefits package, the commission shall seek the opinions of, and information from, the public. The commission shall consider results of official public health assessment and policy development activities, including recommendations of the state board of health, the department of health, and the state health report in discharging its responsibilities under this section. It shall coordinate this activity with the state board of health in its development of the state health report pursuant to RCW 43.20.050.

NEW SECTION. **Sec. 9.** SUPPLEMENTAL BENEFITS. Nothing in this chapter shall preclude disability group insurers, health care service contractors, or health maintenance organizations from insuring,

providing, or contracting for health services not included in the uniform benefits package, and nothing in this chapter shall restrict the right of an employer to offer, an employee representative to negotiate for, or an individual to purchase services not included in the uniform benefits package.

NEW SECTION. **Sec. 10.** CONFLICT OF INTEREST STANDARDS. The commission shall establish standards prohibiting conflict of interest by health service providers. These standards shall be designed to control inappropriate behavior by health service providers that results in financial gain at the expense of consumers or certified health plans. These standards are not intended to inhibit the efficient operation of certified health plans.

NEW SECTION. **Sec. 11.** REPORTS OF HEALTH CARE COST CONTROL AND ACCESS COMMISSION. In carrying out its powers and duties under this chapter, including its responsibilities to develop recommendations regarding the health care liability system, design the uniform benefits package, and develop guidelines and standards, the commission shall consider the reports of the health care cost control and access commission established under House Concurrent Resolution No. 4443 adopted by the legislature in 1990. Nothing in this chapter requires the commission, created by section 3 of this act, to follow any specific recommendation contained in those reports except as it may also be included in this chapter or other law.

NEW SECTION. **Sec. 12.** IMPROPER QUEUING PROTECTION. It is the intent of the legislature that all enrollees receive necessary health services in a timely manner and that every effort be made to avoid delays in service that could be detrimental to an enrollee’s health.

The commission shall develop strategies that will reduce or prevent improper queuing. Upon the adoption of such strategies in rules by the commission, funds from the improper queuing reserve account of the Washington health services trust fund may be used to implement such strategies.

NEW SECTION. **Sec. 13.** STATE HEALTH SERVICES BUDGET. The state health services budget shall reflect total expenditures for all health services included in the uniform benefits package and shall be derived from the following sources:

(1) Medicare, parts A and B, Title XVIII of the federal social security act, as amended;

(2) Medicaid, Title XIX of the federal social security act, as amended;

(3) Other federal health services funds that are allocated for the purposes of health services included in the accounts established pursuant to section 16 of this act;

(4) Legislative general fund--state appropriations;

(5) Employer contribution, as determined in section 14 of this act;

(6) Enrollee premium sharing, as determined in section 14 of this act; and

(7) Enrollee point of service cost-sharing, as determined in section 14 of this act.

NEW SECTION. **Sec. 14.** UNIVERSAL ACCESS MECHANISMS. (1) The commission shall develop recommendations relating to the most effective and cost-efficient methods of providing and financing universal access to the uniform benefits package. Such methods shall ensure access to appropriate and effective health services for all residents of Washington state regardless of age, sex, family structure, ethnicity,

race, health condition, geographic location, employment, or economic status. In developing recommended financing methods, the commission shall consider the financial sources enumerated in section 13 of this act.

(2) The commission shall use the following criteria as the basis for its determination:

(a) Provision of the uniform benefits package to all residents;

(b) Minimal shift of costs from payer to payer;

(c) Compliance with health data requirements as set forth in this chapter;

(d) Accessibility by all residents to the uniform benefits package;

(e) Efficiency through uniformity in billing, claims, and records procedures;

(f) Propensity to resist inflationary increases on cost;

(g) Public accountability;

(h) Portability of benefits, whereby a resident changing employment or traveling out-of-state continues to be covered;

(i) Equity in risk adjustment methods;

(j) Seamlessness;

(k) Simplicity and ease with which residents can comprehend the operation of the health services system; and

(l) Development of appropriate technology.

(3) The commission shall report its findings and recommended methods to the governor and appropriate committees of the legislature no later than December 1, 1993.

(4) Any act or bill passed by the legislature related to methods of providing and financing universal access to the uniform benefits package shall be submitted to the people as a referendum, pursuant to Article II, section 1 of the Constitution of the state of Washington. No methods of providing or financing universal access to the uniform

benefits package shall be implemented or amount collected unless approved by the voters of Washington state by referendum as provided in this subsection.

NEW SECTION. **Sec. 15.** ADVISORY COMMITTEES. In an effort to ensure effective participation in the commission's deliberations, the chair shall appoint an advisory committee with members representing consumers, business, government, labor, insurers, and health service providers. The chair may also appoint ad hoc and special committees for a specified time period.

Members of any committee shall serve without compensation for their services but shall be reimbursed for their expenses while attending meetings on behalf of the commission in accordance with RCW 43.03.050 and 43.03.060.

NEW SECTION. **Sec. 16.** TRUST FUND AND ACCOUNTS. The Washington health services trust fund is hereby established in the state treasury. Funds designated pursuant to section 14 of this act shall be deposited in the Washington health services trust fund. Disbursements from the trust fund shall be on authorization of the commission or a duly authorized representative thereof. In order to maintain an effective expenditure the Washington health services trust fund shall be subject in all respects to chapter 43.88 RCW. However, no appropriation shall be required to permit expenditures and payment of obligations from such fund. The trust fund shall consist of four accounts:

(1) The personal health services account from which funds shall be expended for contracts with certified health plans to deliver the uniform benefits package to enrollees, including access services, personal health services, capital development, and health professions education.

(2) The public health account from which funds shall be expended to maintain and improve the health of all Washington residents, by assuring adequate financing for a public health system to (a) assess and report on the population's health status; (b) develop public policy which promotes and maintains health; and (c) assure the availability and delivery of appropriate and effective health interventions. This public system shall be composed of the state board of health, state department of health, and local public health departments and districts. The commission shall assure that no less than five percent of the state health services budget is used for these assessment, policy development, and assurance functions, as defined by the state board of health in rule. These funds may include fees, federal funds, and general or dedicated state or local tax revenue. The state board of health shall develop policies regarding the extent to which local revenue or fees may be used to meet the five percent requirement. The commission may appropriate funds under its direction in order to assure that five percent of the state health services budget is used as required by this subsection. None of the funds shall be used for any service reimbursable through the uniform benefits package. The commission shall consider the results of official public health assessment and policy development activities, including recommendations of the state board of health, the department of health, and the state health report in discharging its responsibilities, including the assurance of access to appropriate and effective health services and the determination of the actual percentage used for core public health functions. The percent of total health expenditures required for expenditure on core public health functions shall be reviewed by the state board of health as part of its state health report and by the commission as part of any overall evaluation or assessment that may be required under this chapter.

(3) The improper queuing reserve account from which funds shall be expended to reduce unacceptable delays in the delivery of critical health care services as set forth in section 12 of this act.

(4) The health professions and research account from which funds shall be expended to:

(a) Retain needed health service providers in a manner consistent with the health professional shortage provisions set forth in chapter 332, Laws of 1991; and

(b) Conduct research relative to the commission's responsibilities.

NEW SECTION. **Sec. 17.** HEALTH DATA. The commission shall develop, in consultation with the department of health, the health data sources necessary to efficiently implement this chapter. The commission shall have access to all health data presently available to the secretary of health, however, the department of health shall be the designated depository agency for all health data collected pursuant to this chapter. To the extent possible, the commission shall use existing data systems and coordinate among existing agencies. The following data sources shall be developed or made available:

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

(2) The commission, in coordination with the department of health and the health science programs of the state universities shall develop procedures to analyze clinical and other health services outcome data, and conduct other research necessary for the specific purpose of assisting in the design of the uniform benefits package under section 8 of this act.

(3) The commission shall utilize the capability of the insurance commissioner's office in conducting actuarial analyses.

NEW SECTION. **Sec. 18.** A new section is added to chapter 70.170 RCW to read as follows:

DEPARTMENT OF HEALTH DATA REQUIREMENTS. (1) The department is responsible for the implementation and custody of a state-wide personal health services data and information system. The data elements, specifications, and other design features of this data system shall be consistent with criteria adopted by the Washington health services commission. The department shall provide the commission with reasonable assistance in the development of these criteria, and shall provide the commission with periodic progress reports related to the implementation of the system or systems related to those criteria.

(2) The department shall coordinate the development and implementation of the personal health services data and information system with related private activities and with the implementation activities of the data sources identified by the commission. Data shall include: (a) Enrollee identifier, including date of birth, sex, and ethnicity; (b) provider identifier; (c) diagnosis; (d) health services or procedures provided; (e) provider charges; and (f) amount paid. The commission shall establish by rule confidentiality standards to safeguard the information from inappropriate use or release. The department shall assist the commission in establishing reasonable time frames for the completion of system development and system implementation.

NEW SECTION. **Sec. 19.** LONG-TERM CARE. (1) In order to meet the health needs of the residents of Washington state, it is critical to organize the foundation for financing and providing community-based

long-term care and support services through an integrated, comprehensive system that promotes human dignity and recognizes the individuality of all functionally disabled persons. This system shall be available, accessible, and responsive to all residents based upon an assessment of their functional disabilities. The legislature recognizes that families, volunteers, and community organizations are absolutely essential for delivery of effective and efficient community-based long-term care and support services, and that this private and public service infrastructure should be supported and strengthened. Further, it is important to provide secured benefits assurance in perpetuity without requiring family or program beneficiary impoverishment for service eligibility.

(2) Recognizing that financial stability is essential to the success of a comprehensive long-term care system and that current and future demands are exceeding available financial resources, a dedicated fund comprised of state general funds, matching federal funds, public insurance funds, and sliding fee contributions by program beneficiaries should be established.

(3) It is the intent of this chapter that the Washington state legislature develop a program and financial structure for the provision of community-based long-term care and support services for functionally disabled persons as suggested in this section and adopt the necessary legislation no later than the adjournment of the 1994 regular session of the legislature.

NEW SECTION. **Sec. 20.** HEALTH SERVICE RATIONING POLICY. (1) The commission shall establish an explicit policy regarding rationing of health services. This policy shall address rationing in relation to limitations on financial resources and the availability of anatomical gifts.

The health services rationing policy shall address the following factors:

(a) The effectiveness of the specific health service considered;

(b) The cost-effectiveness of such service;

(c) The service's ability to significantly improve quality of life;

(d) The service's ability to improve functioning and independence;

(e) The equity in providing the service to some persons, but not others; and

(f) The service's social value to the health of the community when weighed against other priorities.

(2) The commission shall establish regional health services ethics committees, composed of persons drawn from a broad cross-section of the community to provide, based on the health services rationing policy, guidance to certified health plans in making decisions about the rationing of health services.

NEW SECTION. **Sec. 21.** IMPLEMENTATION SCHEDULE. Consistent with the determinations made pursuant to section 14 of this act, this chapter shall be implemented in developmental phases as follows:

(1) By May 1, 1992, the director of the office of financial management shall constitute a transition team composed of staff of the department of social and health services, the Washington state health care authority, the health care cost control and access commission created by House Concurrent Resolution No. 4443 (1990), the department of health, the department of labor and industries, the Washington basic health plan, and the insurance commissioner's office. The director may request participation of the appropriate legislative committee staff.

The transition team shall conduct analyses and identify:

(a) The necessary transfer and consolidation of responsibilities among state agencies to fully implement this chapter;

(b) State and federal laws that would need to be repealed, amended, or waived to fully implement this chapter; and

(c) Appropriate guidelines for administrative costs of the plan.

The transition team shall report its findings to the director of financial management, the commission, and appropriate committees of the legislature by January 1, 1993, and on that date be disbanded.

(2) By December 1, 1992, the commission shall be appointed. As soon as possible thereafter, the commission shall:

(a) Hire necessary staff;

(b) Develop necessary data sources;

(c) Appoint the initial health service review panel; and

(d) Develop necessary methods to establish the state health services budget.

(3) By September 1, 1993, the director of the office of financial management shall submit to appropriate committees of the legislature an agency transfer and consolidation report, which shall address staffing, equipment, facilities, and funds, along with any necessary proposed legislation.

(4) By September 1, 1993, the commission shall review the result of the studies conducted as required in section 23(1) of this act.

(5) By December 1, 1993, the commission shall submit to the governor and appropriate committees of the legislature:

(a) Draft rules, as provided in section 5(2) of this act;

(b) A report on the extent that federal waivers or exemptions have not been obtained or the extent to which this chapter can be implemented without receipt of all of such waivers;

(c) Recommended methods of providing and financing universal access to the uniform benefits package, as provided in section 14 of this act; and

(d) Proposed recommended uniform benefits package.

(6) By July 1, 1994, the commission shall have reviewed the recommendations of the initial health service review panel.

(7) By October 1, 1994, the commission shall have:

(a) Determined the uniform benefits package;

(b) Identified anti-improper queuing strategies; and

(c) Developed procedures regarding enrollment, premiums, enrollee financial participation, and certified health plan negotiations and payments.

(8) During its 1994 session, the legislature should consider the material submitted as identified in subsection (5) of this section in an expeditious manner, and shall submit any act or bill passed by the legislature related to methods of providing and financing universal access to the uniform benefits package to the people as a referendum, as provided in section 14(4) of this act.

(9) By July 1, 1995, consistent with specific appropriations, all health services provided to recipients of medical assistance, medical care services, and the limited casualty program, as defined in RCW 74.09.010, all enrollees in the Washington basic health plan, as established by chapter 70.47 RCW, all state employees eligible for employee health benefits plans pursuant to chapter 41.05 RCW, and all common school employees eligible for health insurance, or health care insurance under RCW 28A.400.350 shall be enrolled exclusively with a certified health plan, consistent with all provisions of this chapter.

NEW SECTION. **Sec. 22.** CODE REVISIONS AND WAIVERS. (1) The Washington health services commission shall consider the analysis of state and federal laws that would need to be repealed, amended, or waived to implement sections 1 through 26 of this act, as prepared by the transition team pursuant to section 21 of this act, and report its recommendations, with proposed revisions to the Revised Code of

Washington, to the governor and appropriate committees of the legislature by December 31, 1993.

(2) The Washington health services commission shall take the following steps in an effort to receive waivers or exemptions from federal statutes necessary to fully implement sections 1 through 26 of this act:

(a) Negotiate with the United States congress to obtain a statutory exemption from provisions of the employee retirement income security act that limit the state's ability to enact legislation relating to employee health benefits plans administered by employers, including health benefits plans offered by self-insured employers.

(b) Negotiate with the United States congress and the federal department of health and human services, health care financing administration to obtain a statutory or regulatory waiver of provisions of the medicaid statute, Title XIX of the federal social security act, that currently constitute barriers to full implementation of provisions of sections 1 through 26 of this act related to access to health services for low-income residents of Washington state. Such provisions may include and are not limited to: Categorical eligibility restrictions related to age, disability, blindness, or family structure; income and resource limitations tied to financial eligibility requirements of the federal aid to families with dependent children and supplemental security income programs; and limitations on health service provider payment methods.

(c) Negotiate with the United States congress and the federal department of health and human services, health care financing administration to obtain a statutory or regulatory waiver of provisions of the medicare statute, Title XVIII of the federal social security act, that currently constitute barriers to full implementation of provisions of sections 1 through 26 of this act related to access to

health services for elderly and disabled residents of Washington state. Such provisions include and are not limited to: Beneficiary cost-sharing requirements; restrictions on scope of services and limitations on health service provider payment methods.

(d) Negotiate with the United States congress and the federal department of health and human services to obtain any statutory or regulatory waivers of provisions of the United States public health services act necessary to ensure integration of federally funded community health clinics and other health services funded through the public health services act into the health services system established pursuant to sections 1 through 26 of this act.

(3) If the Washington health services commission fails to obtain approval for all necessary federal statutory changes or regulatory waivers necessary to fully implement sections 1 through 26 of this act by January 1, 1996, it shall report to the governor and appropriate committees of the legislature with a proposal for the implementation of sections 1 through 26 of this act to the extent possible without receipt of all of such waivers.

NEW SECTION. **Sec. 23.** EVALUATIONS AND STUDIES. The legislative budget committee, in consultation with the health care policy committees of the legislature, shall conduct directly or by contract the following studies or evaluations:

(1) Studies to determine the desirability and feasibility of consolidating the following programs, services, and funding sources into the system established by sections 1 through 26 of this act:

(a) Medical services component of the worker’s compensation program of the department of labor and industries;

(b) Developmental disabilities, mental health and aging and adult services institutional programs of the department of social and health services;

(c) State and federal veterans' health services; and

(d) Civilian health and medical program of the uniformed services of the federal department of defense and other federal agencies.

The report shall be made to the governor and the appropriate committees of the legislature and the commission by September 1, 1993.

(2) A study to evaluate the implementation of the provisions of sections 1 through 26 of this act. The study shall determine to what extent the plan has been implemented consistent with the principles and elements set forth in chapter 70.-- RCW (sections 1 through 17 and 19 through 21 of this act) and shall report its findings to the governor and appropriate committees of the legislature by July 1, 1998.

NEW SECTION. **Sec. 24.** CONTINUOUS QUALITY IMPROVEMENT AND TOTAL QUALITY MANAGEMENT. To ensure the highest quality health services at the lowest total cost, the Washington health services commission shall establish a total quality management system of continuous quality improvement. Such endeavor shall be based upon the recognized quality science of continuous quality improvement. The commission shall impanel a committee composed of persons from the private sector and related sciences who have broad knowledge and successful experience in continuous quality improvement and total quality management applications. It shall be the responsibility of the committee to develop standards for a Washington state health services supplier certification process and recommend such standards to the commission for review and adoption. Once adopted, the commission shall establish a schedule, with full compliance no later that July 1, 1995, whereby certified health plans must provide evidence that all health service

providers and health service facilities have been reviewed and meet these standards prior to providing uniform benefits package services.

NEW SECTION. **Sec. 25.** HEALTH CARE LIABILITY. On or before December 1, 1994, the commission shall report the following information to the governor and appropriate committees of the legislature:

(1) The status of the commission's development of practice guidelines, as provided in section 5(8) of this act;

(2) The feasibility of implementing a demonstration project in which practice guidelines in specific practice areas may be used as evidence in medical malpractice actions.

In preparing this report, the commission shall consider recommendations related to health care liability that have been developed by the health care cost control and access commission.

NEW SECTION. **Sec. 26.** RESERVATION OF LEGISLATIVE POWER. The legislature reserves the right to amend or repeal all or any part of sections 1 through 26 of this act at any time and there shall be no vested private right of any kind against such amendment or repeal. All rights, privileges, or immunities conferred by sections 1 through 25 of this act or any act done pursuant thereto shall exist subject to the power of the legislature to amend or repeal sections 1 through 25 of this act at any time.

INSURANCE REFORM

NEW SECTION. **Sec. 27.** The legislature finds that in order to make the cost of health coverage more affordable and accessible to individuals and to businesses and their employees, certain marketing and underwriting practices by disability insurers, health care service

contractors, and health maintenance organizations must be reformed and more aggressively regulated. Such reforms work in the public interest and guarantee coverage to individuals, and businesses, their employees and employees' dependents. Practices that hinder access to, affordability of, and equity in health insurance coverage are unacceptable.

It is the intent of the legislature to prohibit certain discriminatory practices, and to require that insurers use community rating methods, at least for individuals, and small business owners and their employees, that more broadly pool and distribute risk, which is a fundamental principle of health insurance coverage.

NEW SECTION. **Sec. 28.** A new section is added to Title 48 RCW to read as follows:

For the purposes of sections 29, 30, and 31 of this act "small business entity" means a business that employs less than one hundred individuals who reside in Washington state and are regularly scheduled to work at least twenty or more hours per week for at least twenty-six weeks per year. For purposes of determining the number of employees of an entity all employees, owners, or principals of all branches and divisions of the principal entity shall be included and may not be segregated by division, job responsibilities, employment status, or on any other basis.

NEW SECTION. **Sec. 29.** A new section is added to chapter 48.21 RCW to read as follows:

Every disability insurer that provides group disability insurance for health care services under this chapter shall make available to all individuals and business entities in this state the opportunity to enroll as an individual or a group in an insured plan without medical

underwriting except as provided in this section. Such plan shall: (1) Allow all such individuals and groups to continue participation on a guaranteed renewable basis; (2) not exclude or discriminate in rate making or in any other way against any category of business, trade, occupation, employment skill, or vocational or professional training; and (3) not exclude or discriminate in rate making or in any other way against any individual, or employee or dependent within a group on any basis, including age, sex, or health status or condition. Disability insurers may adopt a differential rate based only upon actual costs of providing health care that are identifiable on a major geographical basis, such as east and west of the Cascades, and may adopt exclusions for preexisting conditions limited to not more than six months and applicable only to those individuals who have not been insured in the previous three months and have not been continuously insured long enough to satisfy a six-month waiting period. In addition, every disability insurer shall allow individuals and small business entities the opportunity to enroll as a group in an insured plan that uses community rating to establish the premium and may extend to larger sized businesses a similar opportunity to be included within a community rated pool.

An individual or family member who participates as an employee member of a group covered under this section for more than six consecutive months who then terminates his or her employment relationship and wishes to continue the same amount of health care coverage in the same plan shall be allowed that opportunity on an individual or family basis, depending on the coverage provided during active employment. The cost of such individual conversion or continuation coverage shall not exceed one hundred five percent of the rate for active members of the group.

NEW SECTION. **Sec. 30.** A new section is added to chapter 48.44 RCW to read as follows:

Every health care service contractor that provides coverage under group health care service contracts under this chapter shall make available to all individuals and business entities in this state the opportunity to enroll as an individual or a group in a health service contract without medical underwriting except as provided in this section. The health service contract shall: (1) Allow all such individuals and groups to continue participation on a guaranteed renewable basis; (2) not exclude or discriminate in rate making or in any other way against any category of business, trade, occupation, employment skill, or vocational or professional training; and (3) not exclude or discriminate in rate making or in any other way against any individual, or employee or employee's dependent within the group on any basis, including age, sex, or health status or condition. Health care service contractors may adopt a differential rate based only upon actual costs of providing health care that are identifiable on a major geographical basis, such as east and west of the Cascades, and may adopt exclusions for preexisting conditions limited to not more than six months and applicable only to those individuals who have not been insured in the previous three months and have not been continuously insured long enough to satisfy a six-month waiting period. In addition, every health care service contractor shall allow individuals and small business entities the opportunity to enroll as a group in an insured plan that uses community rating to establish the premium and may extend to larger sized businesses a similar opportunity to be included within a community rated pool.

An individual or family member who participates as an employee member of a group covered under this section for more than six consecutive months who then terminates his or her employment

relationship and wishes to continue the same amount of health care coverage in the same plan shall be allowed that opportunity on an individual or family basis, depending on the coverage provided during active employment. The cost of such individual conversion or continuation coverage shall not exceed one hundred five percent of the rate for active members of the group.

NEW SECTION. **Sec. 31.** A new section is added to chapter 48.46 RCW to read as follows:

Every health maintenance organization that provides coverage under group health maintenance organization agreements under this chapter shall make available to all individuals and business entities in this state the opportunity to enroll as an individual or a group in a health maintenance organization agreement without medical underwriting except as provided in this section. Such agreements shall: (1) Allow all such individuals and groups to continue participation on a guaranteed renewable basis; (2) not exclude or discriminate in rate making or in any other way against any category of business, trade, occupation, employment skill, or vocational or professional training; and (3) not exclude or discriminate in rate making or in any other way against any individual, or employee or employee's dependent within the group on any basis, including age, sex, or health status or condition. Such health maintenance organizations may adopt a differential rate based only upon actual costs of providing health care that are identifiable on a major geographical basis, such as east and west of the Cascades, and may adopt exclusions for preexisting conditions limited to not more than six months and applicable only to those individuals who have not been insured in the previous three months and have not been continuously insured long enough to satisfy a six-month waiting period. In addition, every health maintenance organization shall allow individuals

and small business entities the opportunity to enroll as a group in an insured plan that uses community rating to establish the premium and may extend to larger sized businesses a similar opportunity to be included within a community rated pool.

An individual or family member who participates as an employee member of a group covered under this section for more than six consecutive months who then terminates his or her employment relationship and wishes to continue the same amount of health care coverage in the same plan shall be allowed that opportunity on an individual or family basis, depending on the coverage provided during active employment. The cost of such continuation or conversion coverage shall not exceed one hundred five percent of the rate for active members of the group.

NEW SECTION. **Sec. 32.** A new section is added to chapter 48.21 RCW to read as follows:

Notwithstanding other sections of this chapter, the uniform benefits package adopted pursuant to section 5 of this act and from time to time revised by the Washington health services commission shall become the minimum benefits package required of any plan under this chapter. The maximum per capita rate determined and from time to time revised by the Washington health services commission shall become the maximum rate charged for this minimum benefits package.

NEW SECTION. **Sec. 33.** A new section is added to chapter 48.44 RCW to read as follows:

Notwithstanding other sections of this chapter, the uniform benefits package adopted pursuant to section 5 of this act and from time to time revised by the Washington health services commission shall become the minimum benefits package required of any plan under this

chapter. The maximum per capita rate determined and from time to time revised by the Washington health services commission shall become the maximum rate charged for this minimum benefits package.

NEW SECTION. **Sec. 34.** A new section is added to chapter 48.46 RCW to read as follows:

Notwithstanding other sections of this chapter, the uniform benefits package adopted pursuant to section 5 of this act and from time to time revised by the Washington health services commission shall become the minimum benefits package required of any plan under this chapter. The maximum per capita rate determined and from time to time revised by the Washington health services commission shall become the maximum rate charged for this minimum benefits package.

NEW SECTION. **Sec. 35.** A new section is added to Title 48 RCW to read as follows:

The insurance commissioner shall develop a reinsurance mechanism for certified health plans that does not impact the enrollee, enables insurers to share risk, and allows those insurers that assume the entire risk for their enrollees to opt out of the mechanism. The reinsurance mechanism must support itself entirely from funds generated from the participating insurers.

BASIC HEALTH PLAN MODIFICATIONS

NEW SECTION. **Sec. 36.** A new section is added to chapter 70.47 RCW to read as follows:

The powers, duties, and functions of the Washington basic health plan are hereby transferred to the Washington state health care authority. All references to the administrator of the Washington basic

health plan in the Revised Code of Washington shall be construed to mean the administrator of the Washington state health care authority.

NEW SECTION. **Sec. 37.** All reports, documents, surveys, books, records, files, papers, or written material in the possession of the Washington basic health plan shall be delivered to the custody of the Washington state health care authority. All cabinets, furniture, office equipment, motor vehicles, and other tangible property used by the Washington basic health plan shall be made available to the Washington state health care authority. All funds, credits, or other assets held by the Washington basic health plan shall be assigned to the Washington state health care authority.

Any appropriations made to the Washington basic health plan shall, on the effective date of this section, be transferred and credited to the Washington state health care authority. At no time may those funds in the basic health plan trust account, any funds appropriated for the subsidy of any enrollees or any premium payments or other sums made or received on behalf of any enrollees in the basic health plan be commingled with any appropriated funds designated or intended for the purposes of providing health care coverage to any state or other public employees.

Whenever any question arises as to the transfer of any personnel, funds, books, documents, records, papers, files, equipment, or other tangible property used or held in the exercise of the powers and the performance of the duties and functions transferred, the director of financial management shall make a determination as to the proper allocation and certify the same to the state agencies concerned.

NEW SECTION. **Sec. 38.** All employees of the Washington basic health plan are transferred to the jurisdiction of the Washington state

health care authority. All employees classified under chapter 41.06 RCW, the state civil service law, are assigned to the Washington state health care authority to perform their usual duties upon the same terms as formerly, without any loss of rights, subject to any action that may be appropriate thereafter in accordance with the laws and rules governing state civil service.

NEW SECTION. **Sec. 39.** All rules and all pending business before the Washington basic health plan shall be continued and acted upon by the Washington state health care authority. All existing contracts and obligations shall remain in full force and shall be performed by the Washington state health care authority.

NEW SECTION. **Sec. 40.** The transfer of the powers, duties, functions, and personnel of the Washington basic health plan shall not affect the validity of any act performed prior to the effective date of this section.

NEW SECTION. **Sec. 41.** If apportionments of budgeted funds are required because of the transfers directed by sections 37 through 40 of this act, the director of financial management shall certify the apportionments to the agencies affected, the state auditor, and the state treasurer. Each of these shall make the appropriate transfer and adjustments in funds and appropriation accounts and equipment records in accordance with the certification.

NEW SECTION. **Sec. 42.** Nothing contained in sections 36 through 41 of this act may be construed to alter any existing collective bargaining unit or the provisions of any existing collective bargaining

agreement until the agreement has expired or until the bargaining unit has been modified by action of the personnel board as provided by law.

Sec. 43. RCW 70.47.010 and 1987 1st ex.s. c 5 s 3 are each amended to read as follows:

(1) The legislature finds that:

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

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

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

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

(3) It is not the intent of this chapter to provide health care services for those persons who are presently covered through private

employer-based health plans, nor to replace employer-based health plans. Further, it is the intent of the legislature to expand, wherever possible, the availability of private health care coverage and to discourage the decline of employer-based coverage.

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

(b) As a consequence, but always limited to the extent to which funds might be available to subsidize the costs of health services for those in need, enrollment limitations have been modified and the program shall be expanded to additional geographic areas of the state. In addition, the legislature intends to extend an option to enroll to certain citizens with income above two hundred percent of the federal poverty guidelines who reside in communities where the plan is operational and who collectively or individually wish to exercise the opportunity to purchase health care coverage through the basic health plan, if it is done at no cost to the state.

Sec. 44. RCW 70.47.020 and 1987 1st ex.s. c 5 s 4 are each amended to read as follows:

As used in this chapter:

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

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

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

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

(5) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse and/or dependent children not eligible for

medicare, who resides in an area of the state served by a managed health care system participating in the plan, who has a gross family income of less than three hundred percent of the federal poverty level, and who chooses to obtain basic health care coverage from a particular managed health care system at no cost to the state in return for periodic payments to the plan. "Nonsubsidized enrollee" also includes any enrollee who originally enrolled subject to the income limitations specified in subsection (4) of this section, but who subsequently pays the full unsubsidized premium as set forth in RCW 70.47.060(9).

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

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

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

Sec. 45. RCW 70.47.030 and 1991 sp.s. c 13 s 68 and 1991 sp.s. c 4 s 1 are each reenacted and amended to read as follows:

(1) The basic health plan trust account is hereby established in the state treasury. ((~~All~~)) Any nongeneral fund-state funds collected for this program shall be deposited in the basic health plan trust account and may be expended without further appropriation. Moneys in the account shall be used exclusively for the purposes of this chapter,

including payments to participating managed health care systems on behalf of enrollees in the plan and payment of costs of administering the plan. After July 1, 1991, the administrator shall not expend or encumber for an ensuing fiscal period amounts exceeding ninety-five percent of the amount anticipated to be spent for purchased services during the fiscal year.

(2) The basic health plan subscription account is created in the custody of the state treasurer. All receipts from amounts due under RCW 70.47.060 (10) and (11) shall be deposited into the account. Moneys in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of nonsubsidized enrollees in the plan and payment of costs of administering the plan. The account is subject to allotment procedures under chapter 43.88 RCW, but no appropriation is required for expenditures.

(3) The administrator shall take every precaution to see that none of the moneys in the separate account created in this section or that any premiums paid by either subsidized or nonsubsidized enrollees are commingled in any way.

Sec. 46. RCW 70.47.040 and 1987 1st ex.s. c 5 s 6 are each amended to read as follows:

(1) The Washington basic health plan is created as an independent ((~~agency of the state~~)) program within the Washington state health care authority. The administrative head and appointing authority of the plan shall be the administrator ((~~who shall be appointed by the governor, with the consent of the senate, and shall serve at the pleasure of the governor. The salary for this office shall be set by the governor pursuant to RCW 43.03.040~~)) of the Washington state health care authority. The administrator shall appoint a medical director.

The ((~~administrator,~~)) medical director((~~,~~)) and up to five other employees of the plan shall be exempt from the civil service law, chapter 41.06 RCW.

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

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

(4) The administrator may apply for, receive, and accept grants, gifts, and other payments, including property and service, from any governmental or other public or private entity or person, and may make

arrangements as to the use of these receipts, including the undertaking of special studies and other projects relating to health care costs and access to health care.

(5) In the design, organization, and administration of the plan under this chapter, the administrator shall consider the report of the Washington health care project commission established under chapter 303, Laws of 1986. Nothing in this chapter requires the administrator to follow any specific recommendation contained in that report except as it may also be included in this chapter or other law.

Sec. 47. RCW 70.47.060 and 1991 sp.s. c 4 s 2 and 1991 c 3 s 339 are each reenacted and amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, and other services that may be necessary for basic health care, which enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care, shall include all services necessary for prenatal, postnatal, and well-child care, and shall include a separate schedule of basic health care services for children, eighteen years of age and younger, for those enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.42.080, and such other factors as the administrator deems appropriate.

(2)(a) To design and implement a structure of periodic premiums due the administrator from subsidized enrollees that is based upon gross family income, giving appropriate consideration to family size as well as the ages of all family members. The enrollment of children shall not require the enrollment of their parent or parents who are eligible for the plan. With approval of the administrator, a third party may pay the premium, rate, or other amount determined by the administrator to be due to the plan on behalf of any enrollee, by arrangement with the enrollee, and through a mechanism approved by the administrator.

(b) Any premium, rate, or other amount determined to be due from nonsubsidized enrollees shall be in an amount equal to the amount negotiated by the administrator with the participating managed health care system for the plan plus the administrative cost of providing the plan to those enrollees.

(c) The administrator shall give consideration to any schedule of premiums, deductibles, copayments, and coinsurance that may be adopted by the Washington health services commission, but in particular reference to subsidized enrollees the powers, duties, and responsibilities of the administrator under this section and chapter shall not be superseded by action of the commission.

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

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

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

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

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

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

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

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

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

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

Before July 1, ((~~1988~~)) 1994, the administrator shall endeavor to secure participation contracts with managed health care systems in ((~~discrete geographic areas within at least five~~)) all congressional districts.

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

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

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and at least annually thereafter, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. An enrollee who remains current in payment of the sliding-scale premium, as determined under subsection (2) of this section, and whose gross family income has risen above twice the federal poverty level, may continue enrollment ((~~unless and until the enrollee's gross family income has remained above twice the poverty level for six consecutive months,~~)) by making full payment at the unsubsidized rate required for the managed health care system in which he or she may be enrolled plus the administrative cost of providing the plan to that enrollee. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to re-enroll in the plan.

(10) To accept applications from small business owners on behalf of themselves and their employees who reside in an area served by the plan. Such businesses must have less than one hundred employees and enrollment shall be limited to those not eligible for medicare, who has a gross family income of less than three hundred percent of the federal poverty level, who wish to enroll in the plan at no cost to the state and choose to obtain basic health care coverage and services from a managed health care system participating in the plan. The

administrator may require all or a substantial majority of the eligible employees, as determined by the administrator, of any such business to enroll in the plan and establish such other procedures as may be necessary to facilitate the orderly enrollment of such groups in the plan and into a managed health care system. The administrator shall adjust the amount determined to be due on behalf of or from all such enrollees whenever the amount negotiated by the administrator with the participating managed health care system or systems is modified or the administrative cost of providing the plan to such enrollees changes. Any amounts due under this subsection shall be deposited in the basic health plan subscription account. No enrollee of a small business group shall be eligible for any subsidy from the plan and at no time shall the administrator allow the credit of the state or funds from the trust account to be used or extended on their behalf.

(11) On and after July 1, 1994, to accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children not eligible for medicare who wish to enroll in the plan at no cost to the state and choose to obtain basic health care coverage and services from a managed health care system participating in the plan. Any such nonsubsidized enrollee must pay the plan whatever amount is negotiated by the administrator with the participating managed health care system and the administrative cost of providing the plan to such enrollees and shall not be eligible for any subsidy from the plan. Any amounts due under this subsection shall be deposited in the basic health plan subscription account.

(12) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same for similar

enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the administrator shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant.

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

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

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

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

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

Sec. 48. RCW 70.47.080 and 1987 1st ex.s. c 5 s 10 are each amended to read as follows:

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

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

Before July 1, ((~~1988~~)) 1994, the administrator shall endeavor to secure participation contracts from managed health care systems in ((~~discrete geographic areas within at least five~~)) all congressional districts of the state and in such manner as to allow residents of both urban and rural areas access to enrollment in the plan. The administrator shall make a special effort to secure agreements with health care providers in one such area that meets the requirements set forth in RCW 70.47.060(4).

The administrator shall at all times closely monitor growth patterns of enrollment so as not to exceed that consistent with the orderly development of the plan as a whole, in any area of the state or in any participating managed health care system.

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

Sec. 49. RCW 70.47.120 and 1987 1st ex.s. c 5 s 14 are each amended to read as follows:

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

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

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

(3) With public or private agencies, including health care service contractors registered under RCW 48.44.015, and doing business in the state, for marketing and administrative services in connection with participation of managed health care systems, enrollment of enrollees, billing and collection services to the administrator, and other administrative functions ordinarily performed by health care service contractors, other than insurance except that the administrator may purchase or arrange for the purchase of reinsurance, or self-insure for

reinsurance, on behalf of its participating managed health care systems. Any activities of a health care service contractor pursuant to a contract with the administrator under this section shall be exempt from the provisions and requirements of Title 48 RCW.

MISCELLANEOUS

NEW SECTION. **Sec. 50.** The following acts or parts of acts are each repealed:

(1) RCW 43.131.355 and 1987 1st ex.s. c 5 s 24; and

(2) RCW 43.131.356 and 1987 1st ex.s. c 5 s 25.

NEW SECTION. **Sec. 51.** SEVERABILITY. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 52.** SAVINGS CLAUSE. The enactment of this act does not have the effect of terminating, or in any way modifying, any obligation or any liability, civil or criminal, which was already in existence on the effective date of this section.

NEW SECTION. **Sec. 53.** CODIFICATION DIRECTIONS. Sections 1 through 17 and 19 through 21 of this act shall constitute a new chapter in Title 70 RCW.

NEW SECTION. **Sec. 54.** CAPTIONS. Captions used in this act do not constitute any part of the law.

NEW SECTION. **Sec. 55.** SHORT TITLE. This act may be known and cited as the Washington health services act.

NEW SECTION. **Sec. 56.** EMERGENCY CLAUSE. Sections 1 through 26, 51, and 52 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect immediately.

NEW SECTION. **Sec. 57.** (1) Sections 27 through 31 and 35 through 50 of this act shall take effect July 1, 1992.

(2) Sections 32 through 34 of this act shall take effect January 1, 1994.

NEW SECTION. **Sec. 58.** Sections 27 through 35 of this act shall expire on July 1, 1996.