H-3718.3

HOUSE BILL 2641

State of Washington 52nd Legislature 1992 Regular Session

By Representatives Sprenkle, Winsley, Dorn, Paris, Basich, Zellinsky, Roland, Dellwo and Haugen

Read first time 01/22/92. Referred to Committee on Health Care.

AN ACT Relating to health care; amending RCW 74.09.522, 70.47.010, 70.47.020, 70.47.040, 70.47.080, 70.47.120, 82.26.020, 82.24.020, 82.08.150, 82.08.160, 66.24.210, 66.08.180, 66.24.290, and 82.04.500; reenacting and amending RCW 70.47.030 and 70.47.060; adding a new section to chapter 70.47 RCW; adding new sections to Title 48 RCW; adding a new section to chapter 74.09 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 70.170 RCW; adding a new section to chapter 4.24 RCW; adding a new section to chapter 82.32 RCW; adding new sections to chapter 82.04 RCW; adding a new section to chapter 48.14 RCW; adding a new chapter to Title 70 RCW; creating new sections; repealing RCW 43.131.355 and 43.131.356; making an appropriation; providing effective dates; and declaring an emergency.

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

PART I

FINDINGS AND DEFINITIONS

NEW SECTION. **Sec. 101.** (1) The legislature finds that comprehensive, appropriate, and affordable health services should be available to all Washington residents. The legislature further finds that the extraordinary health services available to most Washington state residents both in quality and timeliness are not available to many in an affordable, timely, or dignified manner, and that the costs of the existing system have created an unsustainable burden to individuals, business, and government.

(2) The legislature further finds that the existing system lacks the ability to provide affordable, high quality services because of the design of the health services delivery system and other important factors, which include:

(a) An aging population and public expectations of the health care system;

(b) New technologies for diagnosis and treatment;

(c) Unhealthy lifestyles related specifically to diet, lack of exercise, stress, and inappropriate or excessive use of tobacco products, and drugs and alcohol;

(d) Defensive medicine;

(e) New disease conditions, such as AIDS; and

(f) The lack of incentives for most health services providers and consumers to use health services cost-effectively.

(3) The legislature recognizes that without obtaining optimum value for the money spent on health services, universal access will not be achievable. A substantial increase in value can be achieved by modifying current health services reimbursement, and altering the type

and amount of copayment and premium responsibilities held by individuals.

(4) The legislature finds there are two major approaches to managing health services costs -- strict regulation of providers, or giving individuals and providers much more financial accountability in health care decision making. Significantly greater choice and flexibility for individuals and providers can be maintained through accountability, than through regulation.

(5) The legislature further finds that changes in the health services system must make every effort to sustain and encourage those aspects of the current system that result in high technical quality and consumer responsiveness, while eliminating inefficiencies and inequities.

(6) The legislature further finds that individuals, employers, and providers who currently have or provide affordable access to quality care, highly value that right, and that change should be accomplished in a manner that permits ongoing evaluation and modification in order to accomplish system transformation with as little disruption and as much continuity as possible.

(7) The legislature further finds that most employers that provide health care coverage assume a disproportionate share of costs as compared to other industrialized nations and that if an employment-based health insurance system is to be used, all employers should participate, with sensitivity to their ability to pay.

(8) The legislature further finds that all health services consumers must share in the cost of health services according to their ability to pay and that, to the extent possible, no individual or employer should be confronted with the threat of extreme financial hardship because of the cost of health services.

(9) The legislature recognizes that comprehensive strategies should be developed to eliminate those aspects of defensive medicine that add to the cost, but not the quality of health services. While the Washington state health care cost control and access commission is developing such strategies, the legislature finds that the development and implementation of practice parameters is one part of a comprehensive strategy that should be undertaken.

(10) The legislature further finds that the existing health services delivery system is incapable of providing cost-effective services and that although much, if not all, of the additional costs of providing universal access might be achieved through increasing its efficiency, this will require time and, at least initially, additional revenue will be required to expand access and reconfigure the existing delivery system.

NEW SECTION. **Sec. 102.** DEFINITIONS. As used in this chapter and sections 402 through 412 of this act, unless the context clearly requires otherwise:

(1) "Capitated rate" means the level of payment for provision of the state-purchased uniform benefit package or the private uniform benefit package, paid to an organized delivery system, on a monthly basis, for each individual enrolled in such organized delivery system.

(2) "Community of over fifty thousand population" means a geographic area, defined by the health care authority, in which more than fifty thousand persons reside. In defining such areas, political subdivision boundaries, the location of health care providers and facilities, and distances traveled to receive health care services shall be considered.

(3) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,

rural health 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.

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

(a) A physician licensed under chapter 18.71 or 18.57 RCW or any other 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.

(5) "Insurer" means a disability group insurer regulated under chapter 48.21 or 48.22 RCW, a health care services contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020.

(6) "Organized delivery system" means health care organization, composed of health care providers, health care facilities, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract at least the state-purchased uniform benefit package or the private uniform benefit package, and rendered by health care providers, for a prepaid, capitated rate to a defined patient population on or after July 1, 1992. Physicians participating in an organized delivery system shall

be financially accountable for utilization of pharmaceuticals, laboratory and radiological services, procedures, and inpatient and outpatient health care facilities by the patients of such system.

(7) "Premium" means a periodic payment determined by the health care authority under section 201 of this act, that will be the personal responsibility of the person receiving state-purchased health care services.

(8) "Private uniform benefit package" means health services and benefits defined by the state health policy council pursuant to section 502 of this act.

(9) "State-purchased health care services" means those health care services purchased with state or federal funds on behalf of state employees, local school district employees, basic health plan enrollees, recipients of medical programs defined in RCW 74.09.010, and employees of a county, municipality, or other political subdivision of the state that transfers its health care benefits program to the state pursuant to RCW 41.04.205.

(10) "State-purchased uniform benefit package" means the health services and benefits defined by the health care authority for state-purchased health care services pursuant to section 201 of this act.

PART II

STATE-PURCHASED HEALTH SERVICES

NEW SECTION. **Sec. 201.** (1) On or before September 30, 1993, the state employees' benefits board, established pursuant to RCW 41.05.055, in consultation with the Washington health care cost control and access commission, shall develop a comprehensive state-purchased uniform benefit package and uniform administrative procedures that will be

utilized for all state-purchased health care services. Exclusively for purposes of the development of the state-purchased uniform benefit package and uniform administrative procedures under this section, the membership of the board shall be modified to include:

(a) A representative of the department of health;

(b) A representative of the department of labor and industries;

(c) A representative of the Washington basic health plan;

(d) A representative of the department of social and health services;

(e) A representative of local school district employees; and

(f) A representative of persons with income of less than two hundred percent of the federal poverty level.

(2) Effective July 1, 1994, to the extent not otherwise prohibited by federal law or modified by the legislature, the state-purchased uniform benefit package established pursuant to subsection (1) of this section shall constitute the benefit package offered to all state employees, local district employees, recipients of medical programs as defined in RCW 74.09.010, and employees of counties, municipalities, or other political subdivisions of the state that have transferred their health care benefit programs to the state pursuant to RCW 41.04.205. Effective July 1, 1995, to the extent not otherwise prohibited by federal law or modified by the legislature, the state-purchased uniform benefit package established pursuant to subsection (1) of this section shall constitute the benefit package offered to all Washington basic health plan enrollees.

(3) The uniform benefit package shall have the following components:

(a) Scope of covered services;

(b) Type and amount of financial participation in the cost of health services, including:

(i) Premiums equal to fifty percent of the capitated rate paid to an organized delivery system for the state-purchased uniform benefit package;

(ii) Copayments and coinsurance of a minimum of thirty percent and a maximum of fifty percent to be paid by persons receiving state-purchased health care services, for services, other than primary and preventive care, that are not provided through an organized delivery system. Alternative, but equivalent, cost-sharing obligations may be developed for persons receiving state-purchased health care services, other than primary and preventive care, through organized delivery systems;

(iii) Maximum annual out-of-pocket costs that may be required of each person receiving state-purchased health care services, adjusted for total family income and family size, including premium responsibility, copayments, coinsurance, and other cost-sharing obligations. Financial participation in the cost of health services under the state-purchased uniform benefit package shall not create barriers to the utilization of appropriate services;

(iv) Individual medical accounts that will be funded by the state for each state employee and local school district employee.

(A) The state’s monthly contribution to each employee’s individual medical account shall equal sixty percent of the capitated rate paid to an organized delivery system for the state-purchased uniform benefit package.

(B) Individual medical account funds may be expended by the employee to pay premiums, copayments, coinsurance, or other cost-sharing obligations for the employee, or his or her dependents.

(4) The uniform benefit package revolving fund is created in the custody of the state treasurer. Expenditures from the fund may be used only to provide low-interest hardship loans to persons receiving state-

purchased uniform benefit package services as provided in subsection (1) of this section and to persons receiving private uniform benefit package services. State employees and local school district employees may apply for a loan from the fund to pay for state-purchased uniform benefit package services that exceed amounts in that person's individual medical account, but are less than his or her maximum annual out-of-pocket costs.

(5) Effective July 1, 1994, to the extent not otherwise prohibited by federal law or modified by the legislature, the uniform administrative procedures established pursuant to subsection (1) of this section shall be implemented. The procedures shall address the following:

(a) Uniform enrollment procedures, including an enrollment card for each person eligible to receiving state-purchased health care services. The enrollment card shall:

(i) Indicate the participant's cost-sharing obligations; and

(ii) Be presented and utilized for all provider transactions covered through the state-purchased uniform benefit package;

(b) A monthly statement to each individual or family eligible to receive state-purchased health care services that provides a statement of the premium due, accrued expenses and, where applicable, the individual medical account balance;

(c) Billing and claims payment procedures;

(d) Organized delivery systems and health care provider and facility contracting procedures; and

(e) Organized delivery systems and health care provider and facility oversight and auditing procedures.

NEW SECTION. **Sec. 202.** The health care authority, in consultation with the department of social and health services, shall

develop recommendations to the legislature related to the inclusion of long-term care services in the state-purchased uniform benefit package and report those recommendations to appropriate committees of the legislature on or before December 31, 1994.

NEW SECTION. **Sec. 203.** (1) The health care authority, in consultation with the department of labor and industries and the workers' compensation advisory committee shall develop recommendations to the legislature related to the relationship between workers' compensation and the state-purchased uniform benefit package developed by the health care authority as provided in section 201 of this act. The recommendations shall address issues such as the application of the uniform administrative procedures established pursuant to section 201 of this act to the injured workers' medical benefits program, twenty-four hour coverage, the connection between medical benefits and disability benefits, the impact of allowing private insurers to provide medical benefits to injured workers, and any other relevant issues. The recommendations shall be reported to appropriate committees of the legislature on or before December 31, 1994.

(2) The department of labor and industries and the health care authority shall develop guidelines for the management of care received by injured or disabled workers through organized delivery systems. Such guidelines shall provide that, after an injured worker's disability has continued for six or more months, the department may require that such worker be cared for by a specific panel of providers in an organized delivery system.

NEW SECTION. **Sec. 204.** In the development of the state-purchased uniform benefit package and the uniform administrative procedures as provided in section 201 of this act, the state employees'

benefits board shall consider the reports of the health care cost control and access commission established under House Concurrent Resolution No. 4443 adopted by the legislature March 21, 1990. Nothing in this chapter requires the state employees' benefits board to follow any specific recommendation contained in those reports except to the extent that such recommendation is included in this chapter or other law.

NEW SECTION. **Sec. 205.** (1) The health care authority, in consultation with the Washington basic health plan and the department of social and health services medical assistance administration, shall establish in all communities of over fifty thousand population, organized delivery systems that will be responsible for providing state-purchased uniform benefit package services.

(2) Organized delivery systems shall receive payment for providing the state-purchased uniform benefit package through a capitated rate. At regular and appropriate intervals, not to exceed one fiscal year, each organized delivery system will be retroactively reimbursed for those major medical expenses, such as transplants, major catastrophic injuries or illness and pregnancies, that occurred at a rate in excess of the actuarially predicted rate of occurrence upon which the capitated rate was based.

(3) The capitated rate paid to an organized delivery system for provision of the state-purchased uniform benefit package shall be: (a) For the first three years that an organized delivery system contracts with the state, no less than the indemnity rate paid by the health care authority for the state-purchased uniform benefit package; and

(b) For subsequent contract years, no more than ten percent less than the amount paid by large private employers to insurers for comparable benefit packages.

(4) Unless precluded by extraordinary circumstances, the health care authority shall ensure that at least two such organized delivery systems exist in each community of over fifty thousand population.

(5) Alternative adverse selection reimbursement strategies may be developed by the health care authority for implementation on or after July 1, 1995. Such strategies shall not be implemented without authorization by the legislature.

NEW SECTION. **Sec. 206.** The health care authority shall adopt the following reimbursement methodologies for state-purchased health care services not provided through an organized delivery system:

(1) Medicare resource-based relative value scale at a conversion factor of one for state employees, local school district employees, and employees of counties, municipalities, or political subdivisions of the state whose employee health benefits have been transferred pursuant to RCW 41.04.205;

(2) Medicare resource-based relative value scale at a conversion factor of eight-tenths and six-tenths for primary care and specialty care respectively, for medical programs defined in RCW 74.09.010;

(3) As practice parameters are developed and adopted as provided in section 502 of this act, reimbursement will be provided only for services provided that are consistent with such parameters;

(4) All new diagnostic and therapeutic measures developed after July 1, 1992, that will increase, or have a significant likelihood of resulting in increased health services costs, shall be reviewed and accepted by the health care authority before being eligible for reimbursement;

(5) Except to the extent that the state-purchased health care services are provided through a staff model health maintenance organization payment methodologies shall prohibit payment to health

care providers for laboratory or radiology services provided by a facility in which such a provider has a financial interest, except to the extent that the services provided are:

(a) As a result of a medical emergency;

(b) For patients in isolated rural areas; or

(c) For certain minor or other appropriate services, as defined by the authority in rule.

NEW SECTION. **Sec. 207.** In carrying out its duties under this chapter, the health care authority shall make an ongoing effort to utilize the services of private contractors.

Sec. 208. RCW 74.09.522 and 1989 c 260 s 2 are each amended to read as follows:

(1) ((~~For the purposes of this section, "managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, health insuring organizations, or any combination thereof, that provides directly or by contract health care services covered under RCW 74.09.520 and rendered by licensed providers, on a prepaid capitated case management basis and that meets the requirements of section 1903(m)(1)(A) of Title XIX of the federal social security act.~~

~~(2) No later than July 1, 1991,~~)) The department of social and health services shall enter into agreements with ((~~managed health care~~)) organized delivery systems to provide health care services to all ~~recipients of ((aid to families with dependent children~~)) medical assistance under the following conditions:

(a) ((~~Agreements shall be made for at least thirty thousand recipients state-wide;~~

~~(b) Agreements in at least one county shall include enrollment of all recipients of aid to families with dependent children;~~

~~(c) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act,~~)) Recipients shall have a choice of systems in which to enroll and shall have the right to terminate their enrollment in a system: PROVIDED, That if two or more organized delivery systems in a county have not contracted to provide care to medical assistance recipients by January 1, 1994, medical assistance recipients in such county may be enrolled in the single contracting system: PROVIDED FURTHER, That the department may limit recipient termination of enrollment without cause to the first month of a period of enrollment, which period shall not exceed six months: AND PROVIDED FURTHER, That the department shall not restrict a recipient's right to terminate enrollment in a system for cause;

((~~(d) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act, participating managed health care systems shall not enroll a disproportionate number of medical assistance recipients within the total numbers of persons served by the managed health care systems, except that this subsection (d) shall not apply to entities described in subparagraph (B) of section 1903(m) of Title XIX of the federal social security act;~~

~~(e) Prior to negotiating with any managed health care system, the department shall estimate, on an actuarially sound basis, the expected cost of providing the health care services expressed in terms of upper and lower limits, and recognizing variations in the cost of providing the services through the various systems and in different project areas.~~))

(b) Medical assistance recipients shall not constitute more than fifty percent of the total number of persons enrolled in any participating organized delivery system;

(c) In negotiating with ((~~managed health care~~)) organized delivery systems the department shall adopt a uniform procedure to negotiate and enter into contractual arrangements, including standards regarding the quality of services to be provided; and financial integrity of the responding system;

((~~(f) The department shall seek waivers from federal requirements as necessary to implement this chapter;~~

~~(g) The department shall, wherever possible, enter into prepaid capitation contracts that include inpatient care. However, if this is not possible or feasible, the department may enter into prepaid capitation contracts that do not include inpatient care;~~

~~(h) The department shall define those circumstances under which a managed health care system is responsible for out-of-system services and assure that recipients shall not be charged for such services; and~~

~~(i) Nothing in this section prevents the department from entering into similar agreements for other groups of people eligible to receive services under chapter 74.09 RCW~~)) and

(d) The capitated rate paid to each organized delivery system by the department for the provision of services to medical assistance recipients must be no less than the rate paid to such system for persons who are not eligible for medical assistance.

((~~(3)~~)) (2) The department shall seek to obtain a large number of contracts with providers of health services to medicaid recipients. The department shall ensure that publicly supported community health centers and providers in rural areas, who show serious intent and apparent capability to participate in the project as ((~~managed health care~~)) organized delivery systems are seriously considered as providers in the project. The department shall coordinate these projects with the plans developed under chapter 70.47 RCW.

((~~(4) The department shall work jointly with the state of Oregon and other states in this geographical region in order to develop recommendations to be presented to the appropriate federal agencies and the United States congress for improving health care of the poor, while controlling related costs.~~))

NEW SECTION. **Sec. 209.** A new section is added to chapter 74.09 RCW to read as follows:

(1) The department of social and health services shall amend the Washington state plan for medical assistance, as provided in this chapter, to include all categories of persons for whom federal medical assistance matching funds are currently available, and to include all health services for which federal matching funds are currently available pursuant to federal law.

(2) The department of social and health services shall negotiate with the United States congress and the federal department of health and human services, health care financing administration to obtain statutory or regulatory waivers of provisions of the medicaid statute, Title XIX of the federal social security act, and its implementing regulations, necessary to implement this act.

PART III

ACCESS

BASIC HEALTH PLAN

NEW SECTION. Sec. 301. 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. 302.** 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. 303.** 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. 304.** 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. 305.** 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. 306.** If apportionments of budgeted funds are required because of the transfers directed by sections 302 through 305 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. 307.** Nothing contained in sections 301 through 306 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. 308. 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 above two hundred percent of the federal poverty guidelines within the state who reside in communities where the plan is operational and who collectively or individually wish to exercise the opportunity to purchase health care coverage through the program if it is done at no cost to the state.

Sec. 309. 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 and enrolls individually or through sponsorship of his or her small business employer. 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 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, and who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan, through sponsorship of his or her employer. "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), and 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, has 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 in return for payment of the full unsubsidized premium, as set forth in RCW 70.47.060(11).

(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.

(9) "Small business" means a business with one hundred or fewer employees.

Sec. 310. 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) 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 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 accounts created in this section or that any premiums paid by either subsidized or nonsubsidized enrollees are commingled in any way.

Sec. 311. 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 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. 312. 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. On or after July 1, 1995, the state-purchased uniform benefit package adopted pursuant to section 201 of this act shall be implemented by the administrator as the schedule of covered basic health care services.

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

(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~~)) should 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 or any act appropriating funds for the plan.

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 subject to the following conditions and limitations:

(a) Employees enrolled must be under sixty-five years of age and not otherwise eligible for medicare;

(b) Employees enrolled must have gross family income of less than three hundred percent of the federal poverty level, except that employees of newly established small businesses may be enrolled regardless of their income level for the first three full calendar years of their employer's operation;

(c) The administrator may require that all or a substantial majority of the eligible employees of any such small business 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;

(d) Any small business choosing to enroll its employees in the plan must pay, at a minimum, fifty percent of the monthly amount determined to be due to the plan by the administrator for each employee and his or her eligible dependents. 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; and

(e) Enrolled employees of small business groups who have gross family income of less than two hundred percent of the federal poverty level shall receive a subsidy from the plan for an income-adjusted portion of the amount that is the enrollee's responsibility as a member of such small business group.

(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, who have gross family income of less than three hundred percent of the federal poverty level, are under sixty-five years of age and not otherwise eligible for medicare, who wish to enroll in the plan at no cost to the state, and who 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.

(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. 313. 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 subsidized 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. 314. 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.

NEW SECTION. **Sec. 315.** 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. 316.** The sum of ..... dollars, or as much thereof as may be necessary, is appropriated for the biennium ending June 30, 1993, from the health services trust fund to the

Washington basic health plan to increase the number of subsidized enrollees and expand the program into additional urban and rural areas of the state.

NEW SECTION. **Sec. 317.** A new section is added to Title 48 RCW to read as follows:

On or before July 1, 1995, all Washington state residents who are not eligible to receive health care benefits through an employer that self-insures for the purposes of the provision of employee health benefits, shall provide proof of health insurance coverage at least as comprehensive as the uniform benefit package adopted pursuant to section 201 of this act.

NEW SECTION. **Sec. 318.** A new section is added to Title 48 RCW to read as follows:

Any person who has purchased health insurance coverage as an individual, upon providing proof of such coverage, may apply for a low interest loan from the uniform benefit package revolving loan fund established pursuant to section 201 of this act, for the purpose of making copayments, deductibles or other cost-sharing payments under his or her individual health insurance policy, or for payment of health services not covered through such policy.

PART IV

HEALTH INSURANCE REFORM

NEW SECTION. Sec. 401. 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. 402.** A new section is added to Title 48 RCW to read as follows:

For the purposes of sections 403, 404, and 405 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. 403.** 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. 404.** 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 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. 405.** 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 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. 406.** A new section is added to chapter 48.21 RCW to read as follows:

Notwithstanding other sections of this chapter, beginning July 1, 1993, and thereafter:

(1) Every health insurance policy issued by a group disability insurer must require a minimum copayment of thirty percent for health care services other than primary and preventive care services, as defined by rule under this chapter;

(2) Unless otherwise directed by rules adopted by the state health policy council, established pursuant to section 501 of this act, no group disability insurer shall be required to provide payment for experimental procedures or pharmaceuticals; and

(3) Each group disability insurer shall make the following data available to the state health policy council, established pursuant to section 501 of this act, and to the department of health on an annual basis, in a standardized format determined by the department, by rule:

(a) Services provided to insured individuals, including pharmaceuticals, laboratory, radiology, and procedures;

(b) Compensation paid for each of such services; and

(c) For services reported, patient identifiers relating to the age, sex, and diagnostic category of the patient.

NEW SECTION. **Sec. 407.** A new section is added to chapter 48.44 RCW to read as follows:

Notwithstanding other sections of this chapter, beginning July 1, 1993, and thereafter:

(1) Every plan issued by a health care services contractor must require a minimum copayment of thirty percent for health care services other than primary and preventive care services, as defined by rule under this chapter;

(2) Unless otherwise directed by rules adopted by the state health policy council, established pursuant to section 501 of this act, no health care services contractor shall be required to provide payment for experimental procedures or pharmaceuticals; and

(3) Each health care services contractor shall make the following data available to the state health policy council, established pursuant to section 501 of this act, and to the department of health on an annual basis, in a standardized format determined by the department, by rule:

(a) Services provided to insured individuals, including pharmaceuticals, laboratory, radiology, and procedures;

(b) Compensation paid for each of such services; and

(c) For services reported, patient identifiers relating to the age, sex, and diagnostic category of the patient.

NEW SECTION. **Sec. 408.** A new section is added to chapter 48.46 RCW to read as follows:

Notwithstanding other sections of this chapter, beginning July 1, 1993, and thereafter:

(1) Every plan issued by a health maintenance organization must require a minimum copayment of thirty percent for health care services other than primary and preventive care services, as defined by rule under this chapter;

(2) Unless otherwise directed by rules adopted by the state health policy council, established pursuant to section 501 of this act, no health maintenance organization shall be required to provide payment for experimental procedures or pharmaceuticals; and

(3) Each health maintenance organization shall make the following data available to the state health policy council, established pursuant to section 501 of this act, and to the department of health on an annual basis, in a standardized format determined by the department, by rule:

(a) Services provided to insured individuals, including pharmaceuticals, laboratory, radiology, and procedures;

(b) Compensation paid for each of such services; and

(c) For services reported, patient identifiers relating to the age, sex, and diagnostic category of the patient.

NEW SECTION. **Sec. 409.** A new section is added to chapter 48.21 RCW to read as follows:

Notwithstanding other sections of this chapter, beginning January 1, 1995, and thereafter:

(1) The private uniform benefit package adopted pursuant to section 502 of this act and from time to time revised by the state health policy council shall become the minimum benefit package required of any policy under this chapter;

(2) The payment methodology for all physician services under any policy offered under this chapter that does not provide for receipt of health care services through an organized delivery system shall be the medicare resource-based relative value scale;

(3) Payment methodologies for any policy offered under this chapter that does not provide for receipt of health care services through an organized delivery system shall prohibit payment to health care providers for laboratory or radiology services provided by a facility in which such provider has a financial interest, except to the extent that the services provided are:

(a) As a result of a medical emergency;

(b) For patients in isolated rural areas; or

(c) For certain minor or other appropriate services, as defined by the state health policy council in rule; and

(4) At least fifty percent of the premiums paid to each group disability insurer under this chapter for health insurance coverage shall be for policies providing for receipt of health care services through an organized delivery system.

NEW SECTION. **Sec. 410.** A new section is added to chapter 48.44 RCW to read as follows:

Notwithstanding other sections of this chapter, beginning January 1, 1995, and thereafter:

(1) The private uniform benefit package adopted pursuant to section 502 of this act and from time to time revised by the state health policy council shall become the minimum benefit package required of any plan under this chapter;

(2) The payment methodology for all physician services under any plan offered under this chapter that does not provide for receipt of

health care services through an organized delivery system shall be the medicare resource-based relative value scale;

(3) Payment methodologies for any plan offered under this chapter that does not provide for receipt of health care services through an organized delivery system shall prohibit payment to health care providers for laboratory or radiology services provided by a facility in which such provider has a financial interest, except to the extent that the services provided are:

(a) As a result of a medical emergency;

(b) For patients in isolated rural areas; or

(c) For certain minor or other appropriate services, as defined by the state health policy council in rule; and

(4) At least fifty percent of the premiums paid to each health care service contractor under this chapter must be for plans providing for receipt of health care services through an organized delivery system.

NEW SECTION. **Sec. 411.** A new section is added to chapter 48.46 RCW to read as follows:

Notwithstanding other sections of this chapter, beginning January 1, 1995, and thereafter:

(1) The private uniform benefit package adopted pursuant to section 502 of this act and from time to time revised by the state health policy council shall become the minimum benefit package required of any plan under this chapter;

(2) Payment methodology for all physician services under any plan offered under this chapter that does not provide for receipt of health care services through an organized delivery system, except those offered through staff-model health maintenance organizations, shall be the medicare resource-based relative value scale;

(3) Payment methodologies for any plan offered under this chapter that does not provide for receipt of health care services through an organized delivery system, except those offered through staff-model health maintenance organizations, shall prohibit payment to health care providers for laboratory or radiology services provided by a facility in which such provider has a financial interest, except to the extent that the services provided are:

(a) As a result of a medical emergency;

(b) For patients in isolated rural areas; or

(c) For certain minor or other appropriate services, as defined by the state health policy council in rule; and

(4) At least fifty percent of the premiums paid to each health maintenance organization under this chapter must be for plans providing for receipt of health care services through an organized delivery system.

NEW SECTION. **Sec. 412.** A new section is added to Title 48 RCW to read as follows:

The insurance commissioner shall develop a reinsurance mechanism for organized delivery systems 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. It must support itself entirely from funds generated from the participating insurers.

PART V

STATE AND REGIONAL HEALTH POLICY COUNCILS

NEW SECTION. Sec. 501. (1) There is established the state health policy council composed of thirteen members. Twelve members shall be appointed by the governor and confirmed by the senate. In addition, the administrator of the health care authority or the administrator's designee shall serve as a member. In making these appointments, the governor shall ensure that one-third of the members represent health care purchasers, one-third of the members represent health care consumers, one of which represents public health interests, and one-third of the members represent health care providers and health care facilities. Of the appointed members, at least one shall be selected from each of the congressional districts in Washington state. Members shall serve four-year terms. Of the initial members appointed to the council, two shall serve for two years, two shall serve for three years, and two shall serve for four years. Thereafter, members shall be appointed to four-year terms. Vacancies shall be filled by appointment for the remainder of the unexpired term of the position being vacated. The chair of the council shall serve at the pleasure of the governor and shall be a member other than the administrator of the health care authority.

(2) The members, exclusive of the chair and the administrator of the health care authority, shall be compensated as provided in RCW 43.03.250. The members, exclusive of the chair and the administrator of the health care authority, shall be reimbursed for travel expenses as provided in RCW 43.03.050 and 43.03.060.

(3) The chair of the council shall be a full-time employee responsible for the administration of all functions of the council, including hiring and terminating staff, contracting, coordinating with

the governor, the legislature, and other state and local entities, and the delegation of responsibilities as deemed appropriate. The salary of the chair shall be fixed by the governor, subject to RCW 43.03.040.

(4) The chair shall prepare a budget and a work plan that are subject to review and approval by the council.

NEW SECTION. **Sec. 502.** The council shall have the following powers and duties:

(1) To implement, in conjunction with the state and federal governments and medical specialty organizations, giving priority to those practice areas (a) with the highest costs; or (b) making the greatest contribution to malpractice liability premiums and defensive medicine costs, practice parameters for purposes of inclusion in the private uniform benefit package developed pursuant to subsection (4) of this section;

(2) To establish total annual health care services expenditure targets using comprehensive data from previous years. In carrying out this duty, the council shall define health services cost centers in categories that permit the development of cost identification and cost control strategies by individual health service, and collectively. The 1993 expenditure target shall be based on total health services expenditures in Washington for calendar year 1991, adjusted for the amount of actual growth in total health care services expenditures between 1991 and 1992 as determined by the office of financial management. Thereafter, the expenditure target shall be allowed to grow by no more than the amount of actual growth in total health care services expenditures between 1991 and 1992, 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 plus real per capita income growth, as determined by the

office of financial management. The council shall develop a two-year plan and a six-year plan to keep total health expenditures within the targets established in this subsection, and report these plans to appropriate committees of the legislature on or before January 1, 1994;

(3) To monitor the actual growth in total annual health care costs and report to appropriate committees of the legislature by September 1, beginning in 1994, on the extent to which health care costs for the previous calendar year deviated from the expenditure targets set forth in subsection (2) of this section;

(4) To establish a proposed private uniform benefit package for all Washington state residents for submission to the legislature on or before January 1, 1994, which would constitute the minimum benefit package that could be offered by private insurers;

(a) The council shall define proven prevention strategies and incorporate such strategies into the private uniform benefit package;

(b) The council shall provide ample opportunity for public participation in initial development of the private uniform benefit package, and shall provide, on a biannual basis, for public participation in a review of the scope of the private uniform benefit package. Regional health policy councils established as provided in section 503 of this act shall be an integral part of the public participation plan developed by the council;

(5) To establish strategies to address major health care cost centers, including but not limited to use of pharmaceuticals, application of new or expensive technologies and procedures, and intensive management of extremely ill persons;

(6) To develop guidelines for appropriate and consistent utilization review procedures;

(7) To enter into, amend, and terminate contracts with individuals, corporations, or research institutions for the purposes of this chapter;

(8) To receive such gifts, grants, and endowments, in trust or otherwise, for the use and benefit of the purposes of the council. The council may expend the same or any income therefrom according to the terms of the gifts, grants, or endowments;

(9) To conduct studies and research necessary to carry out the duties of the council;

(10) To obtain information regarding health services cost, delivery, and utilization from state and local agencies, boards, and commissions;

(11) To adopt necessary rules in accordance with chapter 34.05 RCW to carry out the purposes of this chapter; and

(12) To prepare a biennial budget request for consideration by the governor and the legislature.

NEW SECTION. **Sec. 503.** PERSONAL HEALTH SERVICES DATA. The council shall develop and adopt criteria for a personal health services data and information system or systems that support its purposes under this chapter and that are operated and maintained by the department of health. As part of the design stage for this development, the council shall consider the personal health services data needed by consumers, purchasers, payers, employers, and health services providers including that currently collected by public or private entities in the state.

To extent practicable, the criteria shall be consistent with any requirements of the federal government in its administration of the medicare and medicaid programs. The criteria shall also be consistent with any requirements of state and local health agencies in their roles of gathering and analyzing public health statistics and

developing programs to address public health needs. The criteria should make use of, to the extent feasible, definitions and data elements from any existing public or private health services data system. The purpose of such coordination is to minimize any unduly burdensome reporting requirements imposed upon the public or private sources of such data.

NEW SECTION. **Sec. 504.** A new section is added to chapter 70.170 RCW to read as follows:

(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 state health policy council. The department shall provide the council with reasonable assistance in the development of these criteria, and shall provide the council 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 council. Such coordination may include contracts with existing public or private data systems for reporting or managing required data sets. The department shall assist the council in establishing reasonable timeframes for the completion of the system development and system implementation.

NEW SECTION. **Sec. 505.** (1) On or before January 1, 1993, each local public health department or health district in the state of Washington shall establish a regional health policy council composed of not less than twelve members. In counties served by local public

health departments, members shall be appointed by the county legislative authority for such county. In counties that are part of a public health district, members shall be appointed by the board of health for such district. In making these appointments, the county legislative authority or board of health shall ensure that one-third of the members represent health care purchasers, one of which represents the state government as a purchaser, one-third of the members represent health care consumers, one of which represents public health interests, and one-third of the members represent health care providers and health care facilities. The chair of the council shall be selected from among its members by the members.

(2) Regional health policy councils shall have the following duties:

(a) To prepare an annual total health services expenditure target for the jurisdiction of the public health department or health district, which shall be reported to the state health policy council on or before November 1 of the year preceding the year for which the annual expenditure target has been developed;

(b) To approve of the development or acquisition of new facilities and new technologies, to be located in the jurisdiction of the public health department or health district, requiring major capital investment or having an immediate or significant potential impact on health services delivery costs;

(c) To identify strategies to address major health care cost centers, including but not limited to use of pharmaceuticals, application of new or expensive technologies and procedures, and intensive management of extremely ill persons;

(d) To identify shortages of health care practitioners and health services in the jurisdiction of the council, and report its findings to

the state health policy council as a part of its annual health services expenditure target report; and

(e) Report the results of public participation activities undertaken by the regional health policy council pursuant to section 502(4) of this act to the state health policy council as a part of its annual health services expenditure target report.

(3) Regional health policy councils shall act in accordance with rules established by the state health policy council pursuant to section 502 of this act. Nothing in this subsection precludes a regional council from exceeding the scope of rules adopted by the state council.

NEW SECTION. **Sec. 506.** The operating costs of regional health policy councils shall be funded by an assessment on health care purchasers, providers and facilities.

(1) One-half of the necessary operating funds will be derived from an assessment on health care purchasers. Each purchaser's assessment will be that portion of one-half of the necessary operating funds that is equivalent to the proportion of total health care expenditures that were expended by that purchaser during the previous calendar year in the regional council's jurisdiction.

(2) One-half of the necessary operating funds will be derived from an assessment on health care providers and facilities. Each provider's or facility's assessment will be that portion of the one-half of the necessary operating funds that is equivalent to the proportion of total health care expenditures that were the result of services provided by that provider or facility during the previous calendar year in the regional council's jurisdiction.

(3) The assessments authorized under this section shall be computed, assessed, and collected annually by the county or counties in each regional council's jurisdiction.

NEW SECTION. **Sec. 507.** A new section is added to chapter 4.24 RCW to read as follows:

(1) The state health policy council established under section 501 of this act, in consultation with obstetrical medical specialty organizations and appropriate governmental entities, shall develop practice parameters in obstetrics for purposes of the health care liability demonstration project set forth in this section. The obstetrical practice parameters shall define appropriate clinical indications and methods of treatment. The parameters shall be consistent with appropriate standards of care and levels of quality. On or before July 1, 1993, the medical disciplinary board shall review the parameters, approve the parameters, and adopt them as rules under chapter 34.05 RCW.

(2) In any claim for professional negligence against a participating physician or the employer of a participating physician that is related to the practice of obstetrics, in which a violation of a standard of care is alleged, the practice parameters developed and adopted under this section shall constitute the standard of care and may be introduced into evidence by the participating physician or the participating physician's employer as an affirmative defense.

(a) Any participating physician or participating physician's employer who pleads compliance with the practice parameters as an affirmative defense to a claim for professional negligence has the burden of proving that the participating physician's conduct was consistent with those parameters in order to rely upon the affirmative defense as the basis for a determination that the participating

physician's conduct did not constitute professional negligence. If the participating physician or the participating physician's employer introduces at trial evidence of compliance with the parameters, then the plaintiff may introduce evidence on the issue of compliance.

(3) Any physician who practices obstetrics in Washington state shall file notice with the medical disciplinary board on or before November 1, 1993, indicating whether he or she elects to participate in the project.

(4) Nothing in this section alters the burdens of proof in existence as of June 30, 1993, in professional negligence proceedings.

(5) This section applies to causes of action accruing after January 1, 1994.

PART VI
REVENUES

NEW SECTION. Sec. 601. The taxes in sections 601 through 614 of this act are intended to provide funding for the purposes of this act for fiscal years 1993 and 1994. The legislature intends to provide additional funding for future years, including an annual growth factor for fiscal years 1995 and 1996 that is equal to the growth provided in sections 601 through 614 of this act for fiscal year 1994 over fiscal year 1993.

NEW SECTION. **Sec. 602.** A new section is added to chapter 82.32 RCW to read as follows:

The health care revenue account is hereby created in the state treasury. Except for unanticipated receipts under chapter 43.79 RCW, moneys in the account may be spent only after appropriation. Moneys in the account shall be allocated by appropriation solely for the purposes

of the basic health plan under chapter 70.47 RCW and the uniform benefit package revolving fund under section 202 of this act.

Sec. 603. RCW 82.26.020 and 1983 2nd ex.s. c 3 s 16 are each amended to read as follows:

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

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

(3) Effective June 1, 1992, an additional tax is imposed equal to seven and forty-five one-hundredths of one percent of the wholesale sales price of tobacco products. Effective June 1, 1993, the additional tax imposed under this subsection is equal to fifteen percent of the wholesale sales price of tobacco products. Revenue collected under this subsection shall be deposited in the health care revenue account under section 602 of this act.

Sec. 604. RCW 82.24.020 and 1989 c 271 s 504 are each amended to read as follows:

(1) There is levied and there shall be collected as hereinafter provided, a tax upon the sale, use, consumption, handling, possession

or distribution of all cigarettes, in an amount equal to the rate of eleven and one-half mills per cigarette.

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

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

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

(5) Effective July 1, 1992, an additional tax is imposed upon the sale, use, consumption, handling, possession, or distribution of all cigarettes, in an amount equal to the rate of one and six hundred seventy-five one-thousandths mills per cigarette. Effective July 1, 1993, the additional tax under this subsection is equal to the rate of three and thirty-five one-hundredths mills per cigarette. Revenue collected under this subsection shall be deposited in the health care revenue account under section 602 of this act.

Sec. 605. RCW 82.08.150 and 1989 c 271 s 503 are each amended to read as follows:

(1) There is levied and shall be collected a tax upon each retail sale of spirits, or strong beer in the original package at the rate of fifteen percent of the selling price. The tax imposed in this subsection shall apply to all such sales including sales by the Washington state liquor stores and agencies, but excluding sales to class H licensees.

(2) There is levied and shall be collected a tax upon each sale of spirits, or strong beer in the original package at the rate of ten percent of the selling price on sales by Washington state liquor stores and agencies to class H licensees.

(3) There is levied and shall be collected an additional tax upon each retail sale of spirits in the original package at the rate of one dollar and seventy-two cents per liter. The additional tax imposed in this subsection shall apply to all such sales including sales by Washington state liquor stores and agencies, and including sales to class H licensees.

(4) An additional tax is imposed equal to the rate specified in RCW 82.02.030 multiplied by the taxes payable under subsections (1), (2), and (3) of this section.

(5) Until July 1, 1995, an additional tax is imposed upon each retail sale of spirits in the original package at the rate of seven cents per liter. The additional tax imposed in this subsection shall apply to all such sales including sales by Washington state liquor stores and agencies, and including sales to class H licensees. All revenues collected during any month from this additional tax shall be deposited in the drug enforcement and education account under RCW 69.50.520 by the twenty-fifth day of the following month.

(6) Effective June 1, 1992, an additional tax is imposed upon each retail sale of spirits in the original package at the rate of twenty-four cents per liter. Effective June 1, 1993, the rate of additional

tax imposed under this subsection is equal to forty-eight cents per liter. The additional tax imposed in this subsection shall apply to all such sales including sales to class H licensees. All revenues collected from the additional tax under this subsection shall be deposited in the health care revenue account under section 602 of this act.

(7) The tax imposed in RCW 82.08.020, as now or hereafter amended, shall not apply to sales of spirits or strong beer in the original package.

((~~(7)~~)) (8) The taxes imposed in this section shall be paid by the buyer to the seller, and each seller shall collect from the buyer the full amount of the tax payable in respect to each taxable sale under this section. The taxes required by this section to be collected by the seller shall be stated separately from the selling price and for purposes of determining the tax due from the buyer to the seller, it shall be conclusively presumed that the selling price quoted in any price list does not include the taxes imposed by this section.

((~~(8)~~)) (9) As used in this section, the terms, "spirits," "strong beer," and "package" shall have the meaning ascribed to them in chapter 66.04 RCW.

Sec. 606. RCW 82.08.160 and 1982 1st ex.s. c 35 s 4 are each amended to read as follows:

On or before the twenty-fifth day of each month, all taxes collected under RCW 82.08.150 during the preceding month shall be remitted to the state department of revenue, to be deposited with the state treasurer, with the exception of the additional taxes under RCW 82.08.150(6), which shall be deposited in the health care revenue account under section 602 of this act. Upon receipt of such moneys the state treasurer shall credit sixty-five percent of the sums collected

and remitted under RCW 82.08.150 (1) and (2) and one hundred percent of the sums collected and remitted under RCW 82.08.150 (3) and (4) to the state general fund and thirty-five percent of the sums collected and remitted under RCW 82.08.150 (1) and (2) to a fund which is hereby created to be known as the "liquor excise tax fund."

Sec. 607. RCW 66.24.210 and 1991 c 192 s 3 are each amended to read as follows:

(1) There is hereby imposed upon all wines sold to wine wholesalers and the Washington state liquor control board, within the state a tax at the rate of twenty and one-fourth cents per liter: PROVIDED, HOWEVER, That wine sold or shipped in bulk from one winery to another winery shall not be subject to such tax. The tax provided for in this section may, if so prescribed by the board, be collected by means of stamps to be furnished by the board, or by direct payments based on wine purchased by wine wholesalers. Every person purchasing wine under the provisions of this section shall on or before the twentieth day of each month report to the board all purchases during the preceding calendar month in such manner and upon such forms as may be prescribed by the board, and with such report shall pay the tax due from the purchases covered by such report unless the same has previously been paid. Any such purchaser of wine whose applicable tax payment is not postmarked by the twentieth day following the month of purchase will be assessed a penalty at the rate of two percent a month or fraction thereof. If this tax be collected by means of stamps, every such person shall procure from the board revenue stamps representing the tax in such form as the board shall prescribe and shall affix the same to the package or container in such manner and in such denomination as required by the board and shall cancel the same prior to the delivery of the package or container containing the wine to the purchaser. If

the tax is not collected by means of stamps, the board may require that every such person shall execute to and file with the board a bond to be approved by the board, in such amount as the board may fix, securing the payment of the tax. If any such person fails to pay the tax when due, the board may forthwith suspend or cancel the license until all taxes are paid.

(2) An additional tax is imposed equal to the rate specified in RCW 82.02.030 multiplied by the tax payable under subsection (1) of this section. All revenues collected during any month from this additional tax shall be transferred to the state general fund by the twenty-fifth day of the following month.

(3) An additional tax is imposed on wines subject to tax under subsection (1) of this section, at the rate of one-fourth of one cent per liter for wine sold after June 30, 1987. Such additional tax shall cease to be imposed on July 1, 1993. All revenues collected under this subsection (3) shall be disbursed quarterly to the Washington wine commission for use in carrying out the purposes of chapter 15.88 RCW.

(4) Until July 1, 1995, an additional tax is imposed on all wine subject to tax under subsection (1) of this section. The additional tax is equal to twenty-three and forty-four one-hundredths cents per liter on fortified wine as defined in RCW 66.04.010(34) when bottled or packaged by the manufacturer and one cent per liter on all other wine. All revenues collected during any month from this additional tax shall be deposited in the drug enforcement and education account under RCW 69.50.520 by the twenty-fifth day of the following month.

(5) Effective May 1, 1992, an additional tax is imposed on all wine subject to taxes under subsection (1) of this section. The additional tax is equal to five cents per liter on fortified wine as defined in RCW 66.04.010(34) when bottled or packaged by the manufacturer and three cents per liter on all other wine. Effective May 1, 1993, the

additional tax imposed under this subsection is equal to ten cents per liter on fortified wine as defined in RCW 66.04.010(34) when bottled or packaged by the manufacturer and six cents per liter on all other wine. Revenue collected under this subsection shall be deposited in the health care revenue account under section 602 of this act.

Sec. 608. RCW 66.08.180 and 1987 c 458 s 10 are each amended to read as follows:

Moneys in the liquor revolving fund shall be distributed by the board at least once every three months in accordance with RCW 66.08.190, 66.08.200 and 66.08.210: PROVIDED, That the board shall reserve from distribution such amount not exceeding five hundred thousand dollars as may be necessary for the proper administration of this title: AND PROVIDED FURTHER, That all license fees, penalties and forfeitures derived under this act from class H licenses or class H licensees shall every three months be disbursed by the board as follows:

(1) 5.95 percent to the University of Washington and 3.97 percent to Washington State University for alcoholism and drug abuse research and for the dissemination of such research;

(2) 1.75 percent, but in no event less than one hundred fifty thousand dollars per biennium, to the University of Washington to conduct the state toxicological laboratory pursuant to RCW ((~~68.08.107~~)) 68.50.107;

(3) 88.33 percent to the general fund to be used by the department of social and health services solely to carry out the purposes of RCW 70.96.085, as now or hereafter amended;

(4) The first fifty-five dollars per license fee provided in RCW 66.24.320 and 66.24.330 up to a maximum of one hundred fifty thousand dollars annually shall be disbursed every three months by the board to

the general fund to be used for juvenile alcohol and drug prevention programs for kindergarten through third grade to be administered by the superintendent of public instruction;

(5) Twenty percent of the remaining total amount derived from license fees pursuant to RCW 66.24.320, 66.24.330, 66.24.340, 66.24.350, 66.24.360, and 66.24.370, shall be transferred to the general fund to be used by the department of social and health services solely to carry out the purposes of RCW 70.96.085; and

(6) One-fourth cent per liter of the tax imposed by RCW 66.24.210, except for the additional tax under RCW 66.24.210(5), shall every three months be disbursed by the board to Washington State University solely for wine and wine grape research, extension programs related to wine and wine grape research, and resident instruction in both wine grape production and the processing aspects of the wine industry in accordance with RCW 28B.30.068. The director of financial management shall prescribe suitable accounting procedures to ensure that the funds transferred to the general fund to be used by the department of social and health services and appropriated are separately accounted for.

Sec. 609. RCW 66.24.290 and 1989 c 271 s 502 are each amended to read as follows:

(1) Any brewer or beer wholesaler licensed under this title may sell and deliver beer to holders of authorized licenses direct, but to no other person, other than the board; and every such brewer or beer wholesaler shall report all sales to the board monthly, pursuant to the regulations, and shall pay to the board as an added tax for the privilege of manufacturing and selling the beer within the state a tax of two dollars and sixty cents per barrel of thirty-one gallons on sales to licensees within the state and on sales to licensees within the state of bottled and canned beer shall pay a tax computed in

gallons at the rate of two dollars and sixty cents per barrel of thirty-one gallons. Any brewer or beer wholesaler whose applicable tax payment is not postmarked by the twentieth day following the month of sale will be assessed a penalty at the rate of two percent per month or fraction thereof. Each such brewer or wholesaler shall procure from the board revenue stamps representing such tax in form prescribed by the board and shall affix the same to the barrel or package in such manner and in such denominations as required by the board, and shall cancel the same prior to commencing delivery from his place of business or warehouse of such barrels or packages. Beer shall be sold by brewers and wholesalers in sealed barrels or packages. The revenue stamps herein provided for need not be affixed and canceled in the making of resales of barrels or packages already taxed by the affixation and cancelation of stamps as provided in this section.

(2) An additional tax is imposed equal to the rate specified in RCW 82.02.030 multiplied by the tax payable under subsection (1) of this section. All revenues collected during any month from this additional tax shall be transferred to the state general fund by the twenty-fifth day of the following month.

(3) Until July 1, 1995, an additional tax is imposed on all beer subject to tax under subsection (1) of this section. The additional tax is equal to two dollars per barrel of thirty-one gallons. All revenues collected during any month from this additional tax shall be deposited in the drug enforcement and education account under RCW 69.50.520 by the twenty-fifth day of the following month.

(4) Effective May 1, 1992, an additional tax is imposed on all beer subject to tax under subsection (1) of this section. The additional tax is equal to fifty-six cents per barrel of thirty-one gallons. Effective May 1, 1993, the additional tax under this subsection is equal to one dollar and twelve cents per barrel of thirty-one gallons.

Revenues collected under this subsection shall be deposited in the health care revenue account under section 602 of this act.

(5) The tax imposed under this section shall not apply to "strong beer" as defined in this title.

NEW SECTION. **Sec. 610.** A new section is added to chapter 82.04 RCW to read as follows:

(1) As used in this section, "snack foods" includes:

(a) Candy, including but not limited to loose, bulk, and individually packaged confections that are commonly considered candy, including hard candy, caramel, chocolate candy, nuts and fruit coated in natural or artificial sweeteners, caramel-coated popcorn, licorice, jelly beans, breath mints, and cotton candy. Confections that are primarily sold for cooking purposes are not candy for the purposes of this section. "Snack foods" does not include jams, jellies, preserves, honey, syrup, frosting, breakfast cereals, granola and other breakfast bars, dried fruit and preparations of fruit in a sugar or similar base, or candy and chocolate primarily intended for the preparation or decorating of baked goods.

(b) All forms of chewing gum, whether sweetened with natural or artificial sweeteners.

(c) Fresh and frozen doughnuts, cakes, cupcakes, cookies, and pies, sold either packaged or in bulk.

(d) Ice cream, ice cream bars, ice milk and ice milk products, or other products made from natural or artificial frozen dairy products, milk shakes, malted milk, and similar beverages made from natural or artificial frozen dairy products, frozen yogurt and frozen yogurt products, including beverages made with frozen yogurt, sherbet, popsicles and similar frozen drink bars, frozen fruit juice bars, frozen pudding, frozen gelatin, or any other similar frozen dessert

that the general consuming public would consider to be an ice cream or similar product.

(e) Potato chips, corn chips, tortilla chips, pretzels, puffed cheese, or similar snack products other than crackers and nuts.

(f) Other food items identified by the department, by rule, as being snack foods consistent with the purposes of this section. "Snack foods" shall not include any item subject to sales tax under RCW 82.08.020.

(2) Effective June 1, 1992, there is levied and shall be collected from every person for the act or privilege of engaging within this state in business as a manufacturer of snack foods an additional tax equal to the value of snack foods manufactured multiplied by the rate of one and one-half percent. Effective June 1, 1993, the rate of tax under this subsection is three percent.

(3) Effective June 1, 1992, there is levied and shall be collected from every person for the act or privilege of engaging within this state in the business of making sales at wholesale of snack foods an additional tax equal to the gross proceeds of sales of snack foods multiplied by the rate of one and one-half percent. Effective June 1, 1993, the rate of tax under this subsection is three percent.

(4) Effective June 1, 1992, there is levied and shall be collected from every person for the act or privilege of engaging within this state in the business of making sales at retail of snack foods an additional tax equal to the gross proceeds of sales of snack foods multiplied by the rate of one and one-half percent. Effective June 1, 1993, the rate of tax under this subsection is three percent.

(5) Revenue collected under this section shall be deposited in the health care revenue account under section 602 of this act.

Sec. 611. RCW 82.04.500 and 1961 c 15 s 82.04.500 are each amended to read as follows:

(1) Except as provided in subsection (2) of this section, it is not the intention of this chapter that the taxes herein levied upon persons engaging in business be construed as taxes upon the purchasers or customers, but that such taxes shall be levied upon, and collectible from, the person engaging in the business activities herein designated and that such taxes shall constitute a part of the operating overhead of such persons.

(2) The taxes imposed in section 610 of this act are intended to be passed on to the ultimate consumer, in the manner and to the extent deemed practical by each taxpayer.

NEW SECTION. **Sec. 612.** A new section is added to chapter 82.04 RCW to read as follows:

In computing tax there may be deducted from the measure of tax amounts derived as compensation for services rendered or to be rendered to patients or from sales of prescription drugs as defined in RCW 82.08.0281 furnished as an integral part of services rendered to patients by a health care organization operating as an organized delivery system under section 206 of this act.

An organization may claim a deduction under this section only during the first three years after the organization executes its initial contract to deliver services as an organized delivery system.

NEW SECTION. **Sec. 613.** A new section is added to chapter 48.14 RCW to read as follows:

Effective January 1, 1995, each group disability insurer that is not complying with section 409(4) of this act shall pay an additional tax on premiums, as part of the tax imposed in RCW 48.14.020, equal to

the tax payable under RCW 48.14.020 on that portion of premiums received through an organized delivery system that exceeds fifty percent of the total premiums received by the group disability insurer.

NEW SECTION. **Sec. 614.** A new section is added to chapter 82.04 RCW to read as follows:

Effective January 1, 1995, there is levied and shall be collected from each health care service contractor that is not complying with section 410(4) of this act and each health maintenance organization that is not complying with section 411(4) of this act, for the act or privilege of engaging in business activities, as a part of the tax imposed in RCW 82.04.290, an additional tax equal to the tax payable under RCW 82.04.290 on that portion of the gross income of the business received through an organized delivery system that exceeds fifty percent of the total gross income of the business of the taxpayer.

PART VII

MISCELLANEOUS

NEW SECTION. **Sec. 701.** Part headings as used in this act constitute no part of the law.

NEW SECTION. **Sec. 702.** Sections 101, 102, 201, 204 through 207, 501 through 503, 505, and 506 of this act shall constitute a new chapter in Title 70 RCW.

NEW SECTION. **Sec. 703.** (1) Sections 301 through 315, 401 through 406, 604, and 612 of this act shall take effect July 1, 1992.

(2) Sections 603, 605, 606, 610, and 611 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 June 1, 1992.

(3) Sections 602, 607, 608, and 609 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 May 1, 1992.

NEW SECTION. **Sec. 704.** 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.