

SIXTY-FIRST DAY

MORNING SESSION

Senate Chamber, Olympia, Friday, March 9, 2007

The Senate was called to order at 9:30 a.m. by President Owen. The Secretary called the roll and announced to the President that all Senators were present with the exception of Senators Berkey, Delvin and Prentice.

The Sergeant at Arms Color Guard consisting of Pages David Hirschberger and Mandi Roach, presented the Colors. Member Mary Lynne Reinier of Temple Beth Hatfiloh Church offered the prayer.

MOTION

On motion of Senator Eide, the reading of the Journal of the previous day was dispensed with and it was approved.

MOTION

On motion of Senator Eide, the Senate advanced to the fourth order of business.

MESSAGE FROM THE HOUSE

March 8, 2007

MR. PRESIDENT:

The House has passed the following bills:
 ENGROSSED SUBSTITUTE HOUSE BILL NO. 1050,
 SECOND SUBSTITUTE HOUSE BILL NO. 1096,
 HOUSE BILL NO. 1517,
 SUBSTITUTE HOUSE BILL NO. 1566,
 ENGROSSED HOUSE BILL NO. 1967,
 ENGROSSED HOUSE BILL NO. 2070,
 and the same are herewith transmitted.

RICHARD NAFZIGER, Chief Clerk

MESSAGE FROM THE HOUSE

March 8, 2007

MR. PRESIDENT:

The House has passed the following bills:
 SUBSTITUTE HOUSE BILL NO. 1091,
 SECOND SUBSTITUTE HOUSE BILL NO. 1106
 SECOND SUBSTITUTE HOUSE BILL NO. 1178,
 SUBSTITUTE HOUSE BILL NO. 1276,
 SUBSTITUTE HOUSE BILL NO. 1337,
 SUBSTITUTE HOUSE BILL NO. 1965,
 SUBSTITUTE HOUSE BILL NO. 2007,
 HOUSE BILL NO. 2026,
 HOUSE BILL NO. 2033,
 SUBSTITUTE HOUSE BILL NO. 2103,
 SUBSTITUTE HOUSE BILL NO. 2129,
 HOUSE BILL NO. 2137,
 HOUSE BILL NO. 2161,
 HOUSE BILL NO. 2263,
 and the same are herewith transmitted.

RICHARD NAFZIGER, Chief Clerk

MESSAGE FROM THE HOUSE

March 8, 2007

MR. PRESIDENT:

The House has passed the following bills:

SECOND SUBSTITUTE HOUSE BILL NO. 1277,
 HOUSE BILL NO. 1298,
 HOUSE BILL NO. 1313,
 HOUSE BILL NO. 2032,
 SECOND SUBSTITUTE HOUSE BILL NO. 2055,
 HOUSE BILL NO. 2163,
 HOUSE JOINT MEMORIAL NO. 4017,
 and the same are herewith transmitted.

RICHARD NAFZIGER, Chief Clerk

MESSAGE FROM THE HOUSE

March 8, 2007

MR. PRESIDENT:

The House has passed the following bills:
 ENGROSSED SUBSTITUTE HOUSE BILL NO. 1030,
 ENGROSSED SUBSTITUTE HOUSE BILL NO. 1147,
 ENGROSSED SUBSTITUTE HOUSE BILL NO. 1226,
 ENGROSSED SUBSTITUTE HOUSE BILL NO. 1512,
 ENGROSSED SUBSTITUTE HOUSE BILL NO. 2073,
 and the same are herewith transmitted.

RICHARD NAFZIGER, Chief Clerk

MOTION

On motion of Senator Eide, the Senate advanced to the fifth order of business.

INTRODUCTION AND FIRST READING

SJM 8020 by Senators Jacobsen and Spanel

Seeking congressional action to limit credit card interchange fees and to develop clear and concise consumer disclosure on such fees.

Referred to Committee on Financial Institutions & Insurance.

INTRODUCTION AND FIRST READING OF HOUSE BILLS

ESHB 1008 by House Committee on Judiciary (originally sponsored by Representatives Moeller, Lovick, Kagi, Cody, Appleton, Conway, Morrell, Kenney, Simpson, B. Sullivan, Goodman and Lantz)

AN ACT Relating to the protection of vulnerable adults; amending RCW 74.34.020, 74.34.110, 74.34.120, 74.34.145, 74.34.150, and 74.34.210; reenacting and amending RCW 74.34.130; and adding new sections to chapter 74.34 RCW.

Referred to Committee on Judiciary.

HB 1049 by Representatives Fromhold, Orcutt, Moeller, Wallace, Dunn and B. Sullivan

AN ACT Relating to the Vancouver national historic reserve; adding new sections to chapter 27.34 RCW; and creating a new section.

Referred to Committee on Government Operations & Elections.

SIXTY-FIRST DAY, MARCH 9, 2007

2SHB 1076 by House Committee on Appropriations (originally sponsored by Representatives Blake, Takko, B. Sullivan and Moeller)

AN ACT Relating to rockfish research; amending RCW 77.65.150, 77.65.210, and 77.32.470; adding a new section to chapter 77.12 RCW; creating a new section; providing an expiration date; and declaring an emergency.

Referred to Committee on Natural Resources, Ocean & Recreation.

HB 1137 by Representatives Fromhold, McDonald, Ormsby, Moeller and Haler

AN ACT Relating to creating the water quality capital account; adding a new section to chapter 70.146 RCW; providing an effective date; and declaring an emergency.

Referred to Committee on Ways & Means.

EHB 1189 by Representatives Dunshee, Lovick, Miloscia, Ormsby, Simpson and Hasegawa

AN ACT Relating to campaign contributions by limited liability companies; and amending RCW 42.17.660.

Referred to Committee on Government Operations & Elections.

SHB 1266 by House Committee on Appropriations (originally sponsored by Representatives Conway, Fromhold, B. Sullivan, Kenney, Ericks, Simpson and Moeller)

AN ACT Relating to death benefits for public employees; and amending RCW 41.04.017, 41.26.048, 41.32.053, 41.35.115, 41.37.110, 41.40.0931, 41.40.0932, and 43.43.285.

Referred to Committee on Ways & Means.

SHB 1278 by House Committee on Commerce & Labor (originally sponsored by Representatives Conway, Simpson and Kenney)

AN ACT Relating to revising the industry average unemployment contribution rates; amending RCW 50.29.025; and creating new sections.

Referred to Committee on Labor, Commerce, Research & Development.

SHB 1314 by House Committee on Technology, Energy & Communications (originally sponsored by Representatives Morris, Crouse, Linville and Anderson)

AN ACT Relating to regulation of gas and hazardous liquid pipelines; amending RCW 81.88.010, 81.88.040, 81.88.050, 81.88.060, 81.88.080, 81.88.090, 81.88.100, 19.122.020, and 81.04.490; adding a new section to chapter 81.88 RCW; and repealing RCW 80.28.205, 80.28.207, 80.28.210, 80.28.212, 80.28.215, and 81.88.150.

Referred to Committee on Water, Energy & Telecommunications.

HB 1430 by Representatives Pettigrew, Haler, Kenney, Chase, P. Sullivan and Linville

AN ACT Relating to financing community and economic development; amending RCW 35.21.735; and creating new sections.

Referred to Committee on Economic Development, Trade & Management.

EHB 1436 by Representatives McIntire, Chase, Dunshee, Sells, Wallace, Jarrett, Anderson, Kenney, Ormsby, Roberts, Haigh, Ericks and O'Brien

AN ACT Relating to authorizing the Washington higher education facilities authority to originate and purchase educational loans and to issue student loan revenue bonds; amending RCW 28B.07.030; adding new sections to chapter 28B.07 RCW; and creating new sections.

Referred to Committee on Higher Education.

HB 1443 by Representatives Grant, Buri, Blake, Walsh, B. Sullivan, Linville, Hailey, Newhouse and O'Brien

AN ACT Relating to a state public utility tax deduction for certain transportation activities with respect to agricultural commodities; and amending RCW 82.16.050.

Referred to Committee on Agriculture & Rural Economic Development.

SHB 1456 by House Committee on Appropriations (originally sponsored by Representatives Green, Hinkle, Appleton, Cody, Moeller, Strow, Crouse, Curtis, Seaquist, Jarrett, Hasegawa, Walsh, P. Sullivan, Buri, Simpson, O'Brien, Lantz, Hunt, McDonald, Sells, Schual-Berke, Linville, Kessler, Hankins, Haler, Skinner, Campbell, Morrell, Darneille, Armstrong, Dunshee, Fromhold, Kagi, Williams, Conway, Barlow, Grant, Priest, Dunn, Hunter, Hurst, Ericks, Pearson, Anderson, Clibborn, Pettigrew, Flannigan, Lovick, Dickerson, Kenney, Ormsby, Haigh, Wood, Rolfes, Santos and McDermott)

AN ACT Relating to home visits by mental health professionals; adding new sections to chapter 71.05 RCW; and creating new sections.

Referred to Committee on Human Services & Corrections.

SHB 1458 by House Committee on Judiciary (originally sponsored by Representatives VanDeWege, Kessler, Rodne, Appleton, Ahern, Curtis, Kenney, Clibborn, Morrell, P. Sullivan, Eickmeyer, Armstrong, Buri, Chandler, Erickson, Hinkle, Condotta, Anderson, Eddy, Goodman, Kelley, Haler, McCune, Kretz, Kagi, Ericks, Warnick, Pedersen, Bailey, Newhouse, McDonald, Priest, Roach, Strow, Green, Campbell, Hunter, Takko, Sells, Springer, McCoy, Upthegrove, Williams, Moeller, Ormsby, Pearson, Haigh, Linville, Conway, Dickerson, Dunn, Hasegawa, Rolfes, Ross and Lantz)

AN ACT Relating to adequate notice to property owners regarding acquisition of property for public purposes through the exercise of eminent domain; amending RCW 8.12.530; adding a new section to chapter 8.25 RCW; adding a new section to chapter 8.04 RCW; adding a new section to chapter 8.08 RCW; adding a new section to chapter 8.12 RCW; adding a new section to chapter 8.16 RCW; and adding a new section to chapter 8.20 RCW.

Referred to Committee on Judiciary.

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

HB 1501 by Representatives Wood, Conway, Williams, Chase, Kenney and Moeller

AN ACT Relating to adjustments to industrial insurance total disability compensation reductions; and amending RCW 51.32.220.

Referred to Committee on Labor, Commerce, Research & Development.

HB 1592 by Representative Hurst

AN ACT Relating to the indeterminate sentenced offenders; and amending RCW 9.95.011, 9.95.420, 9.95.435, and 9.96.050.

Referred to Committee on Human Services & Corrections.

SHB 1605 by House Committee on Select Committee on Puget Sound (originally sponsored by Representatives Eickmeyer, Haigh, Upthegrove, Blake, Lantz, Seaquist, Linville, Chase, Pedersen, Morris, Wood and Rolfes)

AN ACT Relating to the effect of extension of sewer services in aquatic rehabilitation zone one; amending RCW 36.70A.110; and adding a new section to chapter 36.70A RCW.

Referred to Committee on Water, Energy & Telecommunications.

HB 1671 by Representative Green

AN ACT Relating to reclassifications, class studies, and salary adjustments; and amending RCW 41.06.152.

Referred to Committee on Labor, Commerce, Research & Development.

HB 1672 by Representative Green

AN ACT Relating to the authority of the director of the Washington state department of personnel and the Washington personnel resources board; amending RCW 41.06.070, 41.06.093, 41.06.420, 41.48.140, 41.04.670, 43.43.832, 70.24.300, 72.01.210, and 72.02.045; reenacting and amending RCW 41.06.150; and repealing RCW 41.06.136.

Referred to Committee on Government Operations & Elections.

HB 1706 by Representatives Conway, Hunt, Wood, Hurst, Simpson and Appleton

AN ACT Relating to removing expiration dates for state consent to federal court jurisdiction in actions under the Indian gaming regulatory act; and amending RCW 9.46.36001.

Referred to Committee on Labor, Commerce, Research & Development.

HB 1747 by Representatives Simpson and Rodne

AN ACT Relating to the acquisition of insurance for regional transit authority projects over one hundred million dollars; and amending RCW 81.112.060.

Referred to Committee on Transportation.

ESHB 1755 by House Committee on Insurance, Financial Services & Consumer Protection (originally sponsored by Representatives Hurst, O'Brien, Eddy, Kessler, Lovick, Rolfes, Williams, Dunshee, Kenney, Green, Hunter, Quall, VanDeWege, Simpson, Hasegawa and Ormsby)

AN ACT Relating to consumer credit reports; amending RCW 19.182.170; and providing an effective date.

Referred to Committee on Financial Institutions & Insurance.

SHB 1784 by House Committee on Capital Budget (originally sponsored by Representatives Kenney, Sells, Buri and Wood)

AN ACT Relating to investment of funds derived from the sale of lands set apart for institutions of higher education; amending RCW 39.42.070, 39.42.090, 43.33A.150, 43.79.010, 43.79.060, 43.79.110, 43.79.130, and 43.79.160; creating a new section; and providing a contingent effective date.

Referred to Committee on Ways & Means.

HB 1789 by Representatives Kagi, Priest, Hunter, Jarrett, Dunshee, Orcutt, Linville, Strow, Dickerson, McCoy, B. Sullivan, Lantz, Hunt, Chase, Rodne and Schual-Berke

AN ACT Relating to minimizing the environmental threat caused by leaking home heating oil tanks; amending RCW 70.149.040; adding a new section to chapter 70.149 RCW; and creating a new section.

Referred to Committee on Water, Energy & Telecommunications.

HB 1793 by Representatives Lantz, Hinkle, Springer, Rodne, O'Brien, Kenney, Schual-Berke, Clibborn, Newhouse, Lovick, Williams, Dickerson, McIntire, Appleton, Hasegawa, Ericks, Roberts, Wood and Moeller

AN ACT Relating to removing the limit on the number of cities eligible for indigent defense grants through the office of public defense; and amending RCW 10.101.080.

Referred to Committee on Judiciary.

HB 1820 by Representatives Dickerson, Hankins, Lovick, B. Sullivan, Simpson, Hasegawa and Moeller

AN ACT Relating to reducing air pollution through the licensing and use of medium-speed electric vehicles; amending RCW 46.61.688; reenacting and amending RCW 46.04.320 and 46.61.687; adding a new section to chapter 46.04 RCW; adding a new section to chapter 46.61 RCW; prescribing penalties; and providing an effective date.

Referred to Committee on Transportation.

SHB 1832 by House Committee on State Government & Tribal Affairs (originally sponsored by Representatives Hunt, Chandler, Williams, Ormsby and Condotta)

AN ACT Relating to limitation on actions; and amending RCW 42.17.400 and 42.17.410.

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

Referred to Committee on Government Operations & Elections.

HB 1836 by Representatives Ericks, Pearson, Lovick, Williams, Kelley, Kretz, Hurst and Simpson

AN ACT Relating to requiring registered sex and kidnapping offenders to register after serving a term of confinement for a subsequent offense that is not a sex or kidnapping offense; and reenacting and amending RCW 9A.44.130.

Referred to Committee on Human Services & Corrections.

HB 1852 by Representatives Green, Cody, Kenney and Schual-Berke

AN ACT Relating to treatment records; and amending RCW 71.05.630 and 71.05.020.

Referred to Committee on Human Services & Corrections.

SHB 1865 by House Committee on Judiciary (originally sponsored by Representatives Williams, O'Brien, Springer, Fromhold, Warnick and McCune)

AN ACT Relating to limiting the obligations of landlords under writs of restitution; amending RCW 59.18.312; creating a new section; and declaring an emergency.

Referred to Committee on Consumer Protection & Housing.

HB 1870 by Representatives Pedersen, Ross, Lovick, Bailey, Hunt, Hasegawa, Pettigrew, Skinner, Flannigan, Darneille, Roberts, Newhouse, Hankins, Walsh, Appleton, Santos, Lantz, McCoy, Rodne, Schual-Berke, Ormsby, Upthegrove, Morrell, Kessler, Williams, Kenney, McDermott and Chase

AN ACT Relating to a Washington state day of remembrance for Juneteenth; amending RCW 1.16.050; and creating a new section.

Referred to Committee on Government Operations & Elections.

SHB 1880 by House Committee on Appropriations (originally sponsored by Representatives Wallace, Anderson, Ormsby, Buri, Curtis, Haigh, Priest, Armstrong, Jarrett, Roberts, Kenney, Conway, Morrell and Wood)

AN ACT Relating to creating the skills-based economic growth program; amending RCW 28C.18.010; adding new sections to chapter 28C.18 RCW; and creating a new section.

Referred to Committee on Higher Education.

HB 1925 by Representatives Curtis, Fromhold, Orcutt, Moeller, Wallace, Dunn and Hinkle

AN ACT Relating to removing a termination date affecting industrial land banks; and amending RCW 36.70A.367.

Referred to Committee on Government Operations & Elections.

HB 1949 by Representatives Williams, Conway, B. Sullivan, Strow, Sells, Appleton, Kessler, Hinkle, McCoy,

Walsh, Chandler, Pearson, Condotta, Kenney, Hasegawa, Moeller and Ormsby

AN ACT Relating to providing industrial insurance coverage for workers involved in harvesting geoduck clams; and amending RCW 51.12.100.

Referred to Committee on Labor, Commerce, Research & Development.

SHB 1977 by House Committee on Education (originally sponsored by Representatives Quall, Fromhold, Priest, Curtis, Ormsby, Hunt, P. Sullivan, Haigh, Dunn, Kenney, Morrell and Wood)

AN ACT Relating to skill centers; amending RCW 84.52.068; adding a new chapter to Title 28A RCW; and creating a new section.

Referred to Committee on Early Learning & K-12 Education.

SHB 1987 by House Committee on Judiciary (originally sponsored by Representatives Wamick, Armstrong, Haler, Hailey, Sump, McCune, VanDeWege, Skinner, Kristiansen and Rodne)

AN ACT Relating to exempting property owners from injury caused to another person as a result of metal theft; and adding a new section to chapter 4.24 RCW.

Referred to Committee on Judiciary.

SHB 1988 by House Committee on Commerce & Labor (originally sponsored by Representatives Morrell, DeBolt, Lovick, Conway, Green, Hudgins and Kenney)

AN ACT Relating to security guard training; amending RCW 18.170.010; adding a new section to chapter 18.170 RCW; and repealing RCW 18.170.100.

Referred to Committee on Labor, Commerce, Research & Development.

SHB 2003 by House Committee on State Government & Tribal Affairs (originally sponsored by Representatives Alexander, Hunt, Morrell and Ormsby)

AN ACT Relating to a pilot program for the business enterprises program; amending RCW 74.18.200; adding a new section to chapter 74.18 RCW; and declaring an emergency.

Referred to Committee on Labor, Commerce, Research & Development.

HB 2034 by Representatives Jarrett, Clibborn, Roberts and Hurst

AN ACT Relating to providing a civil cause of action for victims of motor vehicle theft; amending RCW 46.20.291; adding a new section to chapter 9A.56 RCW; and prescribing penalties.

Referred to Committee on Judiciary.

HB 2104 by Representatives Curtis, Simpson, Ross and Eddy

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

AN ACT Relating to real property electronic recording; and adding a new chapter to Title 65 RCW.

Referred to Committee on Government Operations & Elections.

HB 2170 by Representatives Ross, O'Brien, Pearson, Newhouse, Curtis, Rodne, McCune, Kelley, Eddy, Goodman, VanDeWege, Hurst, Simpson and Moeller

AN ACT Relating to protecting employees, contract staff, and volunteers of a law enforcement agency; amending RCW 9A.46.110; and prescribing penalties.

Referred to Committee on Judiciary.

ESHB 2171 by House Committee on Commerce & Labor (originally sponsored by Representatives Eddy, Conway, Campbell, Hankins, Sells, Ormsby, Moeller, Ericks, Roberts, Darneille, Hunt, Blake, Kessler, Rolfes, Flannigan, O'Brien, Hurst, Buri, Williams, Grant, Chandler, Hasegawa, Simpson, Santos, Barlow, Morrell, Fromhold, Priest, Lantz, Strow, B. Sullivan, Cody, Hinkle, Eickmeyer, Haigh, Anderson, Appleton, Kenney, Chase, McCoy, Walsh, Haler, Kelley, Springer, Newhouse, Dunshee, Linville, McIntire, Lovick, Sump, Kirby, Schual-Berke, Kagi, Quall, Ahern, Pettigrew, VanDeWege, Condotta, Green, Seaquist, Dickerson, P. Sullivan and Sommers)

AN ACT Relating to crane safety; adding new sections to chapter 49.17 RCW; creating a new section; and providing an effective date.

Referred to Committee on Labor, Commerce, Research & Development.

HB 2204 by Representatives Morrell, Cody and Hasegawa

AN ACT Relating to modifying the nursing home certificate of bed need ratio; adding a new section to chapter 70.38 RCW; providing an effective date; and declaring an emergency.

Referred to Committee on Health & Long-Term Care.

HB 2240 by Representatives Conway, Condotta and Kenney

AN ACT Relating to allowing certain activities between domestic wineries, domestic breweries, microbreweries, certificate of approval holders, and retail sellers of beer or wine; and reenacting and amending RCW 66.28.010.

Referred to Committee on Labor, Commerce, Research & Development.

MOTION

On motion of Senator Eide, all measures listed on the Introduction and First Reading report were referred to the committees as designated.

MOTION

On motion of Senator Eide, the Senate advanced to the eighth order of business.

MOTION

Senator Shin moved adoption of the following resolution:

SENATE RESOLUTION 8626

By Senators Shin, Morton, Schoesler, Rasmussen, Hatfield, Kastama, Jacobsen, Zarelli, Kauffman and Kilmer

WHEREAS, Sergeant Paul D. Hickok became a Lynnwood city patrolman in January 1967, and graduated from the Washington State Basic Law Enforcement Academy in March 1969; and

WHEREAS, Sergeant Hickok received the Lynnwood Jaycees "Outstanding Young Policeman" award in 1970; and

WHEREAS, Sergeant Hickok was promoted to Sergeant of Police in June 1977; was elected President of the Lynnwood Police Officer's Association from 1982 to 1985; served as a field-training officer and assisted in the training of new field sergeants; and was awarded the Robert Burns "Sergeant of the Year" from the Free and Accepted Masons of Washington; and

WHEREAS, Sergeant Hickok was the K-9 Unit Supervisor and received the LPOA "Meritorious" award for his procurement of K-9 ballistic vests in 2001; and he received recognition from the City of Everett Police Department for efforts in helping to provide 13 ballistic vests to improve the safety of police K-9 service dogs throughout the region; and

WHEREAS, Sergeant Hickok deserves acknowledgment and acclamation for his full dedication and superior contributions to the grace and dignity of the City of Lynnwood Police Department, the same commitment, grace, and dignity he brought to work each day;

NOW, THEREFORE, BE IT RESOLVED, That Sergeant Paul D. Hickok be congratulated on his retirement from four decades of public service and wished the very best in pursuing future endeavors; and

BE IT FURTHER RESOLVED, That copies of this resolution be immediately transmitted by the Secretary of the Senate to the Washington State Senate, Sergeant Paul D. Hickok, and the City of Lynnwood Police Department.

Senator Shin spoke in favor of adoption of the resolution.

The President declared the question before the Senate to be the adoption of Senate Resolution No. 8626.

The motion by Senator Shin carried and the resolution was adopted by voice vote.

INTRODUCTION OF SPECIAL GUESTS

The President welcomed and introduced Sergeant Paul D. Hickok who was seated in the gallery.

INTRODUCTION OF SPECIAL GUESTS

The President welcomed and introduced, Dr. Tony Geist, Chair of the Division of Spanish and Portuguese Studies, University of Washington and Jose Ignacio Callen, Director of the Cervantes Institute at the University of Washington who were seated in the gallery.

INTRODUCTION OF SPECIAL GUESTS

The President welcomed and introduced guests from Spain, the Honorary Vice Consul of Spain, Luis Fernando Esteban, Juan Pedro de Basterrechea, Director of Development of the Cervantes Institute in Madrid Spain and Eduardo Lago, Director of the Cervantes Institute in New York City who were seated at the rostrum.

With permission of the Senate, business was suspended to allow Juan Pedro de Basterrechea to address the Senate.

REMARKS BY JUAN PEDRO DE BASTERRECHEA

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

"Mr. President, honorable members of the Senate: It is a great pleasure and a great honor to be here today in the Senate of the State of Washington representing the Institute of Cervantes. As you know the Institute of Cervantes is a Spanish public, nonprofit organization, part of the Spanish Ministry of Foreign Affairs. It was founded in 1991 with a two-fold objective; to promote world wide the Spanish language; and the culture of the Spanish speaking peoples. The King of Spain is the President of honor of the Board of Institute and the Prime Minister is its Executive President. In order to achieve its goals, the Institute of Cervantes is creating a network of centers in the four continents. We are now present in sixty-seven cities, in forty countries in the world. Yesterday, with the attendance of an impressive representation of academic, political, cultural and economic personalities of Seattle and of Washington State, the Cervantes of the University of Washington was solemnly inaugurated. It was a great moment for us. Now, ambitious Spanish-language teaching programs, teacher-training courses and the organization of cultural activities that we have been defining with a very active department of Spanish and Portuguese of the University of Washington, will become true. We have already been able to see that the demand the support and the opportunities for our activity this state are unique. All this has been made possible thanks to the vision of outstanding men. It all began two and a half years ago when the delegation of the State of Washington visited the Institute of Cervantes in Madrid. Amongst them, the President of the Senate and Lt. Governor, Mr. Brad Owen; he sent the champ, Mr. Antonio Sanchez; Mr. William Gates, Sr.; the head of the department of Spanish and Portuguese of the University of Washington Mr. Anthony Geist and the Spanish Counsel in Seattle, Mr. Luis Fernando Esteban. Thanks to their determination, in remarkably short time, many of our goals have been achieved. On behalf of the Institute of Cervantes, I want to pay tribute to their generosity and enthusiasm. From now on, in close collaboration with the University of Washington, we will be able to fulfill our task. We will be able to promote the Spanish language and the culture of the Spanish-speaking peoples amongst the citizens of state of Washington. Thank you very much for this opportunity and for the very, very warm welcome that you will have given us. Thank you."

PERSONAL PRIVILEGE

Senator Eide: "Well, I would like to also welcome you here to Washington State and it is indeed a privilege to have the Cervantes Institute here in the State of Washington. We have a common goal here and that is to provide quality education and foreign language. Also to increase our cultural understanding across borders and also it enables our students to work with people from different countries and helps build new bridges for international trade. Now, on a personal note, I must say that I had the honor of visiting your country in December and thoroughly enjoyed myself and the culture was, and the history, I just can't tell you, it gives me goose bumps even thinking about it but I am looking forward to the day when I can retire in Spain. Thank you very much, it is a pleasure to see you here today and thanks for all that you do for us here in Washington State."

PERSONAL PRIVILEGE

Senator Benton: "I too want to thank the Government of Spain and, of course, King Juan Carlos for the wonderful gift. It is such an honor for us to one of only four centers in the United

States, right here, at our own University of Washington. I too, like the previous speaker have visited Spain. My son and I spent a wonderful time in Barcelona. We enjoyed it very much. The people of Spain are very gracious and welcomed us and we just loved it and we look forward to going back again soon. So to have this relationship, of course our relationship with your country has been a long relationship. It started many years ago. I remember back in 1995, when we first began to doing business with Talgo for the Talgo train and that has continued, of course, to be a very good relationship. We look forward to a long and fruitful, mutual relationship with your country and our great state of Washington. Thank you very much and I look forward to seeing you at noon today."

PERSONAL PRIVILEGE

Senator Kohl-Welles: "Muchas gracias, Mr. President. Welcome to Mr. Vice Counsel, I too have traveled to Spain. The first time, forty-two years ago and loved it then and have always loved being there. I am very excited about the Cervantes Center and it is a great tribute to our state and the University of Washington to be selected to have one of the four centers. I'd also like to say that Don Quijote is one of my most favorite novels that I've ever read and as a very young person reading it, and I may be incorrect, I believe that it was one of the first novels ever published in the world. As a public policy-maker who sometimes is probably thought of as chasing windmills and some of the legislation that I introduced. I think there's a lot to be said for that and certainly Don Quijote is a beloved character in fiction but also it brings a lot in real life. Thank you."

PERSONAL PRIVILEGE

Senator McAuliffe: "I want to welcome you to our beautiful state to Washington State and I want to thank you for crossing the borders and bringing to us your beautiful language so that we may go online and have the opportunity to be tutored and to improve our Spanish. That will be a great experience for all of us and I also do want to thank you for the gifts that you brought, particularly yourselves as well for coming to visit us. One of my favorite songs in the whole world is, 'The Impossible Dream' and I think as a Legislature we always have to dream and sometimes I do feel that you have to do those kind of things because that is why we are here for the people of the State of Washington as you are here for the people of Spain. So welcome and thank you so much."

REMARKS BY THE PRESIDENT

President Owen: " Just a reminder to the members of the reception at noon today. If you are interested in getting the program and going online and doing as Senator Regala has already from what I understand, contact our office and you will be able to obtain, we'll connect you to get your password and your code and you will be able to access this incredible opportunity.

Gracias. Estamos muy emocionado para esta oportunidad.

I should note, by the way, you're going to have to get on and learn that Spanish quick, because the book is in Spanish."

MOTION

On motion of Senator Eide, the Senate advanced to the sixth order of business.

MOTION

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

On motion of Senator Regala, Senators Berkey and Brown were excused.

MOTION

On motion of Senator Brandland, Senators Delvin and Pflug were excused.

SECOND READING

SENATE BILL NO. 5259, by Senators Jacobsen and Morton

Modifying provisions governing the sale of unneeded park land.

The measure was read the second time.

MOTION

On motion of Senator Jacobsen, the rules were suspended, Senate Bill No. 5259 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senator Jacobsen spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Senate Bill No. 5259.

ROLL CALL

The Secretary called the roll on the final passage of Senate Bill No. 5259 and the bill passed the Senate by the following vote: Yeas, 46; Nays, 0; Absent, 1; Excused, 2.

Voting yea: Senators Benton, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 46

Absent: Senator Prentice - 1

Excused: Senators Berkey and Delvin - 2

SENATE BILL NO. 5259, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

MOTION

On motion of Senator Eide, Senator Prentice was excused.

SECOND READING

SENATE BILL NO. 5321, by Senators Carrell, Regala, Stevens, Schoesler, Clements and Rasmussen

Addressing child welfare.

MOTIONS

On motion of Senator Carrell, Substitute Senate Bill No. 5321 was substituted for Senate Bill No. 5321 and the substitute bill was placed on the second reading and read the second time.

On motion of Senator Carrell, the rules were suspended, Substitute Senate Bill No. 5321 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators Carrell and Hargrove spoke in favor of passage of the bill.

MOTION

On motion of Senator Regala, Senator Brown was excused.

The President declared the question before the Senate to be the final passage of Substitute Senate Bill No. 5321.

ROLL CALL

The Secretary called the roll on the final passage of Substitute Senate Bill No. 5321 and the bill passed the Senate by the following vote: Yeas, 43; Nays, 0; Absent, 2; Excused, 4.

Voting yea: Senators Benton, Brandland, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom and Zarelli - 43

Absent: Senators Kline and Weinstein - 2

Excused: Senators Berkey, Brown, Delvin and Prentice - 4
 SUBSTITUTE SENATE BILL NO. 5321, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

MOTION

On motion of Senator Regala, Senators Hobbs and Weinstein were excused.

SECOND READING

SENATE BILL NO. 5625, by Senators Hargrove and Pridemore

Authorizing counties and cities to contract for jail services with counties and cities in adjacent states.

MOTIONS

On motion of Senator Hargrove, Substitute Senate Bill No. 5625 was substituted for Senate Bill No. 5625 and the substitute bill was placed on the second reading and read the second time.

On motion of Senator Hargrove, the rules were suspended, Substitute Senate Bill No. 5625 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senator Hargrove spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Substitute Senate Bill No. 5625.

ROLL CALL

The Secretary called the roll on the final passage of Substitute Senate Bill No. 5625 and the bill passed the Senate by the following vote: Yeas, 44; Nays, 0; Absent, 0; Excused, 5.

Voting yea: Senators Benton, Brandland, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen,

SIXTY-FIRST DAY, MARCH 9, 2007

Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom and Zarelli - 44

Excused: Senators Berkey, Brown, Delvin, Prentice and Weinstein - 5

SUBSTITUTE SENATE BILL NO. 5625, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

SENATE BILL NO. 5855, by Senators Delvin, Shin, Berkey, Kilmer, Oemig and Rasmussen

Implementing the Washington learns modifications.

MOTIONS

On motion of Senator Shin, Substitute Senate Bill No. 5855 was substituted for Senate Bill No. 5855 and the substitute bill was placed on the second reading and read the second time.

On motion of Senator Shin, the rules were suspended, Substitute Senate Bill No. 5855 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senator Shin spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Substitute Senate Bill No. 5855.

ROLL CALL

The Secretary called the roll on the final passage of Substitute Senate Bill No. 5855 and the bill passed the Senate by the following vote: Yeas, 46; Nays, 0; Absent, 0; Excused, 3.

Voting yea: Senators Benton, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 46

Excused: Senators Berkey, Delvin and Prentice - 3

SUBSTITUTE SENATE BILL NO. 5855, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

PERSONAL PRIVILEGE

Senator Rasmussen: "Thank you Mr. President. A good friend of this legislature for the last forty years and a good friend of yours, Mr. President passed away last night. It was Marlyta Deck and I know that you know her and many of you know her but she was lobbyist for the Cattlemen. She worked hard for agriculture, for fairs and for kids. If Senator Deccio was here he would join me along with Senator McCaslin and Senator Newhouse and particularly Tubb Hanson, for those who remember Senator Hanson. Marlyta was the heart and the soul of this legislature. She raised the lobbyist you see outside of our doors, she raised them and she called them her boys. Anybody

2007 REGULAR SESSION

that went to fairs and had kids in 4H knew Marlyta. Marlyta was a Thurston County, she was a State Fair. She's one of the reasons I'm here. She was involved with me in 4H and Future Farmers of America. We started the fair board for the Future Farmers of America. She served as the first president and then I served as a president after her but she got us all involved in all sorts of things that had to do with youth groups. She was a good friend of Ron Crockdett. She was the one that lobbied for Emerald Downs when it was Longacres. She cared about every aspect of agriculture. I know that you'll all join me in wishing her well on her journey to be with our Lord in heaven and she's just been so grand to all of our young people and now I look at those lobbyist that she raised and as we're all getting old when can say, 'Thank you Marlyta, Thank you for what you've done for all of us,' because she, it was a job well done. Could we just have a moment of silence for our friend Marlyta Deck?"

MOMENT OF SILENCE

The senate observed a moment of silence in memory of Mrs. Marlyta Deck who passed away March 8, 2007.

SECOND READING

SENATE BILL NO. 5952, by Senators McAuliffe, Kohl-Welles and Rasmussen

Correcting provisions for the department of early learning.

MOTIONS

On motion of Senator McAuliffe, Substitute Senate Bill No. 5952 was substituted for Senate Bill No. 5952 and the substitute bill was placed on the second reading and read the second time.

On motion of Senator McAuliffe, the rules were suspended, Substitute Senate Bill No. 5952 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators McAuliffe and Clements spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Substitute Senate Bill No. 5952.

ROLL CALL

The Secretary called the roll on the final passage of Substitute Senate Bill No. 5952 and the bill passed the Senate by the following vote: Yeas, 45; Nays, 0; Absent, 1; Excused, 3.

Voting yea: Senators Benton, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 45

Absent: Senator Hargrove - 1

Excused: Senators Berkey, Delvin and Prentice - 3

SUBSTITUTE SENATE BILL NO. 5952, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

MOTION

SIXTY-FIRST DAY, MARCH 9, 2007

At 10:30 a.m., on motion of Senator Eide, the Senate was declared to be at ease subject to the call of the President.

The Senate was called to order at 11:44 a.m. by President Owen.

SECOND READING

SENATE BILL NO. 5261, by Senators Keiser, Franklin, Kohl-Welles, Fairley and Kline

Granting the insurance commissioner the authority to review individual health benefit plan rates.

The measure was read the second time.

MOTION

Senator Rockefeller moved that the following amendment by Senators Rockefeller and Keiser be adopted.

On page 5, after line 13, strike all of sections 4 and 5 and insert the following:

"**Sec. 4.** RCW 48.20.025 and 2003 c 248 s 8 are each amended to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Claims" means the cost to the insurer of health care services, as defined in RCW 48.43.005, provided to a policyholder or paid to or on behalf of the policyholder in accordance with the terms of a health benefit plan, as defined in RCW 48.43.005. This includes capitation payments or other similar payments made to providers for the purpose of paying for health care services for a policyholder.

(b) "Claims reserves" means: (i) The liability for claims which have been reported but not paid; (ii) the liability for claims which have not been reported but which may reasonably be expected; (iii) active life reserves; and (iv) additional claims reserves whether for a specific liability purpose or not.

(c) "Earned premiums" means premiums, as defined in RCW 48.43.005, plus any rate credits or recoupments less any refunds, for the applicable period, whether received before, during, or after the applicable period.

(d) "Incurred claims expense" means claims paid during the applicable period plus any increase, or less any decrease, in the claims reserves.

(e) "Loss ratio" means incurred claims expense as a percentage of earned premiums.

(f) "Reserves" means: (i) Active life reserves; and (ii) additional reserves whether for a specific liability purpose or not.

(2) An insurer shall file, for informational purposes only, a notice of its schedule of rates for its individual health benefit plans with the commissioner prior to use.

(3) An insurer shall file with the notice required under subsection (2) of this section supporting documentation of its method of determining the rates charged. The commissioner may request only the following supporting documentation:

(a) A description of the insurer's rate-making methodology;

(b) An actuarially determined estimate of incurred claims which includes the experience data, assumptions, and justifications of the insurer's projection;

(c) The percentage of premium attributable in aggregate for nonclaims expenses used to determine the adjusted community rates charged; and

(d) A certification by a member of the American academy of

2007 REGULAR SESSION

actuaries, or other person approved by the commissioner, that the adjusted community rate charged can be reasonably expected to result in a loss ratio that meets or exceeds the loss ratio standard established in subsection (7) of this section.

(4) The commissioner may not disapprove or otherwise impede the implementation of the filed rates.

(5) By the last day of May each year any insurer issuing or renewing individual health benefit plans in this state during the preceding calendar year shall file for review by the commissioner supporting documentation of its actual loss ratio for its individual health benefit plans offered or renewed in the state in aggregate for the preceding calendar year. The filing shall include aggregate earned premiums, aggregate incurred claims, and a certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the actual loss ratio has been calculated in accordance with accepted actuarial principles.

(a) At the expiration of a thirty-day period beginning with the date the filing is received by the commissioner, the filing shall be deemed approved unless prior thereto the commissioner contests the calculation of the actual loss ratio.

(b) If the commissioner contests the calculation of the actual loss ratio, the commissioner shall state in writing the grounds for contesting the calculation to the insurer.

(c) Any dispute regarding the calculation of the actual loss ratio shall, upon written demand of either the commissioner or the insurer, be submitted to hearing under chapters 48.04 and 34.05 RCW.

(6) If the actual loss ratio for the preceding calendar year is less than the loss ratio established in subsection (7) of this section, a remittance is due and the following shall apply:

(a) The insurer shall calculate a percentage of premium to be remitted to the Washington state health insurance pool by subtracting the actual loss ratio for the preceding year from the loss ratio established in subsection (7) of this section.

(b) The remittance to the Washington state health insurance pool is the percentage calculated in (a) of this subsection, multiplied by the premium earned from each enrollee in the previous calendar year. Interest shall be added to the remittance due at a five percent annual rate calculated from the end of the calendar year for which the remittance is due to the date the remittance is made.

(c) All remittances shall be aggregated and such amounts shall be remitted to the Washington state high risk pool to be used as directed by the pool board of directors.

(d) Any remittance required to be issued under this section shall be issued within thirty days after the actual loss ratio is deemed approved under subsection (5)(a) of this section or the determination by an administrative law judge under subsection (5)(c) of this section.

(7) The loss ratio applicable to this section shall be ~~((seventy-four))~~ seventy-seven percent minus the premium tax rate applicable to the insurer's individual health benefit plans under RCW 48.14.020.

Sec. 5. RCW 48.44.017 and 2001 c 196 s 11 are each amended to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Claims" means the cost to the health care service contractor of health care services, as defined in RCW 48.43.005, provided to a contract holder or paid to or on behalf of a contract holder in accordance with the terms of a health benefit plan, as defined in RCW 48.43.005. This includes capitation payments or other similar payments made to providers for the purpose of paying for health care services for an enrollee.

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

(b) "Claims reserves" means: (i) The liability for claims which have been reported but not paid; (ii) the liability for claims which have not been reported but which may reasonably be expected; (iii) active life reserves; and (iv) additional claims reserves whether for a specific liability purpose or not.

(c) "Earned premiums" means premiums, as defined in RCW 48.43.005, plus any rate credits or recoupments less any refunds, for the applicable period, whether received before, during, or after the applicable period.

(d) "Incurred claims expense" means claims paid during the applicable period plus any increase, or less any decrease, in the claims reserves.

(e) "Loss ratio" means incurred claims expense as a percentage of earned premiums.

(f) "Reserves" means: (i) Active life reserves; and (ii) additional reserves whether for a specific liability purpose or not.

(2) A health care service contractor shall file, for informational purposes only, a notice of its schedule of rates for its individual contracts with the commissioner prior to use.

(3) A health care service contractor shall file with the notice required under subsection (2) of this section supporting documentation of its method of determining the rates charged. The commissioner may request only the following supporting documentation:

(a) A description of the health care service contractor's rate-making methodology;

(b) An actuarially determined estimate of incurred claims which includes the experience data, assumptions, and justifications of the health care service contractor's projection;

(c) The percentage of premium attributable in aggregate for nonclaims expenses used to determine the adjusted community rates charged; and

(d) A certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the adjusted community rate charged can be reasonably expected to result in a loss ratio that meets or exceeds the loss ratio standard established in subsection (7) of this section.

(4) The commissioner may not disapprove or otherwise impede the implementation of the filed rates.

(5) By the last day of May each year any health care service contractor issuing or renewing individual health benefit plans in this state during the preceding calendar year shall file for review by the commissioner supporting documentation of its actual loss ratio for its individual health benefit plans offered or renewed in this state in aggregate for the preceding calendar year. The filing shall include aggregate earned premiums, aggregate incurred claims, and a certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the actual loss ratio has been calculated in accordance with accepted actuarial principles.

(a) At the expiration of a thirty-day period beginning with the date the filing is received by the commissioner, the filing shall be deemed approved unless prior thereto the commissioner contests the calculation of the actual loss ratio.

(b) If the commissioner contests the calculation of the actual loss ratio, the commissioner shall state in writing the grounds for contesting the calculation to the health care service contractor.

(c) Any dispute regarding the calculation of the actual loss ratio shall upon written demand of either the commissioner or the health care service contractor be submitted to hearing under chapters 48.04 and 34.05 RCW.

(6) If the actual loss ratio for the preceding calendar year is less than the loss ratio standard established in subsection (7) of

this section, a remittance is due and the following shall apply:

(a) The health care service contractor shall calculate a percentage of premium to be remitted to the Washington state health insurance pool by subtracting the actual loss ratio for the preceding year from the loss ratio established in subsection (7) of this section.

(b) The remittance to the Washington state health insurance pool is the percentage calculated in (a) of this subsection, multiplied by the premium earned from each enrollee in the previous calendar year. Interest shall be added to the remittance due at a five percent annual rate calculated from the end of the calendar year for which the remittance is due to the date the remittance is made.

(c) All remittances shall be aggregated and such amounts shall be remitted to the Washington state high risk pool to be used as directed by the pool board of directors.

(d) Any remittance required to be issued under this section shall be issued within thirty days after the actual loss ratio is deemed approved under subsection (5)(a) of this section or the determination by an administrative law judge under subsection (5)(c) of this section.

(7) The loss ratio applicable to this section shall be ((seventy-four)) seventy-seven percent minus the premium tax rate applicable to the health care service contractor's individual health benefit plans under RCW 48.14.0201.

Sec. 6. RCW 48.46.062 and 2001 c 196 s 12 are each amended to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Claims" means the cost to the health maintenance organization of health care services, as defined in RCW 48.43.005, provided to an enrollee or paid to or on behalf of the enrollee in accordance with the terms of a health benefit plan, as defined in RCW 48.43.005. This includes capitation payments or other similar payments made to providers for the purpose of paying for health care services for an enrollee.

(b) "Claims reserves" means: (i) The liability for claims which have been reported but not paid; (ii) the liability for claims which have not been reported but which may reasonably be expected; (iii) active life reserves; and (iv) additional claims reserves whether for a specific liability purpose or not.

(c) "Earned premiums" means premiums, as defined in RCW 48.43.005, plus any rate credits or recoupments less any refunds, for the applicable period, whether received before, during, or after the applicable period.

(d) "Incurred claims expense" means claims paid during the applicable period plus any increase, or less any decrease, in the claims reserves.

(e) "Loss ratio" means incurred claims expense as a percentage of earned premiums.

(f) "Reserves" means: (i) Active life reserves; and (ii) additional reserves whether for a specific liability purpose or not.

(2) A health maintenance organization shall file, for informational purposes only, a notice of its schedule of rates for its individual agreements with the commissioner prior to use.

(3) A health maintenance organization shall file with the notice required under subsection (2) of this section supporting documentation of its method of determining the rates charged. The commissioner may request only the following supporting documentation:

(a) A description of the health maintenance organization's rate-making methodology;

(b) An actuarially determined estimate of incurred claims which includes the experience data, assumptions, and

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

justifications of the health maintenance organization's projection;

(c) The percentage of premium attributable in aggregate for nonclaims expenses used to determine the adjusted community rates charged; and

(d) A certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the adjusted community rate charged can be reasonably expected to result in a loss ratio that meets or exceeds the loss ratio standard established in subsection (7) of this section.

(4) The commissioner may not disapprove or otherwise impede the implementation of the filed rates.

(5) By the last day of May each year any health maintenance organization issuing or renewing individual health benefit plans in this state during the preceding calendar year shall file for review by the commissioner supporting documentation of its actual loss ratio for its individual health benefit plans offered or renewed in the state in aggregate for the preceding calendar year. The filing shall include aggregate earned premiums, aggregate incurred claims, and a certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the actual loss ratio has been calculated in accordance with accepted actuarial principles.

(a) At the expiration of a thirty-day period beginning with the date the filing is received by the commissioner, the filing shall be deemed approved unless prior thereto the commissioner contests the calculation of the actual loss ratio.

(b) If the commissioner contests the calculation of the actual loss ratio, the commissioner shall state in writing the grounds for contesting the calculation to the health maintenance organization.

(c) Any dispute regarding the calculation of the actual loss ratio shall, upon written demand of either the commissioner or the health maintenance organization, be submitted to hearing under chapters 48.04 and 34.05 RCW.

(6) If the actual loss ratio for the preceding calendar year is less than the loss ratio standard established in subsection (7) of this section, a remittance is due and the following shall apply:

(a) The health maintenance organization shall calculate a percentage of premium to be remitted to the Washington state health insurance pool by subtracting the actual loss ratio for the preceding year from the loss ratio established in subsection (7) of this section.

(b) The remittance to the Washington state health insurance pool is the percentage calculated in (a) of this subsection, multiplied by the premium earned from each enrollee in the previous calendar year. Interest shall be added to the remittance due at a five percent annual rate calculated from the end of the calendar year for which the remittance is due to the date the remittance is made.

(c) All remittances shall be aggregated and such amounts shall be remitted to the Washington state high risk pool to be used as directed by the pool board of directors.

(d) Any remittance required to be issued under this section shall be issued within thirty days after the actual loss ratio is deemed approved under subsection (5)(a) of this section or the determination by an administrative law judge under subsection (5)(c) of this section.

(7) The loss ratio applicable to this section shall be ~~((seventy-four))~~ seventy-seven percent minus the premium tax rate applicable to the health maintenance organization's individual health benefit plans under RCW 48.14.0201."

Senators Rockefeller, Pflug and Keiser spoke in favor of adoption of the amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senators Rockefeller and Keiser on page 5, line 13 to Senate Bill No. 5261.

The motion by Senator Rockefeller carried and the amendment was adopted by voice vote.

MOTION

There being no objection, the following title amendments were adopted:

On page 1, beginning on line 3 of the title, after "48.44.020," strike the remainder of the title and insert "48.46.060, 48.20.025, 48.44.017, and 48.46.062."

On page 1, line 2 of the title, after "rates;" insert "and"

MOTION

On motion of Senator Keiser, the rules were suspended, Engrossed Senate Bill No. 5261 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senator Keiser spoke in favor of passage of the bill.

Senators Pflug and Parlette spoke against passage of the bill.

The President declared the question before the Senate to be the final passage of Engrossed Senate Bill No. 5261.

ROLL CALL

The Secretary called the roll on the final passage of Engrossed Senate Bill No. 5261 and the bill passed the Senate by the following vote: Yeas, 29; Nays, 18; Absent, 0; Excused, 2.

Voting yea: Senators Berkey, Brown, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, Murray, Oemig, Poulsen, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Shin, Spanel, Tom and Weinstein - 29

Voting nay: Senators Benton, Brandland, Carrell, Clements, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, McCaslin, Morton, Parlette, Pflug, Schoesler, Sheldon, Stevens, Swecker and Zarelli - 18

Excused: Senators Delvin and Prentice - 2

ENGROSSED SENATE BILL NO. 5261, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

MOTION

At 11:57 a.m., on motion of Senator Eide, the Senate is recessed until 1:30 p.m.

AFTERNOON SESSION

The Senate was called to order by President Owen at 1:30 p.m.

SECOND READING

SENATE BILL NO. 5790, by Senators Hobbs, Rockefeller, Rasmussen, Fairley, McAuliffe, Kohl-Welles, Pridemore, Hatfield, Clements, Jacobsen and Shin

Regarding skill centers.

MOTIONS

On motion of Senator Hobbs, Second Substitute Senate Bill No. 5790 was substituted for Senate Bill No. 5790 and the second substitute bill was placed on the second reading and read the second time.

On motion of Senator Hobbs, the rules were suspended, Second Substitute Senate Bill No. 5790 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators Hobbs, Benton and Parlette spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Second Substitute Senate Bill No. 5790.

ROLL CALL

The Secretary called the roll on the final passage of Second Substitute Senate Bill No. 5790 and the bill passed the Senate by the following vote: Yeas, 47; Nays, 0; Absent, 0; Excused, 2.

Voting yea: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 47

Excused: Senators Delvin and Prentice - 2

SECOND SUBSTITUTE SENATE BILL NO. 5790, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

SENATE BILL NO. 5969, by Senators Kilmer, Delvin, Kastama, Shin, Kauffman, Marr, Murray, Kohl-Welles, Hobbs and Tom

Creating the civic education travel grant program.

The measure was read the second time.

MOTION

On motion of Senator Kilmer, the rules were suspended, Senate Bill No. 5969 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senator Kilmer spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Senate Bill No. 5969.

ROLL CALL

The Secretary called the roll on the final passage of Senate Bill No. 5969 and the bill passed the Senate by the following vote: Yeas, 47; Nays, 0; Absent, 0; Excused, 2.

Voting yea: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens,

Swecker, Tom, Weinstein and Zarelli - 47

Excused: Senators Delvin and Prentice - 2

SENATE BILL NO. 5969, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

POINT OF ORDER

Senator Sheldon: "Well, Mr. President, I was getting a little bit older out here in the back row and I wondered maybe if you could kind a raise the level of your, raise your voice up to about forty-five decibels? I could probably hear you a little better back here."

REPLY BY THE PRESIDENT

President Owen: "I know that there's people in this area, primarily the gallery, that think you were addressing them for some clever reason. The truth of the matter is, ladies and gentlemen, he's referring to himself, who today has turned another year older and is finding it more difficult to hear. Happy Birthday, Senator Sheldon."

SECOND READING

SENATE BILL NO. 5955, by Senators Tom, McAuliffe, Kauffman, Oemig, Kilmer, Eide, Kohl-Welles and Rasmussen

Regarding educator preparation, professional development, and compensation.

MOTIONS

On motion of Senator Tom, Second Substitute Senate Bill No. 5955 was substituted for Senate Bill No. 5955 and the second substitute bill was placed on the second reading and read the second time.

On motion of Senator Tom, the rules were suspended, Second Substitute Senate Bill No. 5955 was advanced to third reading, the second reading considered the third that the bill was placed on final passage.

Senator Zarelli spoke against the motion to advance.

MOTION

On motion of Senator Eide, further consideration of Second Substitute Senate Bill No. 5955 was deferred and the bill held its place on the second reading calendar.

SECOND READING

SENATE BILL NO. 5843, by Senators Oemig, Tom, Rockefeller, Zarelli and Keiser

Regarding educational data and data systems.

MOTION

On motion of Senator Oemig, Second Substitute Senate Bill No. 5843 was substituted for Senate Bill No. 5843 and the second substitute bill was placed on the second reading and read the second time.

MOTION

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

Senator Oemig moved that the following amendment by Senator Oemig and others be adopted.

On 3, after line 15, insert following:

"NEW SECTION. Sec. 3. A new section is added to chapter 28A.300 RCW to read as follows:

(1) The office of superintendent of public instruction is authorized to establish a longitudinal student data system for and on behalf of school districts in the state. Personally identifiable student data will be safeguarded consistent with the requirements of the federal family educational rights privacy act and any relevant state laws. Consistent with privacy protections in the above-referenced laws, data may be disclosed for educational purposes and studies, including but are not limited to:

(a) Educational studies authorized or mandated by the state legislature;

(b) Studies initiated by other state educational authorities and authorized by the office of superintendent of public instruction;

(c) Studies initiated by other state agencies and authorized by the office of superintendent of public instruction;

(d) Studies initiated by private study groups authorized by the office of superintendent of public instruction.

(2) Any group or agency that utilizes this data shall adhere to federal and state laws protecting student data and safeguarding the confidentiality and privacy of student records.

(3) Nothing in this section precludes the office of superintendent of public instruction from collecting and distributing non student level data, nor student level data without personally identifiable information."

Senators Oemig and Holmquist spoke in favor of adoption of the amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator Oemig and others on page 3, after line 15 to Second Substitute Senate Bill No. 5843.

The motion by Senator Oemig carried and the amendment was adopted by voice vote.

MOTION

There being no objection, the following title amendment was adopted:

On page 1, line 1 of the title, "systems" strike the remainder of the title and insert "adding new sections to chapter 28A.300 RCW; and creating new sections."

MOTION

On motion of Senator Oemig, the rules were suspended, Engrossed Second Substitute Senate Bill No. 5843 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators Oemig and Holmquist spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Engrossed Second Substitute Senate Bill No. 5843.

ROLL CALL

The Secretary called the roll on the final passage of Engrossed Second Substitute Senate Bill No. 5843 and the bill passed the Senate by the following vote Yeas, 46; Nays, 1; Absent, 0; Excused, 2.

Voting yea: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 46

Voting nay: Senator Schoesler - 1

Excused: Senators Delvin and Prentice - 2

ENGROSSED SECOND SUBSTITUTE SENATE BILL NO. 5843, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

SENATE BILL NO. 5714, by Senators Roach, Prentice, Rasmussen, Oemig, Clements, Rockefeller, Tom, Fairley, Hobbs, Shin, Swecker, Holmquist, Benton, Stevens, Parlette, Delvin and Kline

Creating a pilot program of Spanish and Chinese language instruction.

MOTIONS

On motion of Senator Roach, Substitute Senate Bill No. 5714 was substituted for Senate Bill No. 5714 and the substitute bill was placed on the second reading and read the second time.

Senator Roach spoke in favor of the substitute bill.

On motion of Senator Eide, the rules were suspended, Substitute Senate Bill No. 5714 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators Eide and Shin spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Substitute Senate Bill No. 5714.

ROLL CALL

The Secretary called the roll on the final passage of Substitute Senate Bill No. 5714 and the bill passed the Senate by the following vote: Yeas, 48; Nays, 0; Absent, 0; Excused, 1.

Voting yea: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 48

Excused: Senator Delvin - 1

SUBSTITUTE SENATE BILL NO. 5714, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

SENATE BILL NO. 5828, by Senators Kauffman, McAuliffe, Tom, Rasmussen, Eide, Oemig, Clements, Hobbs, Weinstein, Rockefeller, Kline and Kohl-Welles

Regarding early child development and learning.

MOTION

On motion of Senator Kauffman, Second Substitute Senate Bill No. 5828 was substituted for Senate Bill No. 5828 and the second substitute bill was placed on the second reading and read the second time.

MOTION

Senator Holmquist moved that the following amendment by Senators Holmquist, McAuliffe and Kauffman be adopted.

On page 5, line 13, insert "(h) One representative from the Washington federation of independent schools."
Renummer the sections consecutively and correct any internal references accordingly.

Senator Holmquist spoke in favor of adoption of the amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senators Holmquist, McAuliffe and Kauffman on page 5, line 13 to Engrossed Second Substitute Senate Bill No. 5828.

The motion by Senator Holmquist carried and the amendment was adopted by voice vote.

MOTION

On motion of Senator Kauffman, the rules were suspended, Engrossed Second Substitute Senate Bill No. 5828 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators Kauffman and Holmquist spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Engrossed Second Substitute Senate Bill No. 5828.

ROLL CALL

The Secretary called the roll on the final passage of Engrossed Second Substitute Senate Bill No. 5828 and the bill passed the Senate by the following vote: Yeas, 47; Nays, 0; Absent, 1; Excused, 1.

Voting yea: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 47

Absent: Senator Pflug - 1

Excused: Senator Delvin - 1

ENGROSSED SECOND SUBSTITUTE SENATE BILL NO. 5828, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

SENATE BILL NO. 5145, by Senators Haugen and Rasmussen

Clarifying existing requirements for conservation of agricultural lands.

MOTIONS

On motion of Senator Rasmussen, Substitute Senate Bill No. 5145 was substituted for Senate Bill No. 5145 and the substitute bill was placed on the second reading and read the second time.

On motion of Senator Rasmussen, the rules were suspended, Substitute Senate Bill No. 5145 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senator Haugen spoke in favor of passage of the bill.

MOTION

On motion of Senator Regala, Senator Keiser was excused.

Senators Kline, Honeyford and Zarelli spoke against passage of the bill

Senators Spanel and Rasmussen spoke in favor of passage of the bill.

Senator Schoesler spoke on passage of the bill.

The President declared the question before the Senate to be the final passage of Substitute Senate Bill No. 5145.

ROLL CALL

The Secretary called the roll on the final passage of Substitute Senate Bill No. 5145 and the bill passed the Senate by the following vote: Yeas, 38; Nays, 9; Absent, 0; Excused, 2.

Voting yea: Senators Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hobbs, Jacobsen, Kastama, Kauffman, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, Murray, Oemig, Parlette, Pflug, Poulsen, Prentice, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Swecker, Tom and Weinstein - 38

Voting nay: Senators Benton, Hewitt, Holmquist, Honeyford, McCaslin, Morton, Pridemore, Stevens and Zarelli - 9

Excused: Senators Delvin and Keiser - 2

SUBSTITUTE SENATE BILL NO. 5145, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

SENATE BILL NO. 5221, by Senators Hargrove, Marr, Stevens, Carrell, Eide, Regala, Brandland, Kilmer and Rasmussen

Revising provisions relating to the release of offenders.

MOTIONS

On motion of Senator Regala, Substitute Senate Bill No. 5221 was substituted for Senate Bill No. 5221 and the substitute bill was placed on the second reading and read the second time.

On motion of Senator Regala, the rules were suspended, Substitute Senate Bill No. 5221 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senator Regal spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Substitute Senate Bill No. 5221.

SIXTY-FIRST DAY, MARCH 9, 2007

ROLL CALL

The Secretary called the roll on the final passage of Substitute Senate Bill No. 5221 and the bill passed the Senate by the following vote: Yeas, 48; Nays, 0; Absent, 0; Excused, 1.

Voting yea: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 48

Excused: Senator Delvin - 1

SUBSTITUTE SENATE BILL NO. 5221, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

SENATE BILL NO. 5332, by Senators Roach, Prentice and Rasmussen

Creating a statewide automated victim information and notification system.

The measure was read the second time.

MOTION

On motion of Senator Roach, the rules were suspended, Senate Bill No. 5332 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senator Roach spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Senate Bill No. 5332.

ROLL CALL

The Secretary called the roll on the final passage of Senate Bill No. 5332 and the bill passed the Senate by the following vote: Yeas, 47; Nays, 0; Absent, 1; Excused, 1.

Voting yea: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 47

Absent: Senator Keiser - 1

Excused: Senator Delvin - 1

SENATE BILL NO. 5332, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

SENATE BILL NO. 5964, by Senators Kline and Hargrove

Excluding offenders who have committed only the crimes of assault 2 and robbery 2 from the definition of persistent offender. Revised for 1st Substitute: Revising the definition of

2007 REGULAR SESSION

"most serious offense" and creating a task force to study crimes included in "most serious offense."

MOTIONS

On motion of Senator Kline, Substitute Senate Bill No. 5964 was substituted for Senate Bill No. 5964 and the substitute bill was placed on the second reading and read the second time.

On motion of Senator Kline, the rules were suspended, Substitute Senate Bill No. 5964 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators Kline, Carrell and Roach spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Substitute Senate Bill No. 5964.

ROLL CALL

The Secretary called the roll on the final passage of Substitute Senate Bill No. 5964 and the bill passed the Senate by the following vote: Yeas, 48; Nays, 0; Absent, 0; Excused, 1.

Voting yea: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 48

Excused: Senator Delvin - 1

SUBSTITUTE SENATE BILL NO. 5964, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

SENATE BILL NO. 6107, by Senators Zarelli, Hatfield and Rasmussen

Reviewing pipeline capacity and distribution in southwest Washington.

The measure was read the second time.

MOTION

On motion of Senator Zarelli, the rules were suspended, Senate Bill No. 6107 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senator Zarelli spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Senate Bill No. 6107.

ROLL CALL

The Secretary called the roll on the final passage of Senate Bill No. 6107 and the bill passed the Senate by the following vote: Yeas, 48; Nays, 0; Absent, 0; Excused, 1.

Voting yea: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig,

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

Parlette, Pflug, Poulsen, Prentice, Pridmore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 48

Excused: Senator Delvin - 1

SENATE BILL NO. 6107, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

MOTION

Senator Keiser moved that the following striking amendment by Senators Keiser and Marr be adopted:

Strike everything after the enacting clause and insert the following:

"NEW SECTION. Sec. 1. It is the public policy of Washington to promote access to medical care for all citizens and to encourage innovative arrangements between patients and providers that will help provide all citizens with a medical home.

Washington needs a multipronged approach to provide adequate health care to many citizens who lack adequate access to it. Direct patient-provider practices, in which patients enter into a direct relationship with medical practitioners and pay a fixed amount directly to the health care provider for primary care services, represent an innovative, affordable option which could improve access to medical care, reduce the number of people who now lack such access, and cut down on emergency room use for primary care purposes, thereby freeing up emergency room facilities to treat true emergencies.

Sec. 2. RCW 48.44.010 and 1990 c 120 s 1 are each amended to read as follows:

For the purposes of this chapter:

(1) "Health care services" means and includes medical, surgical, dental, chiropractic, hospital, optometric, podiatric, pharmaceutical, ambulance, custodial, mental health, and other therapeutic services.

(2) "Provider" means any health professional, hospital, or other institution, organization, or person that furnishes health care services and is licensed to furnish such services.

(3) "Health care service contractor" means any corporation, cooperative group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services. "Health care service contractor" does not include direct patient-provider primary care practices as defined in section 3 of this act.

(4) "Participating provider" means a provider, who or which has contracted in writing with a health care service contractor to accept payment from and to look solely to such contractor according to the terms of the subscriber contract for any health care services rendered to a person who has previously paid, or on whose behalf prepayment has been made, to such contractor for such services.

(5) "Enrolled participant" means a person or group of persons who have entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health care service contractor to receive health care services.

(6) "Commissioner" means the insurance commissioner.

(7) "Uncovered expenditures" means the costs to the health care service contractor for health care services that are the obligation of the health care service contractor for which an enrolled participant would also be liable in the event of the health care service contractor's insolvency and for which no alternative arrangements have been made as provided herein. The term does not include expenditures for covered services when a provider has agreed not to bill the enrolled participant even though the provider is not paid by the health care service contractor, or for services that are guaranteed, insured or assumed by a person or organization other than the health care service contractor.

(8) "Copayment" means an amount specified in a group or individual contract which is an obligation of an enrolled participant for a specific service which is not fully prepaid.

INTRODUCTION OF SPECIAL GUESTS

The President welcomed and introduced former Senator Bob Oke and his wife, Judy, who were seated at the rostrum.

REMARKS BY SENATOR OKE

Senator Oke: "I love you all, even the ones that are new here, I love you too and I do miss this place but I miss you individuals and God bless you for what your doing. Keep your good work going. I just can't say enough for my wonderful wife. I want you to know that she's for hire if you want to have a retirement but she said you can't afford her."

MOTION

On motion of Senator Eide, the Senate reverted to the fourth order of business.

MESSAGE FROM THE HOUSE

March 9, 2007

MR. PRESIDENT:

The House has passed the following bills:

SUBSTITUTE HOUSE BILL NO. 1148,
HOUSE BILL NO. 1371,
HOUSE BILL NO. 1644,
SUBSTITUTE HOUSE BILL NO. 1675,
SECOND SUBSTITUTE HOUSE BILL NO. 1677,
SUBSTITUTE HOUSE BILL NO. 1694,
HOUSE BILL NO. 1887,
HOUSE BILL NO. 1923,
SUBSTITUTE HOUSE BILL NO. 1955,

and the same are herewith transmitted.

RICHARD NAFZIGER, Chief Clerk

MOTION

On motion of Senator Eide, the Senate advanced to the sixth order of business.

SECOND READING

SENATE BILL NO. 5958, by Senators Keiser, Parlette, Marr and Kohl-Welles

Creating innovative primary health care delivery.

MOTION

On motion of Senator Keiser, Second Substitute Senate Bill No. 5958 was substituted for Senate Bill No. 5958 and the second substitute bill was placed on the second reading and read the second time.

SIXTY-FIRST DAY, MARCH 9, 2007

(9) "Deductible" means the amount an enrolled participant is responsible to pay before the health care service contractor begins to pay the costs associated with treatment.

(10) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specific group. The group contract may include coverage for dependents.

(11) "Individual contract" means a contract for health care services issued to and covering an individual. An individual contract may include dependents.

(12) "Carrier" means a health maintenance organization, an insurer, a health care service contractor, or other entity responsible for the payment of benefits or provision of services under a group or individual contract.

(13) "Replacement coverage" means the benefits provided by a succeeding carrier.

(14) "Insolvent" or "insolvency" means that the organization has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

(15) "Fully subordinated debt" means those debts that meet the requirements of RCW 48.44.037(3) and are recorded as equity.

(16) "Net worth" means the excess of total admitted assets as defined in RCW 48.12.010 over total liabilities but the liabilities shall not include fully subordinated debt.

NEW SECTION. Sec. 3. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Direct patient-provider primary care practice" and "direct practice" means a provider, group, or entity that meets the following criteria in (a), (b), (c), and (d) of this subsection:

(a)(i) A health care provider who furnishes primary care services through a direct agreement;

(ii) A group of health care providers who furnish primary care services through a direct agreement; or

(iii) An entity that sponsors, employs, or is otherwise affiliated with a group of health care providers who furnish only primary care services through a direct agreement, which entity is wholly owned by the group of health care providers or is a nonprofit corporation exempt from taxation under section 501(c)(3) of the internal revenue code, and is not otherwise regulated as a health care service contractor, health maintenance organization, or disability insurer under Title 48 RCW. Such entity is not prohibited from sponsoring, employing, or being otherwise affiliated with other types of health care providers not engaged in a direct practice;

(b) Enters into direct agreements with direct patients or parents or legal guardians of direct patients;

(c) Does not accept payment for health care services provided to direct patients from any entity subject to regulation under Title 48 RCW; and

(d) Does not provide, in consideration for the direct fee, services, procedures, or supplies such as prescription drugs, hospitalization costs, major surgery, dialysis, high level radiology (CT, MRI, PET scans or invasive radiology), rehabilitation services, procedures requiring general anesthesia, or similar advanced procedures, services, or supplies.

(2) "Direct patient" means a person who is party to a direct agreement and is entitled to receive primary care services under the direct agreement from the direct practice.

(3) "Direct fee" means a fee charged by a direct practice as consideration for being available to provide and providing primary care services as specified in a direct agreement. The fee must represent the total amount due for all health care services specified in the direct agreement and may be paid by the direct patient or on his or her behalf by others.

(4) "Direct agreement" means a written agreement entered into between a direct practice and an individual direct patient, or the parent or legal guardian of the direct patient or a family of direct patients, whereby the direct practice charges a direct fee as consideration for being available to provide and providing

2007 REGULAR SESSION

health care services to the individual direct patient. A direct agreement must (a) describe the specific health care services the direct practice will provide; (b) be terminable at will upon written notice by the direct patient; and (c) include the following disclaimer: "This agreement does not provide comprehensive health insurance coverage. It provides only the health care services specifically described." The direct agreement may not be sold to a group and may not be entered with a group of subscribers. It must be an agreement between a direct practice and an individual direct patient. Nothing prohibits the presentation of marketing materials to groups of potential subscribers or their representatives.

(5) "Health care provider" or "provider" means a person regulated under Title 18 RCW or chapter 70.127 RCW to practice health or health-related services or otherwise practicing health care services in this state consistent with state law.

(6) "Health carrier" or "carrier" has the same meaning as in RCW 48.43.005.

(7) "Primary care" means routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury.

(8) "Network" means the group of participating providers and facilities providing health care services to a particular health carrier.

NEW SECTION. Sec. 4. (1) A direct practice must charge a direct fee on a monthly basis.

(2) A direct practice must:

(a) Maintain appropriate accounts and provide data regarding payments made and services received to direct patients upon request; and

(b) Either:

(i) Bill patients at the end of each monthly period; or

(ii) If the patient pays the monthly fee in advance, promptly refund to the direct patient all unearned direct fees following receipt of written notice of termination of the direct agreement from the direct patient. The amount of the direct fee considered earned shall be a proration of the monthly fee as of the date the notice of termination is received.

(3) If the patient chooses to pay more than one monthly direct fee in advance, the funds will be held in a trust account and paid to the direct practice as earned at the end of each month. Any unearned direct fees held in trust following receipt of termination of the direct agreement shall be promptly refunded to the direct patient. The amount of the direct fee earned shall be a proration of the monthly fee for the then current month as of the date the notice of termination is received.

(4) A direct practice must designate a contact person to receive and address any patient complaints.

NEW SECTION. Sec. 5. (1) Direct practices may not:

(a) Enter into a participating provider contract as defined in RCW 48.44.010 or 48.46.020 with any carrier or with any carrier's contractor or subcontractor to provide health care services through a direct agreement except as set forth in subsection (2) of this section;

(b) Submit a claim for payment to any carrier or any carrier's contractor or subcontractor for health care services provided to direct patients as covered by their agreement;

(c) With respect to services provided through a direct agreement, be identified by a carrier or any carrier's contractor or subcontractor as a participant in the carrier's or any carrier's contractor or subcontractor network for purposes of determining network adequacy or being available for selection by an enrollee under a carrier's benefit plan; or

(d) Pay for health care services covered by a direct agreement rendered to direct patients by providers other than the providers in the direct practice or their employees, except as described in subsection (2)(b) of this section.

(2) Direct practices and providers may:

SIXTY-FIRST DAY, MARCH 9, 2007

(a) Enter into a participating provider contract as defined by RCW 48.44.010 and 48.46.020 for purposes other than payment of claims for services provided to direct patients through a direct agreement. Such providers shall be subject to all other provisions of the participating provider contract applicable to participating providers including but not limited to the right to:

- (i) Make referrals to other participating providers;
- (ii) Admit the carrier's members to participating hospitals and other health care facilities;
- (iii) Prescribe prescription drugs; and
- (iv) Implement other customary provisions of the contract not dealing with reimbursement of services;

(b) Pay for charges associated with the provision of routine lab and imaging services provided in connection with wellness physical examinations. In aggregate such payments per year per direct patient are not to exceed fifteen percent of the total annual direct fee charged that direct patient. Exceptions to this limitation may occur in the event of short-term equipment failure if such failure prevents the provision of care that should not be delayed; and

(c) Charge an additional fee to direct patients for supplies, medications, and specific vaccines provided to direct patients that are specifically excluded under the agreement, provided the direct practice notifies the direct patient of the additional charge, prior to their administration or delivery.

NEW SECTION. Sec. 6. (1) Direct practices may not decline to accept new direct patients or discontinue care to existing patients solely because of the patient's health status. A direct practice may decline to accept a patient if the practice has reached its maximum capacity, or if the patient's medical condition is such that the provider is unable to provide the appropriate level and type of health care services in the direct practice or if the direct practice reasonably determines that the patient would be better served by another health care provider.

(2) Direct practices may accept payment of direct fees directly or indirectly from nonemployer third parties.

NEW SECTION. Sec. 7. Direct practices, as defined in section 3 of this act, who comply with this chapter are not insurers under RCW 48.01.050, health carriers under chapter 48.43 RCW, health care service contractors under chapter 48.44 RCW, or health maintenance organizations under chapter 48.46 RCW.

NEW SECTION. Sec. 8. A person shall not make, publish, or disseminate any false, deceptive, or misleading representation or advertising in the conduct of the business of a direct practice, or relative to the business of a direct practice.

NEW SECTION. Sec. 9. A person shall not make, issue, or circulate, or cause to be made, issued, or circulated, a misrepresentation of the terms of any direct agreement, or the benefits or advantages promised thereby, or use the name or title of any direct agreement misrepresenting the nature thereof.

NEW SECTION. Sec. 10. Violations of this chapter constitute unprofessional conduct enforceable under RCW 18.130.180.

NEW SECTION. Sec. 11. (1) Direct practices must submit annual statements to the office of insurance commissioner specifying the number of providers in each practice, total number of patients being served, providers' names, and the business address for each direct practice. The form for the annual statement will be developed in a manner prescribed by the commissioner.

(2) A health care provider may not act as, or hold himself or herself out to be, a direct practice in this state, nor may a direct agreement be entered into with a direct patient in this state, unless the provider submits the annual statement in subsection (1) of this section to the commissioner.

(3) The commissioner shall report annually to the legislature on direct practices. The initial report shall be due December 1, 2009.

NEW SECTION. Sec. 12. A comprehensive disclosure statement shall be distributed to all direct patients with their

2007 REGULAR SESSION

enrollment forms. Such disclosure must inform the direct patients of their financial rights and responsibilities to the direct practice as provided for in this chapter, encourage that direct patients obtain and maintain insurance for services not provided by the direct practice, and state that the direct practice will not bill a carrier for services covered under the direct agreement. The disclosure statement shall include contact information for the office of the insurance commissioner.

NEW SECTION. Sec. 13. Sections 3 through 12 of this act constitute a new chapter in Title 48 RCW."

Senator Keiser spoke in favor of adoption of the striking amendment.

MOTION

Senator Jacobsen moved that the following amendment by Senator Jacobsen to the striking amendment be adopted.

On page 3, line 23 of the amendment, after "agreement;" strike "or"

On page 3, beginning on line 28 of the amendment, after "code" strike all material through "RCW" on line 30

On page 3, line 33 of the amendment, after "practice;" insert "or"

(iv) Health care service contractors under chapter 48.44 RCW or health maintenance organizations under chapter 48.46 RCW that contract with or employ primary care providers, and while operating as a direct practice shall only be subject to the provisions of this chapter."

On page 4, line 2 of the amendment, after "RCW" insert "unless the direct practice is owned or operated by a health care service contractor or health maintenance organization"

On page 5, line 33 of the amendment, after "(1)" strike "Direct" and insert "Unless a direct practice is owned or operated by a health care service contractor or health maintenance organization, direct"

On page 7, line 16 of the amendment, after "not" insert "operating as"

Senators Jacobsen and Pflug spoke in favor of adoption of the amendment to the striking amendment.

Senators Keiser and Marr spoke against adoption of the amendment to the striking amendment.

POINT OF ORDER

Senator Pflug: "Mr. President, while it is allowed to be inaccurate it is not allowed, on the floor of the Senate, to impugn motives and to say that the opponents of this or the proponents of this measure, this amendment, are trying to smother the initiative is impugning motives. We're not trying to smother primary care practices, we support them. We think everybody should be allowed to do them if anyone's allowed to do them."

REPLY BY THE PRESIDENT

President Owen: "Thank you Senator. It is correct that the members will speak to the measure and definitely not to the motives of the individuals for introducing the measures."

The President declared the question before the Senate to be the adoption of the amendment by Senator Jacobsen on page 3, line 23 to the striking amendment to Second Substitute Senate Bill No. 5958.

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

The motion by Senator Jacobsen failed and the amendment to the striking amendment was not adopted by voice vote.

MOTION

Senator Jacobsen moved that the following amendment by Senator Jacobsen to the striking amendment be adopted.

On page 3, after line 33 of the amendment, insert the following:

"(b) A direct practice under (a)(i), (ii), and (iii) of this subsection shall provide at least fifteen percent of its primary health care services as charity care for low-income children and adults having no retainer agreement or health coverage."

Reletter the remaining subsections consecutively and correct any internal references accordingly.

Senators Jacobsen and Pflug spoke in favor of adoption of the amendment to the striking amendment.

Senators Keiser and Franklin spoke against adoption of the amendment to the striking amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator Jacobsen on page 3, after line 33 to the striking amendment to Second Substitute Senate Bill No. 5958.

The motion by Senator Jacobsen failed and the amendment to the striking amendment was not adopted by voice vote.

MOTION

Senator Jacobsen moved that the following amendment by Senator Jacobsen to the striking amendment be adopted.

On page 8, after line 22 of the amendment, insert the following:

"**Sec. 14.** RCW 48.14.0201 and 2005 c 405 s 1, 2005 c 223 s 6, and 2005 c 7 s 1 are each reenacted and amended to read as follows:

(1) As used in this section, "taxpayer" means a health maintenance organization as defined in RCW 48.46.020, a health care service contractor as defined in RCW 48.44.010, a direct practice as defined in section 3 of this act, or a self-funded multiple employer welfare arrangement as defined in RCW 48.125.010.

(2) Each taxpayer shall pay a tax on or before the first day of March of each year to the state treasurer through the insurance commissioner's office. The tax shall be equal to the total amount of all premiums and prepayments for health care services received by the taxpayer during the preceding calendar year multiplied by the rate of two percent.

(3) Taxpayers shall prepay their tax obligations under this section. The minimum amount of the prepayments shall be percentages of the taxpayer's tax obligation for the preceding calendar year recomputed using the rate in effect for the current year. For the prepayment of taxes due during the first calendar year, the minimum amount of the prepayments shall be percentages of the taxpayer's tax obligation that would have been due had the tax been in effect during the previous calendar year. The tax prepayments shall be paid to the state treasurer through the commissioner's office by the due dates and in the following amounts:

- (a) On or before June 15, forty-five percent;
- (b) On or before September 15, twenty-five percent;
- (c) On or before December 15, twenty-five percent.

(4) For good cause demonstrated in writing, the commissioner may approve an amount smaller than the

preceding calendar year's tax obligation as recomputed for calculating the health maintenance organization's, health care service contractor's, self-funded multiple employer welfare arrangement's, or certified health plan's prepayment obligations for the current tax year.

(5) Moneys collected under this section shall be deposited in the general fund through March 31, 1996, and in the health services account under RCW 43.72.900 after March 31, 1996.

(6) The taxes imposed in this section do not apply to:

(a) Amounts received by any taxpayer from the United States or any instrumentality thereof as prepayments for health care services provided under Title XVIII (medicare) of the federal social security act.

(b) Amounts received by any taxpayer from the state of Washington as prepayments for health care services provided under:

(i) The medical care services program as provided in RCW 74.09.035;

(ii) The Washington basic health plan on behalf of subsidized enrollees as provided in chapter 70.47 RCW; or

(iii) The medicaid program on behalf of elderly or disabled clients as provided in chapter 74.09 RCW when these prepayments are received prior to July 1, 2009, and are associated with a managed care contract program that has been implemented on a voluntary demonstration or pilot project basis.

(c) Amounts received by any health care service contractor, as defined in RCW 48.44.010, as prepayments for health care services included within the definition of practice of dentistry under RCW 18.32.020.

(d) Participant contributions to self-funded multiple employer welfare arrangements that are not taxable in this state.

(7) Beginning January 1, 2000, the state does hereby preempt the field of imposing excise or privilege taxes upon taxpayers and no county, city, town, or other municipal subdivision shall have the right to impose any such taxes upon such taxpayers. This subsection shall be limited to premiums and payments for health benefit plans offered by health care service contractors under chapter 48.44 RCW, health maintenance organizations under chapter 48.46 RCW, direct practices as defined in section 3 of this act, and self-funded multiple employer welfare arrangements as defined in RCW 48.125.010. The preemption authorized by this subsection shall not impair the ability of a county, city, town, or other municipal subdivision to impose excise or privilege taxes upon the health care services directly delivered by the employees of a health maintenance organization under chapter 48.46 RCW.

(8)(a) The taxes imposed by this section apply to a self-funded multiple employer welfare arrangement only in the event that they are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq. The arrangements and the commissioner shall initially request an advisory opinion from the United States department of labor or obtain a declaratory ruling from a federal court on the legality of imposing state premium taxes on these arrangements. Once the legality of the taxes has been determined, the multiple employer welfare arrangement certified by the insurance commissioner must begin payment of these taxes.

(b) If there has not been a final determination of the legality of these taxes, then beginning on the earlier of (i) the date the fourth multiple employer welfare arrangement has been certified by the insurance commissioner, or (ii) April 1, 2006, the arrangement shall deposit the taxes imposed by this section into an interest bearing escrow account maintained by the arrangement. Upon a final determination that the taxes are not preempted by the employee retirement income security act of

SIXTY-FIRST DAY, MARCH 9, 2007

1974, as amended, 29 U.S.C. Sec. 1001 et seq., all funds in the interest bearing escrow account shall be transferred to the state treasurer.

(9) The effect of transferring contracts for health care services from one taxpayer to another taxpayer is to transfer the tax prepayment obligation with respect to the contracts.

(10) On or before June 1st of each year, the commissioner shall notify each taxpayer required to make prepayments in that year of the amount of each prepayment and shall provide remittance forms to be used by the taxpayer. However, a taxpayer's responsibility to make prepayments is not affected by failure of the commissioner to send, or the taxpayer to receive, the notice or forms."

On page 8, line 24 of the title amendment, after "48.44.010;" insert "reenacting and amending RCW 48.14.0201;"

Senator Jacobsen spoke in favor of adoption of the amendment to the striking amendment.

Senator Keiser spoke against adoption of the amendment to the striking amendment.

POINT OF INQUIRY

Senator Pflug: "Will the good lady yield to a question? Senator Keiser, are the health insurance carriers in Washington covering the kinds of primary care services provided by these direct service practices?"

Senator Keiser: "In some cases but not all. Some carriers with catastrophic plans are not covering these kinds of services but not all."

The President declared the question before the Senate to be the adoption of the amendment by Senator Jacobsen on page 8, after line 22 to the striking amendment to Second Substitute Senate Bill No. 5958.

The motion by Senator Jacobsen failed and the amendment to the striking amendment was not adopted by voice vote.

MOTION

Senator Pflug moved that the following amendment by Senator Pflug to the striking amendment be adopted.

On page 1, beginning on line 3 of the amendment after "1." strike all material through "emergencies." on line 15 of the amendment and insert "It is the public policy of Washington State to allow continued access to medical care for all citizens and to provide the opportunity for continued innovative arrangements between patients and providers that will help provide all citizens with a medical home."

On page 5, beginning on line 9 of the amendment strike sections 4 through sections 13 on page 8, line 21 of the amendment.

On page 8, after line 20 of the amendment, insert

"**NEW SECTION.** The office of the insurance commissioner shall not have the authority and is prohibited from regulating or otherwise controlling direct patient-provider primary care practices and direct practices as defined in this act that are operating in Washington State."

Re-number the sections consecutively and correct any internal references accordingly.

On page 8, beginning on line 24 of the title amendment, after "RCW 48.44.010;" strike "adding a new chapter to Title 48 RCW;"

Senator Pflug spoke in favor of adoption of the amendment

to the striking amendment.

Senator Keiser spoke against adoption of the amendment to the striking amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator Pflug on page 1, line 3 to the striking amendment to Second Substitute Senate Bill No. 5958.

The motion by Senator Pflug failed and the amendment to the striking amendment was not adopted by voice vote.

The President declared the question before the Senate to be the adoption of the striking amendment by Senators Keiser and Marr to Second Substitute Senate Bill No. 5958.

The motion by Senator Keiser carried and the striking amendment was adopted by voice vote.

MOTION

There being no objection, the following title amendment was adopted:

On page 1, line 1 of the title, after "delivery;" strike the remainder of the title and insert "amending RCW 48.44.010; adding a new chapter to Title 48 RCW; and creating a new section."

MOTION

On motion of Senator Keiser, the rules were suspended, Engrossed Second Substitute Senate Bill No. 5958 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators Marr and Keiser spoke in favor of passage of the bill.

Senators Parlette, Jacobsen and Pflug spoke against the passage of the bill.

The President declared the question before the Senate to be the final passage of Engrossed Second Substitute Senate Bill No. 5958.

ROLL CALL

The Secretary called the roll on the final passage of Engrossed Second Substitute Senate Bill No. 5958 and the bill passed the Senate by the following vote: Yeas, 38; Nays, 10; Absent, 0; Excused, 1.

Voting yea: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hobbs, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, Murray, Oemig, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Sheldon, Shin, Spanel, Swecker, Tom, Weinstein and Zarelli - 38

Voting nay: Senators Hewitt, Holmquist, Honeyford, Jacobsen, McCaslin, Morton, Parlette, Pflug, Schoesler and Stevens - 10

Excused: Senator Delvin - 1

ENGROSSED SECOND SUBSTITUTE SENATE BILL NO. 5958, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

MOTION TO LIMIT DEBATE

Senator Eide: "Mr. President, I move that the members of the Senate be allowed to speak but once on each question before

SIXTY-FIRST DAY, MARCH 9, 2007

the Senate, that such speech be limited to three minutes and that members be prohibited from yielding their time, however, the maker of a motion shall be allowed to open and close debate. This motion shall be in effect through March 9, 2007.”

The President declared the question before the Senate to be the motion by Senator Eide to limit debate.

The motion by Senator Eide carried and debate was limited through March 9, 2007.

SECOND READING

SENATE BILL NO. 5712, by Senator Parlette

Revising provisions for the Washington state health insurance pool.

MOTION

On motion of Senator Keiser, Second Substitute Senate Bill No. 5712 was substituted for Senate Bill No. 5712 and the second substitute bill was placed on the second reading and read the second time.

MOTION

Senator Parlette moved that the following striking amendment by Senators Parlette and Keiser be adopted:

Strike everything after the enacting clause and insert the following:

"NEW SECTION. Sec. 1. The legislature finds that the Washington state health insurance pool is a critically important insurance option for people in this state and must reflect health care provisions based on the best available evidence and be financially sustainable over time. The laws governing the Washington state health insurance pool have been read to preclude the program from modifying contracts, and yet coverage needs and options change with time. Everyone in this state benefits when the Washington state health insurance pool is more affordable and higher performing. Changes are needed to the Washington state health insurance pool to increase affordability, offer quality and cost-effective benefits, and enhance the governance and operation of the pool.

Sec. 2. RCW 48.41.110 and 2001 c 196 s 4 are each amended to read as follows:

(1) The pool shall offer one or more care management plans of coverage. Such plans may, but are not required to, include point of service features that permit participants to receive in-network benefits or out-of-network benefits subject to differential cost shares. ~~((Covered persons enrolled in the pool on January 1, 2001, may continue coverage under the pool plan in which they are enrolled on that date. However;))~~ The pool may incorporate managed care features and encourage enrollees to participate in chronic care and disease management and evidence-based protocols into ((such)) existing plans.

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

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

2007 REGULAR SESSION

(4) The pool shall offer at least one policy which at a minimum includes, but is not limited to, the following services or related items:

(a) Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, but limited to a total of one hundred eighty inpatient days in a calendar year, and limited to thirty days inpatient care for mental and nervous conditions, or alcohol, drug, or chemical dependency or abuse per calendar year;

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

(c) The first twenty outpatient professional visits for the diagnosis or treatment of one or more mental or nervous conditions or alcohol, drug, or chemical dependency or abuse rendered during a calendar year by one or more physicians, psychologists, or community mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners, in the case of mental or nervous conditions, and rendered by a state certified chemical dependency program approved under chapter 70.96A RCW, in the case of alcohol, drug, or chemical dependency or abuse;

(d) Drugs and contraceptive devices requiring a prescription;

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

(f) Services of a home health agency;

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

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

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

(l) Diagnostic x-rays and laboratory tests;

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

(n) Maternity care services;

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

(p) Hospice services;

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

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

~~((4))~~ (5) The pool shall offer at least one policy which closely adheres to benefits available in the private, individual market.

~~((6))~~ (6) The board shall design and employ cost containment measures and requirements such as, but not limited to, care coordination, provider network limitations, preadmission certification, and concurrent inpatient review which may make the pool more cost-effective.

~~((5))~~ (7) The pool benefit policy may contain benefit limitations, exceptions, and cost shares such as copayments, coinsurance, and deductibles that are consistent with managed care products, except that differential cost shares may be adopted by the board for nonnetwork providers under point of service plans. ((The pool benefit policy cost shares and limitations must be consistent with those that are generally

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

~~included in health plans approved by the insurance commissioner; however, no limitation, exception, or reduction may be used that would exclude coverage for any disease, illness, or injury.~~

~~(6))~~ (8) The pool may not reject an individual for health plan coverage based upon preexisting conditions of the individual or deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that it shall impose a six-month benefit waiting period for preexisting conditions for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the effective date of coverage. The preexisting condition waiting period shall not apply to prenatal care services. The pool may not avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. Credit against the waiting period shall be as provided in subsection ~~((7))~~ (9) of this section.

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

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

~~((8))~~ (10) If an application is made for the pool policy as a result of rejection by a carrier, then the date of application to the carrier, rather than to the pool, should govern for purposes of determining preexisting condition credit.

(11) The pool shall contract with organizations that provide care management that has been demonstrated to be effective and shall encourage enrollees who are eligible for care management services to participate.

Sec. 3. RCW 48.41.160 and 1987 c 431 s 16 are each amended to read as follows:

(1) A pool policy offered under this chapter prior to the effective date of this section shall contain provisions under which the pool is obligated to renew the policy until the day on which the individual in whose name the policy is issued first becomes eligible for medicare coverage. At that time, coverage of dependents shall terminate if such dependents are eligible for coverage under a different health plan. Dependents who become eligible for medicare prior to the individual in whose name the policy is issued, shall receive benefits in accordance with RCW 48.41.150.

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

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

- (a) Nonpayment of premium;
- (b) Violation of published policies of the pool;
- (c) Failure of a covered person who becomes eligible for medicare benefits by reason of age to apply for a pool medical supplement plan, or a medicare supplement plan or other similar

plan offered by a carrier pursuant to federal laws and regulations;

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

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

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

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

(4)(a) The guarantee of continuity of coverage provided by this section requires that if the pool replaces a plan, it must make the replacement plan available to all individuals in the plan being replaced. The replacement plan must include all of the services covered under the replaced plan, and must not significantly limit access to the kind of services covered under the replaced plan. The pool may also allow individuals who are covered by a plan that is being replaced an unrestricted right to transfer to a fully comparable plan.

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

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

- (i) The cost and quality of care to pool enrollees;
- (ii) Pool financing and enrollment;
- (iii) The board's ability to offer comprehensive and other plans to its enrollees;
- (iv) The ability of carriers to offer health plans in the individual market;
- (v) Other items identified by the board.

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

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

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

~~((7))~~ (6) A pool policy offered under this chapter shall provide that, upon the death of the individual in whose name the policy is issued, every other individual then covered under the policy may elect, within a period specified in the policy, to continue coverage under the same or a different policy.

Sec. 4. RCW 48.41.200 and 2000 c 79 s 17 are each amended to read as follows:

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

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

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

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

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

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

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

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

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

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

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

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

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

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

Sec. 5. RCW 48.41.037 and 2000 c 79 s 36 are each amended to read as follows:

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

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

Sec. 6. RCW 48.41.100 and 2001 c 196 s 3 are each amended to read as follows:

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

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

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

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

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

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

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

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

(c) Inmates of public institutions and persons whose benefits are duplicated under public programs. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

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

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

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

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

(c) The pool administrator shall provide written notice to any person who is no longer eligible for coverage under a pool plan under this subsection (3) within thirty days of the administrator's determination that the person is no longer eligible. The notice shall: (i) Indicate that coverage under the plan will cease ninety days from the date that the notice is dated; (ii) describe any other coverage options, either in or outside of the pool, available to the person; (iii) describe the procedures for the administration of the standard health questionnaire to determine the person's continued eligibility for coverage under

SIXTY-FIRST DAY, MARCH 9, 2007

subsection (1)(b) of this section; and (iv) describe the enrollment process for the available options outside of the pool.
~~(4) The board shall ensure that an independent analysis of the eligibility standards for the pool coverage is conducted, including examining eligibility for medicaid enrollees and other publicly sponsored enrollees, and the impacts on the pool and the state budget. The board shall report the findings to the legislature by December 1, 2007.~~

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

(1) Subject to the limitation provided in subsection ~~((3))~~ (2) of this section, a pool policy offered in accordance with RCW 48.41.110(3) shall impose a deductible. Deductibles of five hundred dollars and one thousand dollars on a per person per calendar year basis shall initially be offered. The board may authorize deductibles in other amounts. The deductible shall be applied to the first five hundred dollars, one thousand dollars, or other authorized amount of eligible expenses incurred by the covered person.

~~(2) (Subject to the limitations provided in subsection (3) of this section, a mandatory coinsurance requirement shall be imposed at the rate of twenty percent of eligible expenses in excess of the mandatory deductible.~~

~~—(3))~~ The maximum aggregate out of pocket payments for eligible expenses by the insured in the form of deductibles and coinsurance under a pool policy offered in accordance with RCW 48.41.110(3) shall not exceed in a calendar year:

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

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

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

~~((4))~~ (3) Eligible expenses incurred by a covered person in the last three months of a calendar year, and applied toward a deductible, shall also be applied toward the deductible amount in the next calendar year.

~~(4) The board may modify cost-sharing as an incentive for enrollees to participate in care management services and other cost-effective programs and policies.~~

Sec. 8. RCW 48.43.005 and 2006 c 25 s 16 are each amended to read as follows:

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

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

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

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

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

(5) "Catastrophic health plan" means:

(a) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand ~~((five))~~ seven hundred fifty dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand five hundred dollars; and

(b) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand five

2007 REGULAR SESSION

hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least ~~((five))~~ six thousand ~~((five hundred))~~ dollars; or

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

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

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

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

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

(10) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty or more hours. The term includes a self-employed individual, including a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not work less than thirty hours per week and derives at least seventy-five percent of his or her income from a trade or business through which he or she has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form. Persons covered under a health benefit plan pursuant to the consolidated omnibus budget reconciliation act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements of chapter 265, Laws of 1995.

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

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

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

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

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

SIXTY-FIRST DAY, MARCH 9, 2007

71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A 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.

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

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

(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.

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

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

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

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

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage; and

(l) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

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

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

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

(23) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care

2007 REGULAR SESSION

service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

(24) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least two but no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor must derive at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year except for a self-employed individual or sole proprietor in an agricultural trade or business, who must derive at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year. A self-employed individual or sole proprietor who is covered as a group of one on the day prior to June 10, 2004, shall also be considered a "small employer" to the extent that individual or group of one is entitled to have his or her coverage renewed as provided in RCW 48.43.035(6).

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

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

Sec. 9. RCW 48.41.190 and 1989 c 121 s 10 are each amended to read as follows:

Neither the participation by members, the establishment of rates, forms, or procedures for coverages issued by the pool, nor any other joint or collective action required by this chapter or the state of Washington shall be the basis of any legal action, civil or criminal liability or penalty against the pool, any member of the board of directors, or members of the pool either jointly or separately. The pool, members of the pool, board directors of the pool, officers of the pool, employees of the pool, the commissioner, the commissioner's representatives, and the commissioner's employees shall not be civilly or criminally liable and shall not have any penalty or cause of action of any nature arise against them for any action taken or not taken, including any discretionary decision or failure to make a discretionary decision, when the action or inaction is done in good faith and in the performance of the powers and duties under this chapter. Nothing in this section prohibits legal

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

actions against the pool to enforce the pool's statutory or contractual duties or obligations.

Sec. 10. RCW 41.05.075 and 2006 c 103 s 3 are each amended to read as follows:

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

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

(a) Encourages competition among insuring entities;

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

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

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

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

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

(5) All claims data shall be the property of the state. The administrator may require of any insuring entity that submits a bid to contract for coverage all information deemed necessary including:

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

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

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

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

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

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

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

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

(i) Facilitate diagnosis or treatment;

(ii) Reduce unnecessary duplication of medical tests;

(iii) Promote efficient electronic physician order entry;

(iv) Increase access to health information for consumers and their providers; and

(v) Improve health outcomes;

(c) Coordinate a strategy for the adoption of health information technology systems using the final health information technology report and recommendations developed under chapter 261, Laws of 2005.

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

NEW SECTION. Sec. 11. This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately."

Senators Parlette and Keiser spoke in favor of adoption of the striking amendment.

The President declared the question before the Senate to be the adoption of the striking amendment by Senators Parlette and Keiser to Second Substitute Senate Bill No. 5712.

The motion by Senator Parlette carried and the striking amendment was adopted by voice vote.

MOTION

There being no objection, the following title amendment was adopted:

On page 1, line 1 of the title, after "pool;" strike the remainder of the title and insert "amending RCW 48.41.110, 48.41.160, 48.41.200, 48.41.037, 48.41.100, 48.41.120, 48.43.005, 48.41.190, and 41.05.075; creating a new section; and declaring an emergency."

MOTION

On motion of Senator Keiser, the rules were suspended, Engrossed Second Substitute Senate Bill No. 5712 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

MOTION

On motion of Senator Regala, Senator Kline was excused.

The President declared the question before the Senate to be the final passage of Engrossed Second Substitute Senate Bill No. 5712.

ROLL CALL

The Secretary called the roll on the final passage of Engrossed Second Substitute Senate Bill No. 5712 and the bill passed the Senate by the following vote: Yeas, 47; Nays, 0; Absent, 0; Excused, 2.

Voting yeas: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 47

Excused: Senators Delvin and Kline - 2

ENGROSSED SECOND SUBSTITUTE SENATE BILL NO. 5712, having received the constitutional majority, was

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

SENATE BILL NO. 5114, by Senators Rockefeller, Parlette, Eide, Weinstein, Fairley, Keiser, Shin, Kohl-Welles, Murray, McAuliffe, Rasmussen, Kauffman, Kilmer, Franklin and Holmquist

Changing student transportation funding.

MOTION

On motion of Senator Rockefeller, Second Substitute Senate Bill No. 5114 was substituted for Senate Bill No. 5114 and the second substitute bill was placed on the second reading and read the second time.

MOTION

Senator Zarelli moved that the following amendment by Senators Zarelli and Morton be adopted.

On page 2, after line 6, strike all material through line 33 and insert the following:

"Sec. 2. RCW 28A.160.160 and 1996 c 279 s 2 are each amended to read as follows:

For purposes of RCW 28A.160.150 through 28A.160.190, except where the context shall clearly indicate otherwise, the following definitions apply:

(1) "Eligible student" means any student served by the transportation program of a school district or compensated for individual transportation arrangements authorized by RCW 28A.160.030 whose route stop is more than one ((radius)) mile using the shortest road mile that is the safest route to travel from the student's school, except that no mileage restriction applies if the student to be transported;

(a) Is disabled under RCW 28A.155.020 and is either not ambulatory or not capable of protecting his or her own welfare while traveling to or from the school or agency where special education services are provided(~~(, in which case no mileage distance restriction applies)~~); or

(b) Qualifies for an exemption due to hazardous walking conditions.

(2) "Superintendent" means the superintendent of public instruction.

(3) "To and from school" means the transportation of students for the following purposes:

(a) Transportation to and from route stops and schools;

(b) Transportation to and from schools pursuant to an interdistrict agreement pursuant to RCW 28A.335.160;

(c) Transportation of students between schools and learning centers for instruction specifically required by statute; ~~(and)~~

(d) Transportation of students for instructional activities necessary to basic education or federal requirements related to special education or no child left behind, or for homeless children; and

(e) Transportation of students with disabilities to and from schools and agencies for special education services.

Except as provided in (a) through (e) of this subsection, extended day transportation shall not be considered part of transportation of students "to and from school" for the purposes of chapter 61, Laws of 1983 1st ex. sess.

(4) "Transportation services" for students living within one radius mile from school means school transportation services including the use of buses, funding of crossing guards, and

matching funds for local and state transportation projects intended to mitigate hazardous walking conditions. Priority for transportation services shall be given to students in grades kindergarten through five.

(5) As used in this section, "hazardous walking conditions" means those instances of the existence of dangerous walkways documented by the board of directors of a school district that meet criteria specified in rules adopted by the superintendent of public instruction.

On page 2, line 34, following "Sec. 3.", strike "Section 1 of this" and insert "This"

Renumber the sections consecutively and correct any internal references accordingly.

On page 1, line 1 of the title, after "RCW" insert "28A.160.160 and"

Senator Zarelli spoke in favor of adoption of the amendment.

Senator Rockefeller spoke against adoption of the amendment.

Senator Schoesler demanded a roll call.

The President declared that one-sixth of the members supported the demand and the demand was sustained.

Senators Schoesler, Holmquist, Clements and Parlette spoke in favor of the adoption of the amendment.

Senators Brown spoke against adoption of the amendment.

MOTION

Senator Eide demanded that the previous question be put.

The President declared that at least two additional senators joined the demand and the demand was sustained.

The President declared the question before the Senate to be the motion of Senator Eide, "Shall the main question be now put?"

The motion by Senator Eide that the previous question be put was sustained by voice vote.

Senator Zarelli again spoke in favor of adoption of the amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senators Zarelli and Morton on page 2, after line 6 to Second Substitute Senate Bill No. 5114.

ROLL CALL

The Secretary called the roll on the adoption of the amendment by Senators Zarelli and Morton the amendment was not adopted by the following vote: Yeas, 16; Nays, 32; Absent, 0; Excused, 1.

Voting yea: Senators Benton, Brandland, Carrell, Clements, Hewitt, Holmquist, Honeyford, McCaslin, Morton, Parlette, Pflug, Roach, Schoesler, Stevens, Swecker and Zarelli - 16

Voting nay: Senators Berkey, Brown, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hobbs, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, Murray, Oemig, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Rockefeller, Sheldon, Shin, Spanel, Tom and Weinstein - 32

Excused: Senator Delvin - 1

MOTION

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

On motion of Senator Rockefeller, the rules were suspended, Second Substitute Senate Bill No. 5114 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators Rockefeller and Zarelli spoke in favor of passage of the bill.

Senators Honeyford and Pflug spoke against passage of the bill.

The President declared the question before the Senate to be the final passage of Second Substitute Senate Bill No. 5114.

ROLL CALL

The Secretary called the roll on the final passage of Second Substitute Senate Bill No. 5114 and the bill passed the Senate by the following vote: Yeas, 45; Nays, 3; Absent, 0; Excused, 1.

Voting yea: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 45

Voting nay: Senators Honeyford, Pflug and Schoesler - 3

Excused: Senator Delvin - 1

SECOND SUBSTITUTE SENATE BILL NO. 5114, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

SENATE BILL NO. 5841, by Senators Hobbs, McAuliffe, Rockefeller, Tom, Oemig, Kauffman, Regala, Kohl-Welles and Rasmussen

Enhancing student learning opportunities and achievement.

MOTION

On motion of Senator Hobbs, Second Substitute Senate Bill No. 5841 was substituted for Senate Bill No. 5841 and the second substitute bill was placed on the second reading and read the second time.

MOTION

Senator Zarelli moved that the following amendment by Senator Zarelli be adopted.

On page 2, after line 9, insert the following:

"In furtherance of those goals, and in recognition it is the legislature's paramount duty to make ample provision for the education of all of Washington's children, it is the intent of the legislature to require that all appropriations for K-12 basic education, together with appropriations for other K-12 education programs, be enacted into law before the legislature takes final action on omnibus operating appropriations legislation.

Sec. 2. RCW 28A.150.380 and 2001 c 3 s 10 are each amended to read as follows:

(1) The state legislature shall, at each regular session in an odd-numbered year, appropriate from the state general fund for the current use of the common schools such amounts as needed for state support to the common schools during the ensuing biennium as provided in this chapter, RCW 28A.160.150

through 28A.160.210, 28A.300.170, and 28A.500.010.

(2) The state legislature shall also, at each regular session in an odd-numbered year, appropriate from the student achievement fund and education construction fund solely for the purposes of and in accordance with the provisions of the student achievement act during the ensuing biennium.

(3) Beginning with the 2009-2011 fiscal biennium and thereafter, appropriations for the purposes of this section and other K-12 education purposes must be made in legislation that is separate from the omnibus operating appropriations act. Such appropriations shall be enacted into law before it is in order for the legislature to take final action on omnibus operating appropriations legislation.

Renumber the sections consecutively and correct any internal references accordingly.

On page 1, line 2 of the title, after "RCW 28A.150.210", insert "and 28A.150.380"

Senators Zarelli and Holmquist spoke in favor of adoption of the amendment.

Senator Hobbs spoke against adoption of the amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator Zarelli on page 2, after line 9 to Second Substitute Senate Bill No. 5841.

The motion by Senator Zarelli failed and the amendment was not adopted by voice vote.

REMARKS BY THE PRESIDENT

President Owen: "While most of the members.... the President would like to make an announcement. As we're getting quite busy at this time and a lot of things are going on, we have some new members, remind members that standing in the wings during the vote and waving at someone to come off or winking at them is still considered 'approaching the bar.' Please do not do that or you may hear the gavel be rapped and one of us will be embarrassed. Just a reminder. Just my annual reminder I guess I should say."

MOTION

Senator Clements moved that the following amendment by Senator Clements be adopted.

On page 2, line 22, after "support", strike "students who qualify for free and reduced-price lunch program support" and insert "all students at the school who are enrolled in kindergarten"

Senator Clements spoke in favor of adoption of the amendment.

Senators Hobbs and Brown spoke against adoption of the amendment.

Senator Carrell spoke on the amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator Clements on page 2, line 22 to Second Substitute Senate Bill No. 5841.

The motion by Senator Clements failed and the amendment was not adopted by voice vote.

MOTION

Senator Carrell moved that the following amendment by Senators Carrell and Zarelli be adopted.

On page 6, following line 24, insert the following:

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

NEW SECTION. Sec. 5. The state auditor's office, in consultation with the office of financial management and the joint legislative audit and review committee, will conduct an audit and evaluation of the current process for determining student eligibility for free and reduced price lunch. The audit and review shall include, but is not limited to: (1) and assessment of the current error rate for determining eligibility for free or reduced price lunch; (2) recommendations on methods and procedures that would reduce the error rate; and (3) an analysis of other poverty measures that could be used as a more accurate indicator of school district poverty. The audit and review shall be submitted to the office of financial management and the appropriate policy and fiscal committees of the legislature by September 1, 2008."

Renumber the sections consecutively and correct any internal references accordingly.

On page 1, line 4 of the title, after "creating", strike "a new section" and insert "new sections"

Senators Carrell and Hobbs spoke in favor of adoption of the amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator Carrell on page 6, line 24 to Second Substitute Senate Bill No. 5841.

The motion by Senator Carrell carried and the amendment was adopted by voice vote.

MOTION

Senator Brandland moved that the following amendment by Senator Brandland be adopted.

On page 6, following line 24, insert the following:

"NEW SECTION. Sec. 5. A new section is added to chapter 28A.155 RCW to read as follows:

(1) Beginning with the 2007-08 school year and each school year thereafter, an additional two hundred dollars per each average annual special education student will be allocated to augment the special education safety net in section 507 of the omnibus appropriations act.

(2) The funds appropriated in this section are in addition to any special education safety net funds appropriated in section 507 of the omnibus appropriations act. Any funds from this appropriation not expended for special education safety net awards shall be allocated to school districts based on the number of resident students ages three to twenty-one receiving specially designed instruction in accordance with a properly formulated individualized education program."

Renumber the sections consecutively and correct any internal references accordingly.

On page 1, line 3 of the title, after "28A.630 RCW;" insert "adding a new section to 28A.155 RCW;"

Senator Brandland spoke in favor of adoption of the amendment.

Senator Prentice spoke against adoption of the amendment.

WITHDRAWAL OF AMENDMENT

On motion of Senator Brandland, the amendment by Senator Brandland on page 6, line 24 to Second Substitute Senate Bill No. 5841 was withdrawn.

MOTION

Senator Brandland moved that the following amendment by Senators Brandland, Hobbs and McAuliffe be adopted.

On page 6, after line 24, insert the following:

"New Section. Sec. 5. A new section is added to 28A.155 RCW to read as follows:

(1) To the extent necessary, funds shall be made available for safety net awards for districts with demonstrated needs for special education funding beyond the amounts provided through the special education funding formula. If safety net awards exceed the amount appropriated, then the superintendent shall expend all available federal discretionary funds necessary to meet this need. Safety net funds shall be awarded by the state safety net oversight committee subject to the following conditions and limitations:

(a) The committee shall consider additional funds for districts that can convincingly demonstrate that all legitimate expenditures for special education exceed all available revenues from state funding formulas. In the determination of need, the committee shall also consider additional available revenues from federal sources. Differences in program costs attributable to district philosophy, service delivery choice, or accounting practices are not a legitimate basis for safety net awards.

(b) The committee shall then consider the extraordinary high cost needs of one or more individual special education students. Differences in costs attributable to district philosophy, service delivery choice, or accounting practices are not a legitimate basis for safety net awards.

(c) The committee shall then consider extraordinary costs associated with communities that draw a larger number of families with children in need of special education services.

(d) The maximum allowable indirect cost for calculating safety net eligibility may not exceed the federal restricted indirect cost rate for the district plus one percent.

(e) Safety net awards shall be adjusted based on the percent of potential medicaid eligible students billed as calculated by the superintendent in accordance with chapter 318, Laws of 1999.

(f) Safety net awards must be adjusted for any audit findings or exceptions related to special education funding.

(2) The superintendent of public instruction may adopt such rules and procedures as are necessary to administer the special education funding and safety net award process. Prior to revising any standards, procedures, or rules, the superintendent shall consult with the office of financial management and the fiscal committees of the legislature. In adopting and revising the rules, the superintendent shall ensure the application process to access safety net funding is streamlined, timelines for submission are not in conflict, feedback to school districts is timely and provides sufficient information to allow school districts to know what they need to do to correct any deficiencies in their safety net application, and that there is consistency between awards approved by school districts and by application period. The office of the superintendent of public instruction shall also provide technical assistance to school districts to assist them in preparing and submitting their special education safety net application.

(3) On an annual basis, the superintendent shall survey districts regarding their satisfaction with the safety net process and consider feedback to improve the safety net process. Each year by December 1st, the superintendent shall prepare and submit a report to the office of financial management and the appropriate policy and fiscal committees of the legislature that summarizes the survey results and changes made to the safety net process as a result of the school district feedback.

(4) The safety net oversight committee appointed by the superintendent of public instruction shall consist of:

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

(a) One staff from the office of superintendent of public instruction;

(b) Staff of the office of the state auditor who shall be nonvoting members of the committee; and

(c) One or more representatives from school districts or educational service districts knowledgeable of special education programs and funding.

NEW SECTION. **Sec. 6.(1)** In addition to the responsibilities in section 5 of this act, the state special education safety net oversight committee, with the assistance of the office of the superintendent of public instruction, shall conduct further evaluation of issues raised in the recently completed review of the special education excess cost accounting procedures by the office of the superintendent of public instruction and the 2006 report of the joint legislative audit and review committee report on the accounting of special education excess costs. Specifically, the state special education safety net oversight committee shall evaluate options for modifying or replacing the current accounting methodology in place for the 2005-06 school year in a way that better reflects the special education program funding and spending. By November 1, 2008, the oversight committee shall submit a report to the office of financial management and the appropriate policy and fiscal committees of the legislature outlining the options for replacing the current excess cost method. One of the options will be based on, to the maximum extent appropriate, a full cost accounting.

(2) This section expires June 30, 2009."

Renumber the sections consecutively and correct any internal references accordingly.

Senators Brandland and McAuliffe spoke in favor of adoption of the amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senators Brandland, Hobbs and McAuliffe on page 6, after line 24 to Second Substitute Senate Bill No. 5841.

The motion by Senator Brandland carried and the amendment was adopted by voice vote.

MOTION

There being no objection, the following title amendment was adopted:

On page 1, line 3 of the title, after "28A.150 RCW", insert "adding new sections to chapter 28A.155;"

MOTION

Senator Pflug moved that the following amendment by Senator Pflug be adopted.

On page 6, after line 26, insert the following:

"**Sec. 6** RCW 28A.185.020 and 1990 c 33 s 168 are each amended to read as follows:

Supplementary funds as may be provided by the state for this program, in accordance with RCW 28A.150.370, shall be categorical funding on an excess cost basis based upon a per student amount not to exceed three percent of any district's full-time equivalent enrollment. Beginning with 2007-08 school year and in each subsequent school year, the legislature shall appropriate sufficient funds to provide per student allocations for three percent of a district's full-time equivalent enrollment. School districts shall use the increased allocations to expand and offer additional advanced placement opportunities for students."

On page 1, line 2 of the title, after " RCW 28A.150.210;" insert "amending RCW 28A.185.020;"

Senator Pflug spoke in favor of adoption of the amendment. Senator Hobbs spoke against adoption of the amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator Pflug on page 6, after line 26 to Second Substitute Senate Bill No. 5841.

The motion by Senator Pflug failed and the amendment was not adopted by voice vote.

MOTION

On motion of Senator Hobbs, the rules were suspended, Engrossed Second Substitute Senate Bill No. 5841 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators Hobbs, Holmquist and Roach spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Engrossed Second Substitute Senate Bill No. 5841.

ROLL CALL

The Secretary called the roll on the final passage of Engrossed Second Substitute Senate Bill No. 5841 and the bill passed the Senate by the following vote: Yeas, 48; Nays, 0; Absent, 0; Excused, 1.

Voting yeas: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 48

Excused: Senator Delvin - 1

ENGROSSED SECOND SUBSTITUTE SENATE BILL NO. 5841, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

The Senate resumed consideration of Second Substitute Senate Bill No. 5955 which had been deferred earlier in the day.

MOTION

Senator Tom withdrew his motion to advance Second Substitute Senate Bill No. 5955 to third reading and final passage.

MOTION

Senator Zarelli moved that the following amendment by Senator Zarelli be adopted.

On page 8, after line 16, insert the following:

"**Sec. 8** RCW 28A.405.140 and 1993 c 336 s 403 are each amended to read as follows:

(1) After an evaluation conducted pursuant to RCW 28A.405.100, the principal or the evaluator may require the teacher to take in-service training provided by the district in the area of teaching skills needing improvement, and may require the teacher to have a mentor for purposes of achieving such

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

improvement.

(2) Notwithstanding the provisions of RCW 28A.405.210 and RCW 28A.405.220, if after three years of unsuccessful improvement based on the in-service training and mentoring provided pursuant to subsection 1 of this section and after a finding that the lack of a teacher's progress in improving his or her teaching skills is detrimental to the academic performance of their students, the principal may initiate an action to dismiss the teacher. In the event the principal makes this determination, the teacher shall be notified in writing. The notification shall include a detailed explanation of the reasons for the principal making this determination.

(3) Within ten days of receiving notice pursuant to this section, every teacher receiving such notice, at his or her request, shall be provided an opportunity to meet informally with the principal for the purpose of requesting the principal reconsider their decision. At such meeting, the teacher shall be given the opportunity to refute any facts upon which the principal's determination was made.

(4) Within ten days following the meeting with the teacher, the principal shall either reinstate the teacher or shall submit to the school district board of directors for consideration at its next regular meeting a written report recommending the employment contract of the teacher be terminated. A copy of the report shall be delivered to the teacher at least ten days prior to the scheduled meeting of the board of directors. At the board of directors meeting, the teacher shall be given the opportunity to present information and provide documentation refuting any facts upon which the principal's determination was made.

(5) The board of directors shall notify the teacher in writing of its final decision within ten days following the meeting at which the principal's recommendation was considered. The decision of the board of directors to terminate the contract of a teacher pursuant to this section shall be final and not subject to appeal.

(6) All school district collective bargaining agreements signed, adopted, or renewed after September 1, 2008 shall include provisions consistent with this section."

Renumber the sections consecutively and correct any internal references accordingly.

On page 1, line 2 of the title, after "RCW 28A.310.350;" insert "amending RCW 28A.405.140;"

Senator Zarelli spoke in favor of adoption of the amendment.

Senator Tom spoke against adoption of the amendment.

Senator Schoesler demanded a roll call.

The President declared that one-sixth of the members supported the demand and the demand was sustained.

The President declared the question before the Senate to be the adoption of the amendment by Senator Zarelli on page 8, after line 16 to Second Substitute Senate Bill No. 5955.

ROLL CALL

The Secretary called the roll on the adoption of the amendment by Senator Zarelli and the amendment was not adopted by the following vote: Yeas, 18; Nays, 30; Absent, 0; Excused, 1.

Voting yea: Senators Benton, Brandland, Carrell, Clements, Hewitt, Holmquist, Honeyford, Keiser, McCaslin, Morton, Parlette, Pflug, Roach, Rockefeller, Schoesler, Stevens, Swecker and Zarelli - 18

Voting nay: Senators Berkey, Brown, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hobbs, Jacobsen,

Kastama, Kauffman, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, Murray, Oemig, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Sheldon, Shin, Spanel, Tom and Weinstein - 30

Excused: Senator Delvin - 1

MOTION

Senator Zarelli moved that the following amendment by Senator Zarelli be adopted.

On page 8, after line 16, insert the following:

"NEW SECTION. Sec. 9. A new section is added to chapter 28A.400 RCW to read as follows:

PERFORMANCE-BASED INCENTIVE PAY PILOT PROGRAM

(1) Beginning with the 2008-09 school year, a voluntary performance-based incentive pay pilot program shall be established in a minimum of three school districts. To the maximum extent possible, school districts participating in the pilot program shall be selected to ensure adequate representation based on school district size and geographic location throughout the state.

(2) Beginning with the 2008-09 school year through the 2012-2013 school year, the legislature shall annually appropriate five million dollars for grants to implement the performance-based incentive pay pilot program. While the performance-based incentive pay pilot grants are intended to be flexible based on local school districts needs, school districts participating in the pilot program created in this section will agree to award the incentive based pay on the criteria developed as a result of subsection 3 of this section.

(3) By March 1, 2008, the Washington Institute for Public Policy, with the technical assistance of the office of superintendent of public instruction, will develop the criteria for awarding the performance-based incentive pay for school districts participating in the pilot program. The criteria developed shall be based on the indicators that the research indicates are the most important in impacting student academic performance, the school has direct influence on, and can be objectively assessed. This includes, but is not limited to, student grades, performance on the Washington assessment of student learning, dropping out of school, and improving student attendance. The criteria will also be based on awarding the performance-based incentive pay on a school wide basis for those schools improving in the objective indicators from a baseline which will also be established by the Washington Institute for Public Policy.

(4) By September 1, 2010, the Washington Institute for Public Policy shall provide a preliminary evaluation of the performance-based incentive pay pilot program to the office of financial management and the appropriate policy and fiscal committees of the legislature. By September 1, 2014, the Washington Institute for Public Policy shall submit a final report on the effectiveness of the performance-based incentive pay pilot program to the office of financial management and the appropriate policy and fiscal committees of the legislature. To the extent supported by the results of the pilot program, the final report may include recommendations for statewide implementation of a performance-based incentive pay system."

Renumber the sections consecutively and correct any internal references accordingly.

On page 1, line 3 of the title, after "28A.415 RCW;" insert "adding a new section to chapter 28A.400 RCW;"

Senator Zarelli spoke in favor of adoption of the

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

amendment.

Senator Tom spoke against adoption of the amendment.

Senator Zarelli demanded a roll call.

The President declared that one-sixth of the members supported the demand and the demand was sustained.

The President declared the question before the Senate to be the adoption of the amendment by Senator Zarelli on page 8, after line 16 to Second Substitute Senate Bill No. 5955.

ROLL CALL

The Secretary called the roll on the adoption of the amendment by Senator Zarelli and the amendment was not adopted by the following vote: Yeas, 14; Nays, 34; Absent, 0; Excused, 1.

Voting yea: Senators Benton, Brandland, Carrell, Hewitt, Holmquist, McCaslin, Morton, Parlette, Pflug, Schoesler, Sheldon, Stevens, Swecker and Zarelli - 14

Voting nay: Senators Berkey, Brown, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hobbs, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, Murray, Oemig, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Shin, Spanel, Tom and Weinstein - 34

Excused: Senator Delvin - 1

MOTION

On motion of Senator Tom, the rules were suspended, Second Substitute Senate Bill No. 5955 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators Tom spoke in favor of passage of the bill.

Senators Holmquist and Zarelli spoke against passage of the bill.

The President declared the question before the Senate to be the final passage of Second Substitute Senate Bill No. 5955.

ROLL CALL

The Secretary called the roll on the final passage of Second Substitute Senate Bill No. 5955 and the bill passed the Senate by the following vote: Yeas, 40; Nays, 8; Absent, 0; Excused, 1.

Voting yea: Senators Benton, Berkey, Brandland, Brown, Carrell, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hobbs, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Murray, Oemig, Pflug, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Tom and Weinstein - 40

Voting nay: Senators Clements, Hewitt, Holmquist, Morton, Parlette, Stevens, Swecker and Zarelli - 8

Excused: Senator Delvin - 1

SECOND SUBSTITUTE SENATE BILL NO. 5955, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

RULING BY THE PRESIDENT

President Owen: "Senator Schoesler has a raised the question as to whether Substitute Senate Bill 5080 takes a simple majority or a two-thirds vote on final passage, because it implicates provisions of the law commonly referred to as Initiative 601. The President believes this is an important issue

and wants to be clear in his explanation, and therefore asks for the body's patience as he issues this ruling.

The workings of the statutes enacted by I-601 are complex, made more complex by various amendments to the original law enacted by the Legislature over the years. At its heart, though, one of the primary limitations in this collective law is clear: The legislature may not take action which raises state revenue unless the enacting legislation is passed with a two-thirds vote of the Senate.

The key to this ruling, as with many of the President's past rulings, is whether or not the measure before us raises state revenue. The President has a long history of differentiating between taxes and fees when making this analysis. In general, enacting a tax increase requires a supermajority vote, while enacting a fee takes only a simple majority vote. The President has taken guidance from Article VIII, Section 1(c) of our state Constitution in making this determination. In short, a fee is collected for a specific, limited purpose. It is often placed into a specific account. This narrow nexus between the collection of the money and its limitation on being spent for a specific purpose is crucial in classifying a revenue action as a fee and not a more general tax. By contrast, where there is not a specific connection between the collection of money and a limitation as to the purpose for which it will be spent, it is more likely that the revenue action is a tax. In making this analysis, the accounts into which fees are placed are important, but not controlling; more important is the limitation on the funds. The President does believe that the interplay between various accounts is far more controlling with respect to transfers, rainy day funds, and expenditure limits, but not for making the initial determination as to whether the revenue action is a fee or tax increase in the first place. A careful review of all of the President's past rulings will show this to be the overriding factor, and, while the President has never specifically ruled on the matter before us, this ruling is consistent with and continues past precedent.

Applying this analysis to the matter before the body, the President believes a brief recitation of the bill's background is helpful. The waste tire fee is not new to this body or enacted by this bill. As originally implemented, there was a solid nexus between the fee collected and the purpose for which the proceeds could be spent: \$1 per tire sold was collected, placed into a dedicated account, and the proceeds were limited to waste tire clean-up and prevention. Under this bill, the amount collected would be unchanged, but its distribution is significantly altered. While half of the money would essentially be deposited and spent as before, the other half would be placed into a more general account, with the only limitation being that it be spent for transportation purposes. And, in 2010, this bill would direct that all of the money would be placed into this more general account, with only the more general limitation. In so doing, the President believes the bill would convert a dedicated fee—which is not subject to I-601's supermajority provisions—into a general tax.

For these reasons, Senator Schoesler's point is well-taken, and passage of this bill will require a two-thirds vote of this body."

MOTION

On motion of Senator Eide, further consideration of Substitute Senate Bill No. 5080 was deferred and the bill held its place on the second reading calendar.

SECOND READING

SIXTY-FIRST DAY, MARCH 9, 2007

SENATE BILL NO. 5930, by Senators Keiser, Kohl-Welles, Shin and Rasmussen

Providing high quality, affordable health care to Washingtonians based on the recommendations of the blue ribbon commission on health care costs and access.

MOTION

On motion of Senator Keiser, Second Substitute Senate Bill No. 5930 was substituted for Senate Bill No. 5930 and the second substitute bill was placed on the second reading and read the second time.

MOTION

Senator Keiser moved that the following striking amendment by Senator Keiser be adopted:

Strike everything after the enacting clause and insert the following:

"USE STATE PURCHASING TO IMPROVE HEALTH CARE QUALITY

NEW SECTION. Sec. 1. The health care authority and the department of social and health services shall, by September 1, 2007, develop a five-year plan to change reimbursement within state purchased health care programs to:

- (1) Reward quality health outcomes rather than simply paying for the receipt of particular services or procedures;
- (2) Pay for care that reflects patient preference and is of proven value;
- (3) Require the use of evidence-based standards of care where available;
- (4) Tie provider rate increases to measurable improvements in access to quality care;
- (5) Direct enrollees to quality care systems;
- (6) Better support primary care and provide a medical home to all enrollees; and
- (7) Pay for e-mail consultations, telemedicine, and telehealth where doing so reduces the overall cost of care.

The plan shall identify any existing barriers and opportunities to support implementation, including needed changes to state or federal law and be submitted to the governor and the legislature upon completion.

NEW SECTION. Sec. 2. The legislature finds that unwarranted variations in health care, variations not explained by illness, patient preference, or the dictates of evidence-based medicine, are a significant feature of health care in Washington state. There is growing evidence that, for preference-sensitive care involving elective surgery, the quality of patient-practitioner communication about the benefits, harms, and uncertainty of available treatment options can be improved by introducing high-quality decision aids that encourage shared decision making. The international patient decision aid standards collaboration, a network of over one hundred researchers, practitioners, patients, and policy makers from fourteen countries, have developed standards for constructing high-quality decision aids. The legislature declares an intent to focus on improving the quality of patient-practitioner communication and on increasing the extent to which patients make genuinely informed, preference-based treatment decisions. Randomized clinical trial evidence indicates that effective use of well designed decision aids is likely to improve the quality of patient decision making, reduce unwarranted variations in health care, and result in lower health care costs overall. Despite this growing body of evidence, widespread use of decision aids has yet to occur. Barriers include: (1) Lack of awareness of existing, appropriate, high-quality decision aids; (2) poor accessibility to such decision aids; (3) low practitioner acceptance of decision

2007 REGULAR SESSION

aids in terms of compatibility with their practice, ease of use, and expense to incorporate into practice; (4) lack of incentives for use, such as reduced liability and reimbursement for their use; and (5) lack of a process to certify that a decision aid meets the standards required of a high-quality decision aid. The legislature intends to promote new public/private collaborative efforts to broaden the development, use, evaluation, and certification of effective decision aids and intends to support the collaborative through providing new recognition of the shared decision-making process and patient decision aids in the state's laws on informed consent. The legislature also intends to establish a process for certifying that a given decision aid meets the standards required for a high-quality decision aid.

NEW SECTION. Sec. 3. The state health care authority shall work in collaboration with the health professions and quality improvement communities to increase awareness of appropriate, high-quality decision aids, and to train physicians and other practitioners in their use. The effort shall focus on one or more of the preference-sensitive conditions with high rates of unwarranted variation in Washington, and can include strategies such as prominent linkage to such decision aids in state web sites, and training/awareness programs in conjunction with professional and quality improvement groups. The state health care authority shall, in consultation with the national committee for quality assurance, identify a certification process for patient decision aids. The state health care authority may accept donations or grants to support such efforts.

NEW SECTION. Sec. 4. The state health care authority shall work with contracting health carriers and health care providers, and a nonproprietary public interest research group and/or university-based research group, to implement practical and usable models to demonstrate shared decision making in everyday clinical practice. The demonstrations shall be conducted at one or more multispecialty group practice sites providing state purchased health care in the state of Washington, and may include other practice sites providing state purchased health care. The demonstrations must include the following elements: Incorporation into clinical practice of one or more decision aids for one or more identified preference-sensitive care areas combined with ongoing training and support of involved practitioners and practice teams, preferably at sites with necessary supportive health information technology. The evaluation must include the following elements: (1) A comparison between the demonstration sites and, if appropriate, between the demonstration sites and a control group, of the impact of the shared decision-making process employing the decision aids on: The use of preference-sensitive health care services; and associated costs saved and/or expended; and (2) an assessment of patient knowledge of the relevant health care choices, benefits, harms, and uncertainties; concordance between patient values and care received; and satisfaction with the decision-making process and their health outcomes by patients and involved physicians and other health care practitioners. The health care authority may solicit and accept funding to support the demonstration and evaluation.

Sec. 5. RCW 7.70.060 and 1975-'76 2nd ex.s. c 56 s 11 are each amended to read as follows:

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

((+)) (a) A description, in language the patient could reasonably be expected to understand, of:

((+)) (i) The nature and character of the proposed treatment;

((+)) (ii) The anticipated results of the proposed treatment;

SIXTY-FIRST DAY, MARCH 9, 2007

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

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

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

(2) If a patient while legally competent, or his or her representative if he or she is not competent, signs an acknowledgement of shared decision making as described in subsection (3) of this section, such acknowledgement shall constitute prima facie evidence that the patient gave his or her informed consent to the treatment administered and the patient has the burden of rebutting this by clear and convincing evidence. An acknowledgement of shared decision making shall include:

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

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

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

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

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

(3) "Shared decision making" means a process in which the physician or other health care practitioner discusses with the patient or his or her representative the information specified in subsection (1)(a) of this section, with or without the use of a patient decision aid, and the patient shares with the provider such relevant personal information as might make one treatment or side effect more or less tolerable than others. The goal of shared decision making is for the patient and physician or other health care practitioner to feel they appropriately understand the nature of the procedure, the risks and benefits, as well as the individual values and preferences that influence the treatment decision, such that both are willing to sign a statement acknowledging that they have engaged in shared decision making and setting forth the agreed treatment to be furnished.

(4) "Patient decision aid" means a written, audio-visual, or online tool that provides a balanced presentation of the condition and treatment options, benefits, and harms, including, if appropriate, a discussion of the limits of scientific knowledge about outcomes, and that is certified by one or more national certifying organizations approved by the health care authority. In order to be an approved national certifying organization, an organization must use a rigorous evaluation process to assure that decision aids are competently developed, provide a balanced presentation of treatment options, benefits, and harms, and are efficacious at improving decision making.

(5) Failure to use a form or to engage in shared decision making, with or without the use of a patient decision aid, shall

2007 REGULAR SESSION

not be admissible as evidence of failure to obtain informed consent. There shall be no liability, civil or otherwise, resulting from a health care provider choosing either the signed consent form set forth in subsection (1)(a) of this section or the signed acknowledgement of shared decision making as set forth in subsection (2) of this section.

PREVENTION AND MANAGEMENT OF CHRONIC ILLNESS

NEW SECTION. Sec. 6. A new section is added to chapter 74.09 RCW to read as follows:

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

(a) Design and implement medical homes for its aged, blind, and disabled clients in conjunction with chronic care management programs to improve health outcomes, access, and cost-effectiveness. Programs must be evidence based, facilitating the use of information technology to improve quality of care, and must improve coordination of primary, acute, and long-term care for those clients with multiple chronic conditions. The department shall consider expansion of existing medical home and chronic care management programs and build on the Washington state collaborative initiative. The department shall use best practices in identifying those clients best served under a chronic care management model using predictive modeling through claims or other health risk information; and

(b) Contract for a study of chronic care management, to include evaluation of current efforts in the health and recovery services administration and the aging and disability services administration, comparison to best practices, and recommendations for future efforts and organizational structure to improve chronic care management.

(2) For purposes of this section:

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

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

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

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

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

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

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

(c) Clinical delivery system design;

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

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

(3) In selecting primary care providers to participate in the program, the department shall consider the number and type of patients with chronic conditions the provider serves, and the provider's participation in the medicaid and medicare programs.

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

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

NEW SECTION. Sec. 8. A new section is added to chapter 41.05 RCW to read as follows:

The Washington state quality forum is established within the authority. The forum shall collaborate with the Puget Sound health alliance and other local organizations and shall:

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

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

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

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

(5) Produce an annual quality report detailing clinical practice patterns identified to purchasers, providers, insurers, and policy makers.

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

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

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

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

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

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

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

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

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

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

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

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

(3) Members of the board may be compensated for participation in the work of the committee in accordance with a personal services contract to be executed after appointment and before commencement of activities related to the work of the

board. Members of the stakeholder committee shall not receive compensation but shall be reimbursed under RCW 43.03.050 and 43.03.060.

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

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

Sec. 10. RCW 43.70.110 and 2006 c 72 s 3 are each amended to read as follows:

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

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

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

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

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

(c) For physicians licensed under chapter 18.71 RCW, physician assistants licensed under chapter 18.71A RCW, osteopathic physicians licensed under chapter 18.57 RCW, osteopathic physicians' assistants licensed under chapter 18.57A RCW, naturopaths licensed under chapter 18.36A RCW, podiatrists licensed under chapter 18.22 RCW, chiropractors licensed under chapter 18.25 RCW, psychologists licensed under chapter 18.83 RCW, registered nurses licensed under chapter 18.79 RCW, optometrists licensed under chapter 18.53 RCW, mental health counselors licensed under chapter 18.225 RCW, massage therapists licensed under chapter 18.108 RCW, clinical social workers licensed under chapter 18.225 RCW, and acupuncturists licensed under chapter 18.06 RCW, the license fees shall include the cost to the department of contracting with the University of Washington to allow online access to selected vital clinical resources negotiated and maintained for the exclusive use of the licensed health professionals included in this subsection by the University of Washington health sciences library.

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

REDUCING UNNECESSARY EMERGENCY ROOM USE

Sec. 11. RCW 41.05.220 and 1998 c 245 s 38 are each amended to read as follows:

(1) State general funds appropriated to the department of health for the purposes of funding community health centers to provide primary health and dental care services, migrant health services, and maternity health care services shall be transferred to the state health care authority. Any related administrative

SIXTY-FIRST DAY, MARCH 9, 2007

funds expended by the department of health for this purpose shall also be transferred to the health care authority. The health care authority shall exclusively expend these funds through contracts with community health centers to provide primary health and dental care services, migrant health services, and maternity health care services. The administrator of the health care authority shall establish requirements necessary to assure community health centers provide quality health care services that are appropriate and effective and are delivered in a cost-efficient manner. The administrator shall further assure that community health centers have appropriate referral arrangements for acute care and medical specialty services not provided by the community health centers.

(2) The authority, in consultation with the department of health, shall work with community and migrant health clinics and other providers of care to underserved populations, to ensure that the number of people of color and underserved people receiving access to managed care is expanded in proportion to need, based upon demographic data.

(3) In contracting with community health centers to provide primary health and dental services, migrant health services, and maternity health care services under subsection (1) of this section the authority shall give priority to those community health centers working with local hospitals, local community health collaboratives, and/or local health jurisdictions to successfully reduce unnecessary emergency room use.

NEW SECTION. Sec. 12. The Washington state health care authority and the department of social and health services shall report to the legislature by December 1, 2007, on recent trends in unnecessary emergency room use by enrollees in state purchased health care programs and the uninsured, and then partner with community organizations and local health care providers to design a demonstration pilot to reduce such unnecessary visits.

REDUCE HEALTH CARE ADMINISTRATIVE COSTS

NEW SECTION. Sec. 13. By September 1, 2007, the insurance commissioner shall provide a report to the governor and the legislature that identifies the key contributors to health care administrative costs and evaluates opportunities to reduce them, including suggested changes to state law. The report shall be completed in collaboration with health care providers, carriers, state health purchasing agencies, the Washington healthcare forum, and other interested parties.

COVERAGE FOR DEPENDENTS TO AGE TWENTY-FIVE

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

(1) Any plan offered to employees under this chapter must offer each employee the option of covering any unmarried dependent of the employee under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

(2) Any employee choosing under subsection (1) of this section to cover a dependent who is: (a) Age twenty through twenty-three and not a registered student at an accredited secondary school, college, university, vocational school, or school of nursing; or (b) age twenty-four, shall be required to pay the full cost of such coverage.

(3) Any employee choosing under subsection (1) of this section to cover a dependent with disabilities, developmental disabilities, mental illness, or mental retardation, who is incapable of self-support, may continue enrollment under the same premium and payment structure as for dependents under the age of twenty, irrespective of age.

NEW SECTION. Sec. 15. A new section is added to chapter 48.20 RCW to read as follows:

2007 REGULAR SESSION

Any disability insurance contract that provides coverage for a subscriber's dependent must offer the option of covering any unmarried dependent under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

NEW SECTION. Sec. 16. A new section is added to chapter 48.21 RCW to read as follows:

Any group disability insurance contract or blanket disability insurance contract that provides coverage for a participating member's dependent must offer each participating member the option of covering any unmarried dependent under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

NEW SECTION. Sec. 17. A new section is added to chapter 48.44 RCW to read as follows:

(1) Any individual health care service plan contract that provides coverage for a subscriber's dependent must offer the option of covering any unmarried dependent under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

(2) Any group health care service plan contract that provides coverage for a participating member's dependent must offer each participating member the option of covering any unmarried dependent under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

NEW SECTION. Sec. 18. A new section is added to chapter 48.46 RCW to read as follows:

(1) Any individual health maintenance agreement that provides coverage for a subscriber's dependent must offer the option of covering any unmarried dependent under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

(2) Any group health maintenance agreement that provides coverage for a participating member's dependent must offer each participating member the option of covering any unmarried dependent under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

WASHINGTON HEALTH INSURANCE CONNECTOR

NEW SECTION. Sec. 19. A new section is added to chapter 41.05 RCW to read as follows:

(1) The authority, in collaboration with an advisory board established under subsection (3) of this section, shall design a Washington health insurance connector and submit implementing legislation and supporting information, including funding options, to the governor and the legislature by December 1, 2007. The connector shall be designed to serve as a statewide, public-private partnership, offering maximum value for Washington state residents, through which nonlarge group health insurance may be bought and sold. It is the goal of the connector to:

(a) Ensure that employees of small businesses and other individuals can find affordable health insurance;

(b) Provide a mechanism for small businesses to contribute to their employees' coverage without the administrative burden of directly shopping or contracting for insurance;

(c) Ensure that individuals can access coverage as they change and/or work in multiple jobs;

(d) Coordinate with other state agency health insurance assistance programs, including the department of social and health services medical assistance programs and the authority's basic health program; and

(e) Lead the health insurance marketplace in implementation of evidence-based medicine, data transparency, prevention and wellness incentives, and outcome-based reimbursement.

(2) In designing the connector, the authority shall:

(a) Address all operational and governance issues;

SIXTY-FIRST DAY, MARCH 9, 2007

(b) Consider best practices in the private and public sectors regarding, but not limited to, such issues as risk and/or purchasing pooling, market competition drivers, risk selection, and consumer choice and responsibility incentives; and

(c) Address key functions of the connector, including but not limited to:

(i) Methods for small businesses and their employees to realize tax benefits from their financial contributions;

(ii) Options for offering choice among a broad array of affordable insurance products designed to meet individual needs, including waiving some current regulatory requirements. Options may include a health savings account/high-deductible health plan, a comprehensive health benefit plan, and other benchmark plans;

(iii) Benchmarking health insurance products to a reasonable standard to enable individuals to make an informed choice of the coverage that is right for them;

(iv) Aggregating premium contributions for an individual from multiple sources: Employers, individuals, philanthropies, and government;

(v) Mechanisms to collect and distribute workers' enrollment information and premium payments to the health plan of their choice;

(vi) Mechanisms for spreading health risk widely to support health insurance premiums that are more affordable;

(vii) Opportunities to reward carriers and consumers whose behavior is consistent with quality, efficiency, and evidence-based best practices;

(viii) Coordination of the transmission of premium assistance payments with the department of social and health services for individuals eligible for the department's employer-sponsored insurance program.

(3) The authority shall appoint an advisory board and designate a chair. Members of the advisory board shall receive no compensation, but shall be reimbursed for expenses under RCW 43.03.050 and 43.03.060. Meetings of the board are subject to chapter 42.30 RCW, the open public meetings act, including RCW 42.30.110(1)(l), which authorizes an executive session during a regular or special meeting to consider proprietary or confidential nonpublished information.

(4) The authority may enter into contracts to issue, distribute, and administer grants that are necessary or proper to carry out the requirements of this section.

SUSTAINABILITY AND ACCESS TO PUBLIC PROGRAMS

NEW SECTION. Sec. 20. (1) The department of social and health services shall seek necessary federal waivers and state plan amendments to expand coverage and leverage federal and state resources for the state's basic health program, for the medical assistance program, as codified at Title XIX of the federal social security act, and the state's children's health insurance program, as codified at Title XXI of the federal social security act. The department shall propose options including but not limited to:

(a) Offering alternative benefit designs to promote high quality care, improve health outcomes, and encourage cost-effective treatment options, including benefit designs that discourage the use of emergency rooms for nonemergent care, and redirect savings to finance additional coverage;

(b) Creation of a health opportunity account demonstration program; and

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

(2) The department of social and health services, in collaboration with the Washington state health care authority,

2007 REGULAR SESSION

shall ensure that enrollees are not simultaneously enrolled in the state's basic health program and the medical assistance program or the state's children's health insurance program to ensure coverage for the maximum number of people within available funds. Priority enrollment in the basic health program shall be given to those who disenrolled from the program in order to enroll in medicaid, and subsequently became ineligible for medicaid coverage.

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

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

REINSURANCE

NEW SECTION. Sec. 22. (1) The office of financial management, in collaboration with the office of the insurance commissioner, shall evaluate and design a state-supported reinsurance program to address the impact of high cost enrollees in the individual and small group health insurance markets, and submit implementing legislation and supporting information, including financing options, to the governor and the legislature by December 1, 2007. In designing the program, the office of financial management shall:

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

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

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

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

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

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

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

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

THE WASHINGTON STATE HEALTH INSURANCE POOL

NEW SECTION. **Sec. 23.** The legislature finds that the Washington state health insurance pool is a critically important insurance option for people in this state and must reflect health care provisions based on the best available evidence and be financially sustainable over time. The laws governing the Washington state health insurance pool have been read to preclude the program from modifying contracts, and yet coverage needs and options change with time. Everyone in this state benefits when the Washington state health insurance pool is more affordable and higher performing. Changes are needed to the Washington state health insurance pool to increase affordability, offer quality and cost-effective benefits, and enhance the governance and operation of the pool.

Sec. 24. RCW 48.41.110 and 2001 c 196 s 4 are each amended to read as follows:

(1) The pool shall offer one or more care management plans of coverage. Such plans may, but are not required to, include point of service features that permit participants to receive in-network benefits or out-of-network benefits subject to differential cost shares. ~~((Covered persons enrolled in the pool on January 1, 2001, may continue coverage under the pool plan in which they are enrolled on that date. However,))~~ The pool may incorporate managed care features and encourage enrollees to participate in chronic care and disease management and evidence-based protocols into ((such)) existing plans.

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

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

(4) The pool shall offer at least one policy which at a minimum includes, but is not limited to, the following services or related items:

(a) Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, but limited to a total of one hundred eighty inpatient days in a calendar year, and limited to thirty days inpatient care for mental and nervous conditions, or alcohol, drug, or chemical dependency or abuse per calendar year;

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

(c) The first twenty outpatient professional visits for the diagnosis or treatment of one or more mental or nervous conditions or alcohol, drug, or chemical dependency or abuse rendered during a calendar year by one or more physicians,

psychologists, or community mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners, in the case of mental or nervous conditions, and rendered by a state certified chemical dependency program approved under chapter 70.96A RCW, in the case of alcohol, drug, or chemical dependency or abuse;

(d) Drugs and contraceptive devices requiring a prescription;

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

(f) Services of a home health agency;

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

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

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

(l) Diagnostic x-rays and laboratory tests;

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

(n) Maternity care services;

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

(p) Hospice services;

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

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

~~((#))~~ (5) The pool shall offer at least one policy which closely adheres to benefits available in the private, individual market.

~~((#))~~ (6) The board shall design and employ cost containment measures and requirements such as, but not limited to, care coordination, provider network limitations, preadmission certification, and concurrent inpatient review which may make the pool more cost-effective.

~~((#))~~ (7) The pool benefit policy may contain benefit limitations, exceptions, and cost shares such as copayments, coinsurance, and deductibles that are consistent with managed care products, except that differential cost shares may be adopted by the board for nonnetwork providers under point of service plans. ((The pool benefit policy cost shares and limitations must be consistent with those that are generally included in health plans approved by the insurance commissioner; however, no limitation, exception, or reduction may be used that would exclude coverage for any disease, illness, or injury.

~~((#))~~ (8) The pool may not reject an individual for health plan coverage based upon preexisting conditions of the individual or deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that it shall impose a six-month benefit waiting period for preexisting conditions for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the effective date of coverage. The preexisting condition waiting period shall not apply to prenatal care services. The pool may not avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. Credit against the waiting period shall be as provided in subsection ~~((#))~~ (9) of this section.

SIXTY-FIRST DAY, MARCH 9, 2007

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

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

~~((8))~~ (10) If an application is made for the pool policy as a result of rejection by a carrier, then the date of application to the carrier, rather than to the pool, should govern for purposes of determining preexisting condition credit.

(11) The pool shall contract with organizations that provide care management that has been demonstrated to be effective and shall encourage enrollees who are eligible for care management services to participate.

Sec. 25. RCW 48.41.160 and 1987 c 431 s 16 are each amended to read as follows:

(1) A pool policy offered under this chapter prior to the effective date of this section shall contain provisions under which the pool is obligated to renew the policy until the day on which the individual in whose name the policy is issued first becomes eligible for medicare coverage. At that time, coverage of dependents shall terminate if such dependents are eligible for coverage under a different health plan. Dependents who become eligible for medicare prior to the individual in whose name the policy is issued, shall receive benefits in accordance with RCW 48.41.150.

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

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

- (a) Nonpayment of premium;
- (b) Violation of published policies of the pool;
- (c) Failure of a covered person who becomes eligible for medicare benefits by reason of age to apply for a pool medical supplement plan, or a medicare supplement plan or other similar plan offered by a carrier pursuant to federal laws and regulations;
- (d) Failure of a covered person to pay any deductible or copayment amount owed to the pool and not the provider of health care services;
- (e) Covered persons committing fraudulent acts as to the pool;
- (f) Covered persons materially breaching the pool policy; or
- (g) Changes adopted to federal or state laws when such changes no longer permit the continued offering of such coverage.

(4)(a) The guarantee of continuity of coverage provided by this section requires that if the pool replaces a plan, it must make the replacement plan available to all individuals in the plan being replaced. The replacement plan must include all of the services covered under the replaced plan, and must not significantly limit access to the kind of services covered under the replaced plan. The pool may also allow individuals who are covered by a plan that is being replaced an unrestricted right to transfer to a fully comparable plan.

2007 REGULAR SESSION

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

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

- (i) The cost and quality of care to pool enrollees;
- (ii) Pool financing and enrollment;
- (iii) The board's ability to offer comprehensive and other plans to its enrollees;
- (iv) The ability of carriers to offer health plans in the individual market;
- (v) Other items identified by the board.

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

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

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

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

Sec. 26. RCW 48.41.200 and 2000 c 79 s 17 are each amended to read as follows:

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

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

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

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

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

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

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

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

(i) The rate for any person (~~aged fifty to sixty-four~~) whose current gross family income is less than two hundred fifty-one

SIXTY-FIRST DAY, MARCH 9, 2007

percent of the federal poverty level shall be reduced by thirty percent from what it would otherwise be;

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

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

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

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

Sec. 27. RCW 48.41.037 and 2000 c 79 s 36 are each amended to read as follows:

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

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

Sec. 28. RCW 48.41.100 and 2001 c 196 s 3 are each amended to read as follows:

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

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

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

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

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

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

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

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

(c) Inmates of public institutions and persons whose benefits are duplicated under public programs. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

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

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

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

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

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

(4) The board shall ensure that an independent analysis of the eligibility standards is conducted, with emphasis on those populations identified in subsection (2) of this section and the impacts on the pool and the state budget. The board shall report the findings to the legislature by December 1, 2007.

Sec. 29. RCW 48.43.005 and 2006 c 25 s 16 are each amended to read as follows:

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

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

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

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

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

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

(5) "Catastrophic health plan" means:

(a) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand ~~((five))~~ seven hundred fifty dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand five hundred dollars; and

(b) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least ~~((five))~~ six thousand ((five hundred)) dollars; or

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

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

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

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

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

(10) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty or more hours. The term includes a self-employed individual, including a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not work less than thirty hours per week and derives at least seventy-five percent of his or her income from a trade or business through which he or she has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form. Persons covered under a health benefit plan pursuant to the consolidated omnibus budget reconciliation act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements of chapter 265, Laws of 1995.

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

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

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

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

(15) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A 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.

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

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

(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.

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

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

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

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

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage; and

(l) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written

SIXTY-FIRST DAY, MARCH 9, 2007

request for such classification by the carrier and subsequent written approval by the insurance commissioner.

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

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

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

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

(24) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least two but no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor must derive at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year except for a self-employed individual or sole proprietor in an agricultural trade or business, who must derive at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year. A self-employed individual or sole proprietor who is covered as a group of one on the day prior to June 10, 2004, shall also be considered a "small employer" to the extent that individual or group of one is entitled to have his or her coverage renewed as provided in RCW 48.43.035(6).

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

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

Sec. 30. RCW 48.41.190 and 1989 c 121 s 10 are each amended to read as follows:

2007 REGULAR SESSION

Neither the participation by members, the establishment of rates, forms, or procedures for coverages issued by the pool, nor any other joint or collective action required by this chapter or the state of Washington shall be the basis of any legal action, civil or criminal liability or penalty against the pool, any member of the board of directors, or members of the pool either jointly or separately. The pool, members of the pool, board directors of the pool, officers of the pool, employees of the pool, the commissioner, the commissioner's representatives, and the commissioner's employees shall not be civilly or criminally liable and shall not have any penalty or cause of action of any nature arise against them for any action taken or not taken, including any discretionary decision or failure to make a discretionary decision, when the action or inaction is done in good faith and in the performance of the powers and duties under this chapter. Nothing in this section prohibits legal actions against the pool to enforce the pool's statutory or contractual duties or obligations.

Sec. 31. RCW 41.05.075 and 2006 c 103 s 3 are each amended to read as follows:

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

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

(a) Encourages competition among insuring entities;

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

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

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

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

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

(5) All claims data shall be the property of the state. The administrator may require of any insuring entity that submits a bid to contract for coverage all information deemed necessary including:

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

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

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

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

(a) Use evidence-based medicine principles to develop common performance measures and implement financial

SIXTY-FIRST DAY, MARCH 9, 2007

incentives in contracts with insuring entities, health care facilities, and providers that:

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

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

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

(i) Facilitate diagnosis or treatment;

(ii) Reduce unnecessary duplication of medical tests;

(iii) Promote efficient electronic physician order entry;

(iv) Increase access to health information for consumers and their providers; and

(v) Improve health outcomes;

(c) Coordinate a strategy for the adoption of health information technology systems using the final health information technology report and recommendations developed under chapter 261, Laws of 2005.

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

STRENGTHEN THE PUBLIC HEALTH SYSTEM

NEW SECTION. Sec. 32. A new section is added to chapter 43.70 RCW to read as follows:

(1) By December 31, 2007, within funds specifically appropriated therefor, the department shall award basic, noncategorical state public health funding to local public health jurisdictions through an annual contract which is based on performance measures for public health improvement, and which requires regular reporting to demonstrate progress toward meeting performance goals. This shall include local capacity development funds and any additional funds approved by the legislature to strengthen the public health system.

The department shall require the local health jurisdiction to regularly document compliance with contract requirements, and shall report to the legislature every two years on progress toward achieving public health improvement goals with funds provided for this purpose.

(2) Each contract with a local public health jurisdiction shall require reports of data on specific local public health indicators published in the most recent public health improvement plan, and a record of efforts to protect and improve the health of people in each local jurisdiction. To establish a basis for judging progress toward health goals:

(a) The local public health jurisdiction shall report data to document trends in protecting and improving public health using the local public health indicators;

(b) The department shall assist in assuring that needed data can be obtained at the county or local jurisdiction level;

(c) Technical assistance and information about evidence-based practice shall be provided to local jurisdictions through the efforts of the department; and

(d) The department shall routinely publish information on successful practices so that all local jurisdictions have information to improve effectiveness.

(3) To qualify for state funding under this section, local health jurisdictions must participate in demonstrating basic capacity to perform expected functions described in *Standards for Public Health* and published in the public health services improvement plan under RCW 43.70.520:

(a) The *Standards for Public Health* shall serve as the basic framework for evaluating each local health jurisdiction's ability

2007 REGULAR SESSION

to meet minimum expectations to perform public health functions;

(b) A measurement of every local jurisdiction shall be conducted no less than every third year;

(c) The department shall participate in the standards measurement process so that state-level support of the public health system is demonstrated; and

(d) Each local jurisdiction shall develop a quality improvement plan to use standards measurement results to improve capacity to meet public health standards prior to the next measurement cycle.

PREVENTION AND HEALTH PROMOTION

NEW SECTION. Sec. 33. The Washington state health care authority, the department of social and health services, the department of labor and industries, and the department of health shall, by September 1, 2007, develop a five-year plan to integrate disease and accident prevention and health promotion into state health programs by:

(1) Structuring benefits and reimbursements to promote healthy choices and disease and accident prevention;

(2) Requiring enrollees in state health programs to complete a health assessment, and providing appropriate follow up;

(3) Reimbursing for cost-effective prevention activities; and

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

The plan shall identify any existing barriers and opportunities to support implementation, including needed changes to state or federal law, and be submitted to the governor and the legislature upon completion. The agencies shall include health insurance carriers in the development of the plan.

Sec. 34. RCW 41.05.540 and 2005 c 360 s 8 are each amended to read as follows:

(1) The health care authority, in coordination with ~~((the department of personnel,))~~ the department of health, health plans participating in public employees' benefits board programs, and the University of Washington's center for health promotion, ~~((may create a worksite health promotion program to develop and implement initiatives designed to increase physical activity and promote improved self-care and engagement in health care decision-making among state employees.~~

~~—(2) The health care authority shall report to the governor and the legislature by December 1, 2006, on progress in implementing, and evaluating the results of, the worksite health promotion program)) shall establish and maintain a state employee health program focused on reducing the health risks of state employees, dependents, and retirees enrolled in the public employees' benefits board. The program shall use public and private sector best practices to achieve goals of measurable health outcomes, measurable productivity improvements, positive impact on the cost of medical care, and positive return on investment.~~

~~—(2) The state employee health program shall:~~

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

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

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

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

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

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

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

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

(3) The health care authority shall report to the legislature in December 2008, 2009, and 2010 on outcome goals for the employee health program.

NEW SECTION. Sec. 35. A new section is added to chapter 41.05 RCW to read as follows:

(1) The health care authority through the state employee health program shall create a state employee health demonstration project in four state agencies: The department of health, department of personnel, department of natural resources, and department of labor and industries. Demonstration project agencies shall operate employee health programs for their employees in collaboration with the state employee health program. Agency demonstration project employee health programs:

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

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

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

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

(2) The state employee health program shall evaluate each of the four programs separately and compare outcomes for each of them with the entire state employee population to assess effectiveness of the programs. Specifically, the program shall measure at least the following outcomes in the demonstration population: The reduction in the percent of the population that is overweight or obese, the reduction in risk factors related to diabetes, the reduction in risk factors related to absenteeism, the reduction in tobacco consumption, and the increase in appropriate use of preventive health services. The state employee health program shall report to the legislature in December 2008, 2009, and 2010 on the demonstration project.

(3) This section expires June 30, 2011.

NEW SECTION. Sec. 36. The legislature finds that prescription drug abuse has been on the rise and that often dispensers and prescribing providers are unaware of prescriptions provided by others both in and out of state.

It is the intent of the legislature to establish an electronic database available in real time to dispensers and prescribers of controlled substances. And further, that the department in as much as possible should establish a common dataset with other sets of other states.

NEW SECTION. Sec. 37. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

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

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

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

(4) "Dispenser" means a person who delivers a Schedule II, III, IV, or V controlled substance to the ultimate user, but does not include:

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

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

NEW SECTION. Sec. 38. (1) The department shall establish and maintain a web-based interactive prescription monitoring program available in real time to monitor the prescribing and dispensing of all Schedules II, III, IV, and V controlled substances and any additional drugs identified by the board of pharmacy as demonstrating a potential for abuse by all professionals licensed to prescribe or dispense such substances in this state. As much as possible, the department should establish a common database with other states.

(2) Each dispenser shall submit to the department by electronic means information regarding each prescription dispensed for a drug included under subsection (1) of this section. Drug prescriptions for more than immediate one day use should be immediately reported. The information submitted for each prescription shall include, but not be limited to:

- (a) Patient identifier;
- (b) Drug dispensed;
- (c) Date of dispensing;
- (d) Quantity dispensed;
- (e) Prescriber; and
- (f) Dispenser.

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

(4) The department may issue a waiver to a dispenser that is unable to submit prescription information by electronic means; however, all dispensers shall be required to submit prescription information by electronic means within one year from the effective date of this section. The waiver may permit the dispenser to submit prescription information by paper form or other means, provided all information required in subsection (2) of this section is submitted in this alternative format.

(5) The department shall seek federal grants to cover the costs of operating the prescription monitoring program. The department may not require a practitioner or a pharmacist to pay a fee or tax specifically dedicated to the operation of the system.

(6) The department shall report to the legislature on the implementation of this chapter by December 1, 2009.

NEW SECTION. Sec. 39. (1) Prescription information submitted to the department shall be confidential, in compliance with the health insurance portability and accountability act, and not subject to disclosure, except as provided in subsections (3), (4), and (5) of this section.

(2) The department shall maintain procedures to ensure that the privacy and confidentiality of patients and patient information collected, recorded, transmitted, and maintained is not disclosed to persons except as in subsections (3), (4), and (5) of this section.

(3) The department shall review the prescription information. The department shall notify the practitioner and allow explanation or correction of any problem. If there is reasonable cause to believe a violation of law or breach of professional standards may have occurred, the department shall notify the appropriate law enforcement or professional licensing, certification, or regulatory agency or entity, and provide prescription information required for an investigation.

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

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

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

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

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

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

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

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

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

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

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

NEW SECTION. Sec. 40. The department may contract with another agency of this state or with a private vendor, as necessary, to ensure the effective operation of the prescription monitoring program. Any contractor is bound to comply with the provisions regarding confidentiality of prescription information in section 39 of this act and is subject to the penalties specified in section 42 of this act for unlawful acts.

NEW SECTION. Sec. 41. The department shall adopt rules to implement this chapter.

NEW SECTION. Sec. 42. (1) A dispenser who knowingly fails to submit prescription monitoring information to the department as required by this chapter or knowingly submits incorrect prescription information is subject to disciplinary action under chapter 18.130 RCW.

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

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

(4) In accordance with the health insurance portability and accountability act, any physician or pharmacist authorized to access a patient's prescription monitoring may discuss or release that information to other health care providers involved with the patient in order to provide safe and appropriate care coordination.

NEW SECTION. Sec. 43. 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.

Sec. 44. RCW 42.56.360 and 2006 c 209 s 9 and 2006 c 8 s 112 are each reenacted and amended to read as follows:

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

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

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

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

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

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

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

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

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

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

~~(h) Information obtained by the department of health under chapter 69.-- RCW (sections 36 through 43 of this act).~~

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

NEW SECTION. Sec. 45. Sections 36 through 43 of this act constitute a new chapter in Title 69 RCW.

NEW SECTION. Sec. 46. Subheadings used in this act are not any part of the law.

NEW SECTION. Sec. 47. Sections 14 through 18 of this act take effect January 1, 2008.

NEW SECTION. Sec. 48. If specific funding for the purposes of the following sections of this act, referencing the section of this act by bill or chapter number and section number, is not provided by June 30, 2007, in the omnibus appropriations act, the section is null and void:

(1) Section 8 of this act (Washington state quality forum);

(2) Section 9 of this act (health records banking pilot project);

(3) Section 19 of this act (health insurance connector); and

(4) Section 35 of this act (state employee health demonstration project).

NEW SECTION. Sec. 49. Sections 23 through 31 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 take effect immediately."

WITHDRAWAL OF AMENDMENT

On motion of Senator Keiser, the striking amendment by Senator Keiser to Second Substitute Senate Bill No. 5930 was withdrawn.

MOTION

Senator Keiser moved that the following striking amendment by Senator Keiser be adopted:

Strike everything after the enacting clause and insert the following:

"USE STATE PURCHASING TO IMPROVE HEALTH CARE QUALITY

NEW SECTION. Sec. 1. The health care authority and the department of social and health services shall, by September 1, 2007, develop a five-year plan to change reimbursement within state purchased health care programs to:

- (1) Reward quality health outcomes rather than simply paying for the receipt of particular services or procedures;
- (2) Pay for care that reflects patient preference and is of proven value;
- (3) Require the use of evidence-based standards of care where available;
- (4) Tie provider rate increases to measurable improvements in access to quality care;
- (5) Direct enrollees to quality care systems;
- (6) Better support primary care and provide a medical home to all enrollees; and
- (7) Pay for e-mail consultations, telemedicine, and telehealth where doing so reduces the overall cost of care.

The plan shall identify any existing barriers and opportunities to support implementation, including needed changes to state or federal law and be submitted to the governor and the legislature upon completion.

NEW SECTION. Sec. 2. The legislature finds that unwarranted variations in health care, variations not explained by illness, patient preference, or the dictates of evidence-based medicine, are a significant feature of health care in Washington state. There is growing evidence that, for preference-sensitive care involving elective surgery, the quality of patient-practitioner communication about the benefits, harms, and uncertainty of available treatment options can be improved by introducing high-quality decision aids that encourage shared decision making. The international patient decision aid standards collaboration, a network of over one hundred researchers, practitioners, patients, and policy makers from fourteen countries, have developed standards for constructing high-quality decision aids. The legislature declares an intent to focus on improving the quality of patient-practitioner communication and on increasing the extent to which patients make genuinely informed, preference-based treatment decisions. Randomized clinical trial evidence indicates that effective use of well designed decision aids is likely to improve the quality of patient decision making, reduce unwarranted variations in health care, and result in lower health care costs overall. Despite this growing body of evidence, widespread use of decision aids has yet to occur. Barriers include: (1) Lack of awareness of existing, appropriate, high-quality decision aids; (2) poor accessibility to such decision aids; (3) low practitioner acceptance of decision aids in terms of compatibility with their practice, ease of use, and expense to incorporate into practice; (4) lack of incentives for use, such as reduced liability and reimbursement for their use; and (5) lack of a process to certify that a decision aid meets the standards required of a high-quality decision aid. The legislature intends to promote new public/private collaborative efforts to broaden the development, use, evaluation, and certification of effective decision aids and intends to support the collaborative through providing new recognition of the shared decision-making process and patient decision aids in the state's laws on informed consent. The legislature also intends to establish a process for certifying that a given decision aid meets the standards required for a high-quality decision aid.

NEW SECTION. Sec. 3. The state health care authority shall work in collaboration with the health professions and quality improvement communities to increase awareness of appropriate, high-quality decision aids, and to train physicians and other practitioners in their use. The effort shall focus on one or more of the preference-sensitive conditions with high rates of unwarranted variation in Washington, and can include strategies such as prominent linkage to such decision aids in state web sites, and training/awareness programs in conjunction with professional and quality improvement groups. The state health care authority shall, in consultation with the national committee

for quality assurance, identify a certification process for patient decision aids. The state health care authority may accept donations or grants to support such efforts.

NEW SECTION. Sec. 4. The state health care authority shall work with contracting health carriers and health care providers, and a nonproprietary public interest research group and/or university-based research group, to implement practical and usable models to demonstrate shared decision making in everyday clinical practice. The demonstrations shall be conducted at one or more multispecialty group practice sites providing state purchased health care in the state of Washington, and may include other practice sites providing state purchased health care. The demonstrations must include the following elements: Incorporation into clinical practice of one or more decision aids for one or more identified preference-sensitive care areas combined with ongoing training and support of involved practitioners and practice teams, preferably at sites with necessary supportive health information technology. The evaluation must include the following elements: (1) A comparison between the demonstration sites and, if appropriate, between the demonstration sites and a control group, of the impact of the shared decision-making process employing the decision aids on: The use of preference-sensitive health care services; and associated costs saved and/or expended; and (2) an assessment of patient knowledge of the relevant health care choices, benefits, harms, and uncertainties; concordance between patient values and care received; and satisfaction with the decision-making process and their health outcomes by patients and involved physicians and other health care practitioners. The health care authority may solicit and accept funding to support the demonstration and evaluation.

Sec. 5. RCW 7.70.060 and 1975-'76 2nd ex.s. c 56 s 11 are each amended to read as follows:

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

- ~~((1))~~ (a) A description, in language the patient could reasonably be expected to understand, of:
 - ~~((a))~~ (i) The nature and character of the proposed treatment;
 - ~~((b))~~ (ii) The anticipated results of the proposed treatment;
 - ~~((c))~~ (iii) The recognized possible alternative forms of treatment; and
 - ~~((d))~~ (iv) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including nontreatment;

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

(2) If a patient while legally competent, or his or her representative if he or she is not competent, signs an acknowledgement of shared decision making as described in subsection (3) of this section, such acknowledgement shall constitute prima facie evidence that the patient gave his or her informed consent to the treatment administered and the patient has the burden of rebutting this by clear and convincing evidence. An acknowledgement of shared decision making shall include:

- (a) A statement that the patient, or his or her representative, and the health care provider have engaged in shared decision making as an alternative means of meeting the informed consent requirements set forth by laws, accreditation standards, and other mandates;
- (b) A brief description of the services that the patient and provider jointly have agreed will be furnished;

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

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

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

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

(3) "Shared decision making" means a process in which the physician or other health care practitioner discusses with the patient or his or her representative the information specified in subsection (1)(a) of this section, with or without the use of a patient decision aid, and the patient shares with the provider such relevant personal information as might make one treatment or side effect more or less tolerable than others. The goal of shared decision making is for the patient and physician or other health care practitioner to feel they appropriately understand the nature of the procedure, the risks and benefits, as well as the individual values and preferences that influence the treatment decision, such that both are willing to sign a statement acknowledging that they have engaged in shared decision making and setting forth the agreed treatment to be furnished.

(4) "Patient decision aid" means a written, audio-visual, or online tool that provides a balanced presentation of the condition and treatment options, benefits, and harms, including, if appropriate, a discussion of the limits of scientific knowledge about outcomes, and that is certified by one or more national certifying organizations approved by the health care authority. In order to be an approved national certifying organization, an organization must use a rigorous evaluation process to assure that decision aids are competently developed, provide a balanced presentation of treatment options, benefits, and harms, and are efficacious at improving decision making.

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

PREVENTION AND MANAGEMENT OF CHRONIC ILLNESS

NEW SECTION. Sec. 6. A new section is added to chapter 74.09 RCW to read as follows:

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

(a) Design and implement medical homes for its aged, blind, and disabled clients in conjunction with chronic care management programs to improve health outcomes, access, and cost-effectiveness. Programs must be evidence based, facilitating the use of information technology to improve quality of care, and must improve coordination of primary, acute, and long-term care for those clients with multiple chronic conditions. The department shall consider expansion of existing medical home and chronic care management programs and build on the Washington state collaborative initiative. The department shall use best practices in identifying those clients

best served under a chronic care management model using predictive modeling through claims or other health risk information; and

(b) Contract for a study of chronic care management, to include evaluation of current efforts in the health and recovery services administration and the aging and disability services administration, comparison to best practices, and recommendations for future efforts and organizational structure to improve chronic care management.

(2) For purposes of this section:

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

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

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

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

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

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

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

(c) Clinical delivery system design;

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

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

(3) In selecting primary care providers to participate in the program, the department shall consider the number and type of patients with chronic conditions the provider serves, and the provider's participation in the medicaid and medicare programs.

COST AND QUALITY INFORMATION FOR CONSUMERS AND PROVIDERS

NEW SECTION. Sec. 8. A new section is added to chapter 41.05 RCW to read as follows:

The Washington state quality forum is established within the authority. The forum shall collaborate with the Puget Sound health alliance and other local organizations and shall:

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

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

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

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

(5) Produce an annual quality report detailing clinical practice patterns identified to purchasers, providers, insurers, and policy makers.

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

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

SIXTY-FIRST DAY, MARCH 9, 2007

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 10. RCW 43.70.110 and 2006 c 72 s 3 are each amended to read as follows:

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

(2) Except as provided in ~~(RCW 18.79.202, until June 30, 2013, and except for the cost of regulating retired volunteer medical workers in accordance with RCW 18.130.360)~~ subsection (3) of this section, fees charged shall be based on, but

2007 REGULAR SESSION

shall not exceed, the cost to the department for the licensure of the activity or class of activities and may include costs of necessary inspection.

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

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

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

(c) For physicians licensed under chapter 18.71 RCW, physician assistants licensed under chapter 18.71A RCW, osteopathic physicians licensed under chapter 18.57 RCW, osteopathic physicians' assistants licensed under chapter 18.57A RCW, naturopaths licensed under chapter 18.36A RCW, podiatrists licensed under chapter 18.22 RCW, chiropractors licensed under chapter 18.25 RCW, psychologists licensed under chapter 18.83 RCW, registered nurses licensed under chapter 18.79 RCW, optometrists licensed under chapter 18.53 RCW, mental health counselors licensed under chapter 18.225 RCW, massage therapists licensed under chapter 18.108 RCW, clinical social workers licensed under chapter 18.225 RCW, and acupuncturists licensed under chapter 18.06 RCW, the license fees shall include the cost to the department of contracting with the University of Washington to allow online access to selected vital clinical resources negotiated and maintained for the exclusive use of the licensed health professionals included in this subsection by the University of Washington health sciences library.

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

REDUCING UNNECESSARY EMERGENCY ROOM USE

Sec. 11. RCW 41.05.220 and 1998 c 245 s 38 are each amended to read as follows:

(1) State general funds appropriated to the department of health for the purposes of funding community health centers to provide primary health and dental care services, migrant health services, and maternity health care services shall be transferred to the state health care authority. Any related administrative funds expended by the department of health for this purpose shall also be transferred to the health care authority. The health care authority shall exclusively expend these funds through contracts with community health centers to provide primary health and dental care services, migrant health services, and maternity health care services. The administrator of the health care authority shall establish requirements necessary to assure community health centers provide quality health care services that are appropriate and effective and are delivered in a cost-efficient manner. The administrator shall further assure that community health centers have appropriate referral arrangements for acute care and medical specialty services not provided by the community health centers.

(2) The authority, in consultation with the department of health, shall work with community and migrant health clinics and other providers of care to underserved populations, to ensure that the number of people of color and underserved people receiving access to managed care is expanded in proportion to need, based upon demographic data.

(3) In contracting with community health centers to provide primary health and dental services, migrant health services, and maternity health care services under subsection (1) of this section the authority shall give priority to those community health centers working with local hospitals, local community health collaboratives, and/or local health jurisdictions to successfully reduce unnecessary emergency room use.

SIXTY-FIRST DAY, MARCH 9, 2007

NEW SECTION. Sec. 12. The Washington state health care authority and the department of social and health services shall report to the legislature by December 1, 2007, on recent trends in unnecessary emergency room use by enrollees in state purchased health care programs and the uninsured, and then partner with community organizations and local health care providers to design a demonstration pilot to reduce such unnecessary visits.

REDUCE HEALTH CARE ADMINISTRATIVE COSTS

NEW SECTION. Sec. 13. By September 1, 2007, the insurance commissioner shall provide a report to the governor and the legislature that identifies the key contributors to health care administrative costs and evaluates opportunities to reduce them, including suggested changes to state law. The report shall be completed in collaboration with health care providers, carriers, state health purchasing agencies, the Washington healthcare forum, and other interested parties.

COVERAGE FOR DEPENDENTS TO AGE TWENTY-FIVE

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

(1) Any plan offered to employees under this chapter must offer each employee the option of covering any unmarried dependent of the employee under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

(2) Any employee choosing under subsection (1) of this section to cover a dependent who is: (a) Age twenty through twenty-three and not a registered student at an accredited secondary school, college, university, vocational school, or school of nursing; or (b) age twenty-four, shall be required to pay the full cost of such coverage.

(3) Any employee choosing under subsection (1) of this section to cover a dependent with disabilities, developmental disabilities, mental illness, or mental retardation, who is incapable of self-support, may continue enrollment under the same premium and payment structure as for dependents under the age of twenty, irrespective of age.

NEW SECTION. Sec. 15. A new section is added to chapter 48.20 RCW to read as follows:

Any disability insurance contract that provides coverage for a subscriber's dependent must offer the option of covering any unmarried dependent under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

NEW SECTION. Sec. 16. A new section is added to chapter 48.21 RCW to read as follows:

Any group disability insurance contract or blanket disability insurance contract that provides coverage for a participating member's dependent must offer each participating member the option of covering any unmarried dependent under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

NEW SECTION. Sec. 17. A new section is added to chapter 48.44 RCW to read as follows:

(1) Any individual health care service plan contract that provides coverage for a subscriber's dependent must offer the option of covering any unmarried dependent under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

(2) Any group health care service plan contract that provides coverage for a participating member's dependent must offer each participating member the option of covering any unmarried dependent under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

2007 REGULAR SESSION

NEW SECTION. Sec. 18. A new section is added to chapter 48.46 RCW to read as follows:

(1) Any individual health maintenance agreement that provides coverage for a subscriber's dependent must offer the option of covering any unmarried dependent under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

(2) Any group health maintenance agreement that provides coverage for a participating member's dependent must offer each participating member the option of covering any unmarried dependent under the age of twenty-five who is a "qualifying child" or "qualifying relative" as defined in section 152 of the internal revenue code.

WASHINGTON HEALTH INSURANCE CONNECTOR

NEW SECTION. Sec. 19. A new section is added to chapter 41.05 RCW to read as follows:

(1) The authority, in collaboration with an advisory board established under subsection (3) of this section, shall design a Washington health insurance connector and submit implementing legislation and supporting information, including funding options, to the governor and the legislature by December 1, 2007. The connector shall be designed to serve as a statewide, public-private partnership, offering maximum value for Washington state residents, through which nonlarge group health insurance may be bought and sold. It is the goal of the connector to:

(a) Ensure that employees of small businesses and other individuals can find affordable health insurance;

(b) Provide a mechanism for small businesses to contribute to their employees' coverage without the administrative burden of directly shopping or contracting for insurance;

(c) Ensure that individuals can access coverage as they change and/or work in multiple jobs;

(d) Coordinate with other state agency health insurance assistance programs, including the department of social and health services medical assistance programs and the authority's basic health program; and

(e) Lead the health insurance marketplace in implementation of evidence-based medicine, data transparency, prevention and wellness incentives, and outcome-based reimbursement.

(2) In designing the connector, the authority shall:

(a) Address all operational and governance issues;

(b) Consider best practices in the private and public sectors regarding, but not limited to, such issues as risk and/or purchasing pooling, market competition drivers, risk selection, and consumer choice and responsibility incentives; and

(c) Address key functions of the connector, including but not limited to:

(i) Methods for small businesses and their employees to realize tax benefits from their financial contributions;

(ii) Options for offering choice among a broad array of affordable insurance products designed to meet individual needs, including waiving some current regulatory requirements. Options may include a health savings account/high-deductible health plan, a comprehensive health benefit plan, and other benchmark plans;

(iii) Benchmarking health insurance products to a reasonable standard to enable individuals to make an informed choice of the coverage that is right for them;

(iv) Aggregating premium contributions for an individual from multiple sources: Employers, individuals, philanthropies, and government;

(v) Mechanisms to collect and distribute workers' enrollment information and premium payments to the health plan of their choice;

(vi) Mechanisms for spreading health risk widely to support health insurance premiums that are more affordable;

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

(vii) Opportunities to reward carriers and consumers whose behavior is consistent with quality, efficiency, and evidence-based best practices;

(viii) Coordination of the transmission of premium assistance payments with the department of social and health services for individuals eligible for the department's employer-sponsored insurance program.

(3) The authority shall appoint an advisory board and designate a chair. Members of the advisory board shall receive no compensation, but shall be reimbursed for expenses under RCW 43.03.050 and 43.03.060. Meetings of the board are subject to chapter 42.30 RCW, the open public meetings act, including RCW 42.30.110(1)(I), which authorizes an executive session during a regular or special meeting to consider proprietary or confidential unpublished information.

(4) The authority may enter into contracts to issue, distribute, and administer grants that are necessary or proper to carry out the requirements of this section.

SUSTAINABILITY AND ACCESS TO PUBLIC PROGRAMS

NEW SECTION. Sec. 20. (1) The department of social and health services shall seek necessary federal waivers and state plan amendments to expand coverage and leverage federal and state resources for the state's basic health program, for the medical assistance program, as codified at Title XIX of the federal social security act, and the state's children's health insurance program, as codified at Title XXI of the federal social security act. The department shall propose options including but not limited to:

(a) Offering alternative benefit designs to promote high quality care, improve health outcomes, and encourage cost-effective treatment options, including benefit designs that discourage the use of emergency rooms for nonemergent care, and redirect savings to finance additional coverage;

(b) Creation of a health opportunity account demonstration program; and

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

(2) The department of social and health services, in collaboration with the Washington state health care authority, shall ensure that enrollees are not simultaneously enrolled in the state's basic health program and the medical assistance program or the state's children's health insurance program to ensure coverage for the maximum number of people within available funds. Priority enrollment in the basic health program shall be given to those who disenrolled from the program in order to enroll in medicaid, and subsequently became ineligible for medicaid coverage.

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

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

REINSURANCE

NEW SECTION. Sec. 22. (1) The office of financial management, in collaboration with the office of the insurance commissioner, shall evaluate and design a state-supported reinsurance program to address the impact of high cost enrollees in the individual and small group health insurance markets, and

submit implementing legislation and supporting information, including financing options, to the governor and the legislature by December 1, 2007. In designing the program, the office of financial management shall:

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

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

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

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

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

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

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

THE WASHINGTON STATE HEALTH INSURANCE POOL

NEW SECTION. Sec. 23. The legislature finds that the Washington state health insurance pool is a critically important insurance option for people in this state and must reflect health care provisions based on the best available evidence and be financially sustainable over time. The laws governing the Washington state health insurance pool have been read to preclude the program from modifying contracts, and yet coverage needs and options change with time. Everyone in this state benefits when the Washington state health insurance pool is more affordable and higher performing. Changes are needed to the Washington state health insurance pool to increase affordability, offer quality and cost-effective benefits, and enhance the governance and operation of the pool.

Sec. 24. RCW 48.41.110 and 2001 c 196 s 4 are each amended to read as follows:

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

(1) The pool shall offer one or more care management plans of coverage. Such plans may, but are not required to, include point of service features that permit participants to receive in-network benefits or out-of-network benefits subject to differential cost shares. ~~((Covered persons enrolled in the pool on January 1, 2001, may continue coverage under the pool plan in which they are enrolled on that date. However,))~~ The pool may incorporate managed care features and encourage enrollees to participate in chronic care and disease management and evidence-based protocols into ~~((such))~~ existing plans.

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

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

(4) The pool shall offer at least one policy which at a minimum includes, but is not limited to, the following services or related items:

(a) Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, but limited to a total of one hundred eighty inpatient days in a calendar year, and limited to thirty days inpatient care for mental and nervous conditions, or alcohol, drug, or chemical dependency or abuse per calendar year;

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

(c) The first twenty outpatient professional visits for the diagnosis or treatment of one or more mental or nervous conditions or alcohol, drug, or chemical dependency or abuse rendered during a calendar year by one or more physicians, psychologists, or community mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners, in the case of mental or nervous conditions, and rendered by a state certified chemical dependency program approved under chapter 70.96A RCW, in the case of alcohol, drug, or chemical dependency or abuse;

(d) Drugs and contraceptive devices requiring a prescription;

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

(f) Services of a home health agency;

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

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

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

(l) Diagnostic x-rays and laboratory tests;

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

(n) Maternity care services;

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

(p) Hospice services;

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

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

~~((4))~~ (5) The pool shall offer at least one policy which closely adheres to benefits available in the private, individual market.

~~((6))~~ (6) The board shall design and employ cost containment measures and requirements such as, but not limited to, care coordination, provider network limitations, preadmission certification, and concurrent inpatient review which may make the pool more cost-effective.

~~((5))~~ (7) The pool benefit policy may contain benefit limitations, exceptions, and cost shares such as copayments, coinsurance, and deductibles that are consistent with managed care products, except that differential cost shares may be adopted by the board for nonnetwork providers under point of service plans. ~~((The pool benefit policy cost shares and limitations must be consistent with those that are generally included in health plans approved by the insurance commissioner; however, no limitation, exception, or reduction may be used that would exclude coverage for any disease, illness, or injury.))~~

~~((6))~~ (8) The pool may not reject an individual for health plan coverage based upon preexisting conditions of the individual or deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that it shall impose a six-month benefit waiting period for preexisting conditions for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the effective date of coverage. The preexisting condition waiting period shall not apply to prenatal care services. The pool may not avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. Credit against the waiting period shall be as provided in subsection ~~((7))~~ (9) of this section.

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

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

~~((8))~~ (10) If an application is made for the pool policy as a result of rejection by a carrier, then the date of application to the carrier, rather than to the pool, should govern for purposes of determining preexisting condition credit.

(11) The pool shall contract with organizations that provide care management that has been demonstrated to be effective and shall encourage enrollees who are eligible for care management services to participate.

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

Sec. 25. RCW 48.41.160 and 1987 c 431 s 16 are each amended to read as follows:

(1) A pool policy offered under this chapter prior to the effective date of this section shall contain provisions under which the pool is obligated to renew the policy until the day on which the individual in whose name the policy is issued first becomes eligible for medicare coverage. At that time, coverage of dependents shall terminate if such dependents are eligible for coverage under a different health plan. Dependents who become eligible for medicare prior to the individual in whose name the policy is issued, shall receive benefits in accordance with RCW 48.41.150.

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

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

- (a) Nonpayment of premium;
- (b) Violation of published policies of the pool;
- (c) Failure of a covered person who becomes eligible for medicare benefits by reason of age to apply for a pool medical supplement plan, or a medicare supplement plan or other similar plan offered by a carrier pursuant to federal laws and regulations;
- (d) Failure of a covered person to pay any deductible or copayment amount owed to the pool and not the provider of health care services;
- (e) Covered persons committing fraudulent acts as to the pool;
- (f) Covered persons materially breaching the pool policy; or
- (g) Changes adopted to federal or state laws when such changes no longer permit the continued offering of such coverage.

(4)(a) The guarantee of continuity of coverage provided by this section requires that if the pool replaces a plan, it must make the replacement plan available to all individuals in the plan being replaced. The replacement plan must include all of the services covered under the replaced plan, and must not significantly limit access to the kind of services covered under the replaced plan. The pool may also allow individuals who are covered by a plan that is being replaced an unrestricted right to transfer to a fully comparable plan.

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

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

- (i) The cost and quality of care to pool enrollees;
- (ii) Pool financing and enrollment;
- (iii) The board's ability to offer comprehensive and other plans to its enrollees;
- (iv) The ability of carriers to offer health plans in the individual market;
- (v) Other items identified by the board.

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

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

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

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

Sec. 26. RCW 48.41.200 and 2000 c 79 s 17 are each amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 27. RCW 48.41.037 and 2000 c 79 s 36 are each amended to read as follows:

The Washington state health insurance pool account is created in the custody of the state treasurer. All receipts from moneys specifically appropriated to the account must be deposited in the account. Expenditures from this account shall be used to cover deficits incurred by the Washington state health insurance pool under this chapter in excess of the threshold established in this section. To the extent funds are available in the account, funds shall be expended from the account to offset that portion of the deficit that would otherwise have to be recovered by imposing an assessment on members in excess of a

SIXTY-FIRST DAY, MARCH 9, 2007

threshold of seventy cents per insured person per month. The commissioner shall authorize expenditures from the account, to the extent that funds are available in the account, upon certification by the pool board that assessments will exceed the threshold level established in this section. The account is subject to the allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

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

Sec. 28. RCW 48.41.100 and 2001 c 196 s 3 are each amended to read as follows:

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

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

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

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

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

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

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

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

(c) Inmates of public institutions and persons whose benefits are duplicated under public programs. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

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

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

2007 REGULAR SESSION

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

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

(c) The pool administrator shall provide written notice to any person who is no longer eligible for coverage under a pool plan under this subsection (3) within thirty days of the administrator's determination that the person is no longer eligible. The notice shall: (i) Indicate that coverage under the plan will cease ninety days from the date that the notice is dated; (ii) describe any other coverage options, either in or outside of the pool, available to the person; (iii) describe the procedures for the administration of the standard health questionnaire to determine the person's continued eligibility for coverage under subsection (1)(b) of this section; and (iv) describe the enrollment process for the available options outside of the pool. (4) The board shall ensure that an independent analysis of the eligibility standards for the pool coverage is conducted, including examining eligibility for medicaid enrollees and other publicly sponsored enrollees, and the impacts on the pool and the state budget. The board shall report the findings to the legislature by December 1, 2007.

Sec. 29. RCW 48.41.120 and 2000 c 79 s 14 are each amended to read as follows:

(1) Subject to the limitation provided in subsection ~~((3))~~ (2) of this section, a pool policy offered in accordance with RCW 48.41.110(3) shall impose a deductible. Deductibles of five hundred dollars and one thousand dollars on a per person per calendar year basis shall initially be offered. The board may authorize deductibles in other amounts. The deductible shall be applied to the first five hundred dollars, one thousand dollars, or other authorized amount of eligible expenses incurred by the covered person.

~~(2) ((Subject to the limitations provided in subsection (3) of this section, a mandatory coinsurance requirement shall be imposed at the rate of twenty percent of eligible expenses in excess of the mandatory deductible.~~

~~—(3))~~ The maximum aggregate out of pocket payments for eligible expenses by the insured in the form of deductibles and coinsurance under a pool policy offered in accordance with RCW 48.41.110(3) shall not exceed in a calendar year:

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

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

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

~~((4))~~ (3) Eligible expenses incurred by a covered person in the last three months of a calendar year, and applied toward a deductible, shall also be applied toward the deductible amount in the next calendar year.

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

Sec. 30. RCW 48.43.005 and 2006 c 25 s 16 are each amended to read as follows:

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

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

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

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

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

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

(5) "Catastrophic health plan" means:

(a) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand ~~((five))~~ seven hundred fifty dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand five hundred dollars; and

(b) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least ~~((five))~~ six thousand ~~((five hundred))~~ dollars; or

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

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

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

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

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

(10) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty or more hours. The term includes a self-employed individual, including a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not work less than thirty hours per week and derives at least seventy-five percent of his or her income from a trade or business through which he or she has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form. Persons covered under a health benefit plan pursuant to the consolidated omnibus budget reconciliation act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements of chapter 265, Laws of 1995.

(11) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate

medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

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

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

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

(15) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A 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.

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

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

(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.

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

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

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

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

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

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

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

(k) Dental only and vision only coverage; and

(l) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

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

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

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

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

(24) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least two but no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor must derive at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year except for a self-employed individual or sole proprietor in an agricultural trade or business, who must derive at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year. A self-employed individual or sole proprietor who is covered as a group of one on the day prior to June 10, 2004, shall also be considered a "small employer" to the extent that individual or group of one is entitled to have his or her coverage renewed as provided in RCW 48.43.035(6).

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

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

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

Neither the participation by members, the establishment of rates, forms, or procedures for coverages issued by the pool, nor any other joint or collective action required by this chapter or the state of Washington shall be the basis of any legal action, civil or criminal liability or penalty against the pool, any member of the board of directors, or members of the pool either jointly or separately. The pool, members of the pool, board directors of the pool, officers of the pool, employees of the pool, the commissioner, the commissioner's representatives, and the commissioner's employees shall not be civilly or criminally liable and shall not have any penalty or cause of action of any nature arise against them for any action taken or not taken, including any discretionary decision or failure to make a discretionary decision, when the action or inaction is done in good faith and in the performance of the powers and duties under this chapter. Nothing in this section prohibits legal actions against the pool to enforce the pool's statutory or contractual duties or obligations.

Sec. 32. RCW 41.05.075 and 2006 c 103 s 3 are each amended to read as follows:

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

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

(a) Encourages competition among insuring entities;

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

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

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

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

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

(5) All claims data shall be the property of the state. The administrator may require of any insuring entity that submits a bid to contract for coverage all information deemed necessary including:

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

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

(6) All contracts with insuring entities for the provision of health care benefits shall provide that the beneficiaries of such benefit plans may use on an equal participation basis the services of practitioners licensed pursuant to chapters 18.22, 18.25, 18.32, 18.53, 18.57, 18.71, 18.74, 18.83, and 18.79 RCW, as it applies to registered nurses and advanced registered nurse practitioners. However, nothing in this subsection may

SIXTY-FIRST DAY, MARCH 9, 2007

preclude the administrator from establishing appropriate utilization controls approved pursuant to RCW 41.05.065(2) (a), (b), and (d).

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

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

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

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

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

(i) Facilitate diagnosis or treatment;

(ii) Reduce unnecessary duplication of medical tests;

(iii) Promote efficient electronic physician order entry;

(iv) Increase access to health information for consumers and their providers; and

(v) Improve health outcomes;

(c) Coordinate a strategy for the adoption of health information technology systems using the final health information technology report and recommendations developed under chapter 261, Laws of 2005.

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

STRENGTHEN THE PUBLIC HEALTH SYSTEM

NEW SECTION. Sec. 33. A new section is added to chapter 43.70 RCW to read as follows:

(1) By December 31, 2007, within funds specifically appropriated therefor, the department shall award basic, noncategorical state public health funding to local public health jurisdictions through an annual contract which is based on performance measures for public health improvement, and which requires regular reporting to demonstrate progress toward meeting performance goals. This shall include local capacity development funds and any additional funds approved by the legislature to strengthen the public health system.

The department shall require the local health jurisdiction to regularly document compliance with contract requirements, and shall report to the legislature every two years on progress toward achieving public health improvement goals with funds provided for this purpose.

(2) Each contract with a local public health jurisdiction shall require reports of data on specific local public health indicators published in the most recent public health improvement plan, and a record of efforts to protect and improve the health of people in each local jurisdiction. To establish a basis for judging progress toward health goals:

(a) The local public health jurisdiction shall report data to document trends in protecting and improving public health using the local public health indicators;

(b) The department shall assist in assuring that needed data can be obtained at the county or local jurisdiction level;

(c) Technical assistance and information about evidence-based practice shall be provided to local jurisdictions through the efforts of the department; and

2007 REGULAR SESSION

(d) The department shall routinely publish information on successful practices so that all local jurisdictions have information to improve effectiveness.

(3) To qualify for state funding under this section, local health jurisdictions must participate in demonstrating basic capacity to perform expected functions described in *Standards for Public Health* and published in the public health services improvement plan under RCW 43.70.520:

(a) The *Standards for Public Health* shall serve as the basic framework for evaluating each local health jurisdiction's ability to meet minimum expectations to perform public health functions;

(b) A measurement of every local jurisdiction shall be conducted no less than every third year;

(c) The department shall participate in the standards measurement process so that state-level support of the public health system is demonstrated; and

(d) Each local jurisdiction shall develop a quality improvement plan to use standards measurement results to improve capacity to meet public health standards prior to the next measurement cycle.

PREVENTION AND HEALTH PROMOTION

NEW SECTION. Sec. 34. The Washington state health care authority, the department of social and health services, the department of labor and industries, and the department of health shall, by September 1, 2007, develop a five-year plan to integrate disease and accident prevention and health promotion into state health programs by:

(1) Structuring benefits and reimbursements to promote healthy choices and disease and accident prevention;

(2) Requiring enrollees in state health programs to complete a health assessment, and providing appropriate follow up;

(3) Reimbursing for cost-effective prevention activities; and

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

The plan shall identify any existing barriers and opportunities to support implementation, including needed changes to state or federal law, and be submitted to the governor and the legislature upon completion. The agencies shall include health insurance carriers in the development of the plan.

Sec. 35. RCW 41.05.540 and 2005 c 360 s 8 are each amended to read as follows:

(1) The health care authority, in coordination with ~~(the department of personnel,)~~ the department of health, health plans participating in public employees' benefits board programs, and the University of Washington's center for health promotion, ~~((may create a worksite health promotion program to develop and implement initiatives designed to increase physical activity and promote improved self-care and engagement in health care decision-making among state employees.~~

~~(2) The health care authority shall report to the governor and the legislature by December 1, 2006, on progress in implementing, and evaluating the results of, the worksite health promotion program)) shall establish and maintain a state employee health program focused on reducing the health risks of state employees, dependents, and retirees enrolled in the public employees' benefits board. The program shall use public and private sector best practices to achieve goals of measurable health outcomes, measurable productivity improvements, positive impact on the cost of medical care, and positive return on investment.~~

(2) The state employee health program shall:

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

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

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

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

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

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

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

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

(3) The health care authority shall report to the legislature in December 2008, 2009, and 2010 on outcome goals for the employee health program.

NEW SECTION. Sec. 36. A new section is added to chapter 41.05 RCW to read as follows:

(1) The health care authority through the state employee health program shall create a state employee health demonstration project in four state agencies: The department of health, department of personnel, department of natural resources, and department of labor and industries. Demonstration project agencies shall operate employee health programs for their employees in collaboration with the state employee health program. Agency demonstration project employee health programs:

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

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

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

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

(2) The state employee health program shall evaluate each of the four programs separately and compare outcomes for each of them with the entire state employee population to assess effectiveness of the programs. Specifically, the program shall measure at least the following outcomes in the demonstration population: The reduction in the percent of the population that is overweight or obese, the reduction in risk factors related to diabetes, the reduction in risk factors related to absenteeism, the reduction in tobacco consumption, and the increase in appropriate use of preventive health services. The state employee health program shall report to the legislature in December 2008, 2009, and 2010 on the demonstration project.

(3) This section expires June 30, 2011.

NEW SECTION. Sec. 37. The legislature finds that prescription drug abuse has been on the rise and that often dispensers and prescribing providers are unaware of prescriptions provided by others both in and out of state.

It is the intent of the legislature to establish an electronic database available in real time to dispensers and prescribers of controlled substances. And further, that the department in as much as possible should establish a common dataset with other sets of other states.

NEW SECTION. Sec. 38. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

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

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

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

(4) "Dispenser" means a person who delivers a Schedule II, III, IV, or V controlled substance to the ultimate user, but does not include:

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

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

NEW SECTION. Sec. 39. (1) The department shall establish and maintain a web-based interactive prescription monitoring program available in real time to monitor the prescribing and dispensing of all Schedules II, III, IV, and V controlled substances and any additional drugs identified by the board of pharmacy as demonstrating a potential for abuse by all professionals licensed to prescribe or dispense such substances in this state. As much as possible, the department should establish a common database with other states.

(2) Each dispenser shall submit to the department by electronic means information regarding each prescription dispensed for a drug included under subsection (1) of this section. Drug prescriptions for more than immediate one day use should be immediately reported. The information submitted for each prescription shall include, but not be limited to:

(a) Patient identifier;

(b) Drug dispensed;

(c) Date of dispensing;

(d) Quantity dispensed;

(e) Prescriber; and

(f) Dispenser.

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

(4) The department may issue a waiver to a dispenser that is unable to submit prescription information by electronic means; however, all dispensers shall be required to submit prescription information by electronic means within one year from the effective date of this section. The waiver may permit the dispenser to submit prescription information by paper form or other means, provided all information required in subsection (2) of this section is submitted in this alternative format.

(5) The department shall seek federal grants to cover the costs of operating the prescription monitoring program. The department may not require a practitioner or a pharmacist to pay a fee or tax specifically dedicated to the operation of the system.

(6) The department shall report to the legislature on the implementation of this chapter by December 1, 2009.

NEW SECTION. Sec. 40. (1) Prescription information submitted to the department shall be confidential, in compliance with the health insurance portability and accountability act, and not subject to disclosure, except as provided in subsections (3), (4), and (5) of this section.

(2) The department shall maintain procedures to ensure that the privacy and confidentiality of patients and patient information collected, recorded, transmitted, and maintained is not disclosed to persons except as in subsections (3), (4), and (5) of this section.

(3) The department shall review the prescription information. The department shall notify the practitioner and allow explanation or correction of any problem. If there is reasonable cause to believe a violation of law or breach of professional standards may have occurred, the department shall notify the appropriate law enforcement or professional licensing, certification, or regulatory agency or entity, and provide prescription information required for an investigation.

SIXTY-FIRST DAY, MARCH 9, 2007

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

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

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

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

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

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

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

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

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

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

NEW SECTION. Sec. 41. The department may contract with another agency of this state or with a private vendor, as necessary, to ensure the effective operation of the prescription monitoring program. Any contractor is bound to comply with the provisions regarding confidentiality of prescription information in section 40 of this act and is subject to the penalties specified in section 43 of this act for unlawful acts.

NEW SECTION. Sec. 42. The department shall adopt rules to implement this chapter.

NEW SECTION. Sec. 43. (1) A dispenser who knowingly fails to submit prescription monitoring information to the department as required by this chapter or knowingly submits incorrect prescription information is subject to disciplinary action under chapter 18.130 RCW.

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

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

(4) In accordance with the health insurance portability and accountability act, any physician or pharmacist authorized to access a patient's prescription monitoring may discuss or release that information to other health care providers involved with the patient in order to provide safe and appropriate care coordination.

NEW SECTION. Sec. 44. 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.

Sec. 45. RCW 42.56.360 and 2006 c 209 s 9 and 2006 c 8 s 112 are each reenacted and amended to read as follows:

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

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

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

(c) Information and documents created specifically for, and collected and maintained by a quality improvement committee

2007 REGULAR SESSION

under RCW 43.70.510 or 70.41.200, or by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640 or 18.20.390, and notifications or reports of adverse events or incidents made under RCW 70.56.020 or 70.56.040, regardless of which agency is in possession of the information and documents;

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

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

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

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

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

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

~~(h) Information obtained by the department of health under chapter 69.-- RCW (sections 37 through 44 of this act).~~

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

NEW SECTION. Sec. 46. Sections 37 through 44 of this act constitute a new chapter in Title 69 RCW.

NEW SECTION. Sec. 47. Subheadings used in this act are not any part of the law.

NEW SECTION. Sec. 48. Sections 14 through 18 of this act take effect January 1, 2008.

NEW SECTION. Sec. 49. If specific funding for the purposes of the following sections of this act, referencing the section of this act by bill or chapter number and section number, is not provided by June 30, 2007, in the omnibus appropriations act, the section is null and void:

(1) Section 8 of this act (Washington state quality forum);

(2) Section 9 of this act (health records banking pilot project);

(3) Section 19 of this act (health insurance connector); and

(4) Section 36 of this act (state employee health demonstration project).

NEW SECTION. Sec. 50. Sections 23 through 32 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 take effect immediately."

Senator Keiser spoke in favor of adoption of the striking amendment.

MOTION

Senator Pflug moved that the following amendment by Senator Pflug to the striking amendment be adopted.

On page 1, line 24, after "completion.", insert "The agencies shall report annually to the legislature beginning September

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

2007, and September of each year thereafter, initially on (1) what the targets are, and in the years to follow, (2) the effectiveness and efficiency with which each strategy in the plan has achieved the goals of reducing the cost of health care for individuals, improving people's health, and achieving the goals set for this section."

Re-number the sections consecutively and correct any internal references accordingly.

Senators Pflug and Keiser spoke in favor of adoption of the amendment to the striking amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator Pflug on page 1, line 24 to the striking amendment to Second Substitute Senate Bill No. 5930.

The motion by Senator Pflug carried and the amendment to the striking amendment was adopted by voice vote.

MOTION

Senator Pflug moved that the following amendment by Senator Pflug to the striking amendment be adopted.

On page 8, line 5, after "makers.", insert "The agencies shall report annually to the legislature beginning September 2007, and September of each year thereafter, initially on (1) what the targets are, and in the years to follow, (2) the effectiveness and efficiency with which each strategy in the plan has achieved the goals of reducing the cost of health care for individuals, improving people's health, and achieving the goals set for this section."

Re-number the sections consecutively and correct any internal references accordingly.

Senators Pflug and Keiser spoke in favor of adoption of the amendment to the striking amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator Pflug on page 8, line 5 to the striking amendment to Second Substitute Senate Bill No. 5930.

The motion by Senator Pflug carried and the amendment to the striking amendment was adopted by voice vote.

MOTION

Senator Pflug moved that the following amendment by Senator Pflug to the striking amendment be adopted.

On page 11, after line 32, insert "The agencies shall design a plan to require hospitals serving patients enrolled in their state financed health plans to effectively link or refer non-emergent patients seeking care in hospital emergency rooms to twenty-four hour clinics located in the community. The clinic must be reasonably accessible and available to the patient. The agencies shall design a plan to provide all enrollees, beneficiaries, and participants in their health coverage access to a twenty-four hour, seven day a week, nurse hotline that is accessible via the two-one-one system. The agencies shall develop technical service agreements to secure public service announcements through television, radio and print media to inform the public of access to the nurse hotline."

Re-number the sections consecutively and correct any internal references accordingly.

Senators Pflug and Keiser spoke in favor of adoption of the

amendment to the striking amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator Pflug on page 11, after line 32 to the striking amendment to Second Substitute Senate Bill No. 5930.

The motion by Senator Pflug carried and the amendment to the striking amendment was adopted by voice vote.

MOTION

Senator Pflug moved that the following amendment by Senator Pflug to the striking amendment be adopted.

On page 12, line 5, after "parties.", insert "In developing the report, the insurance commissioner shall work with health insurance carriers to develop a plan to implement the recommendations from the 2003-2004 health insurance regulation review and streamlining work group."

Re-number the sections consecutively and correct any internal references accordingly.

Senators Pflug and Keiser spoke in favor of adoption of the amendment to the striking amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator Pflug on page 12, line 5 to the striking amendment to Second Substitute Senate Bill No. 5930.

The motion by Senator Pflug carried and the amendment to the striking amendment was adopted by voice vote.

MOTION

Senator Pflug moved that the following amendment by Senator Pflug to the striking amendment be adopted.

On page 16, line 19, after "coverage." insert "(3) In coordination with the health care authority, the departments shall design and implement a medical home for chronically ill state employees enrolled in the state's self-insured uniform medical plan. Programs must be evidence based, facilitating the use of information technology to improve quality of care and must improve coordination of primary, acute, and long-term care for those enrollees with multiple chronic conditions. The agencies shall consider expansion of existing medical home and chronic care management programs. The agencies shall use best practices in identifying those employees best served under a chronic care management model using predictive modeling through claims or other health risk information."

Re-number the sections consecutively and correct any internal references accordingly.

Senators Pflug and Keiser spoke in favor of adoption of the amendment to the striking amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator Pflug on page 16, line 19 to the striking amendment to Second Substitute Senate Bill No. 5930.

The motion by Senator Pflug carried and the amendment to the striking amendment was adopted by voice vote.

MOTION

Senator Pflug moved that the following amendment by Senator Pflug to the striking amendment be adopted.

On page 38, line 27, after "completion.", insert "The agencies shall report annually to the legislature beginning September 2007, and September of each year thereafter, initially on (1) what the targets are, and in the years to follow, (2) the effectiveness and efficiency with which each strategy in the plan has achieved the goals of reducing the cost of health care for individuals, improving people's health, and achieving the goals set for this section."

Renumber the sections consecutively and correct any internal references accordingly.

Senators Pflug and Keiser spoke in favor of adoption of the amendment to the striking amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator Pflug on page 38, line 27 to the striking amendment to Engrossed Second Substitute Senate Bill No. 5930.

The motion by Senator Pflug carried and the amendment to the striking amendment was adopted by voice vote.

MOTION

Senator Parlette moved that the following amendment by Senators Parlette and Haugen to the striking amendment be adopted.

On page 45, after line 33 of the amendment, insert the following:

"**Sec. 46.** RCW 48.43.041 and 2000 c 79 s 26 are each amended to read as follows:

(1) All individual health benefit plans, other than catastrophic health plans (~~(- offered or renewed on or after October 1, 2000)~~) and plans for young adults as described in subsection (3) of this section, shall include benefits described in this section. Nothing in this section shall be construed to require a carrier to offer an individual health benefit plan.

(a) Maternity services that include, with no enrollee cost-sharing requirements beyond those generally applicable cost-sharing requirements: Diagnosis of pregnancy; prenatal care; delivery; care for complications of pregnancy; physician services; hospital services; operating or other special procedure rooms; radiology and laboratory services; appropriate medications; anesthesia; and services required under RCW 48.43.115; and

(b) Prescription drug benefits with at least a two thousand dollar benefit payable by the carrier annually.

(2) If a carrier offers a health benefit plan that is not a catastrophic health plan to groups, and it chooses to offer a health benefit plan to individuals, it must offer at least one health benefit plan to individuals that is not a catastrophic health plan.

(3) Carriers may design and offer a separate health plan targeted at young adults between nineteen and thirty-four years of age. The plan may include the benefits required under subsections (1) and (2) of this section but is not required to include these benefits. The health plan designed for young adults may be exempt from the requirements of RCW 48.43.045(1), 48.43.515(5), 48.44.327, 48.20.392, and 48.46.277.

Sec. 47. RCW 48.44.022 and 2006 c 100 s 3 are each amended to read as follows:

(1) Except for health benefit plans covered under RCW 48.44.021, premium rates for health benefit plans for individuals shall be subject to the following provisions:

(a) The health care service contractor shall develop its rates based on an adjusted community rate and may only vary the

adjusted community rate for:

- (i) Geographic area;
- (ii) Family size;
- (iii) Age;
- (iv) Tenure discounts; and
- (v) Wellness activities.

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

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

(d) Except as provided in subsection (2) of this section, the permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

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

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

- (i) Changes to the family composition;
- (ii) Changes to the health benefit plan requested by the individual; or
- (iii) Changes in government requirements affecting the health benefit plan.

(g) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(h) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall pool the medical experience of all individuals purchasing coverage, except individuals purchasing coverage under RCW 48.44.021, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.44.023. Carriers may treat young adults and products developed specifically for them consistent with RCW 48.43.041(3) as a single banded experience pool for purposes of establishing rates. The rates established for this age group are not subject to subsection (1)(d) of this section.

(3) As used in this section and RCW 48.44.023 "health benefit plan," "small employer," "adjusted community rates," and "wellness activities" mean the same as defined in RCW 48.43.005.

Sec. 48. RCW 48.46.064 and 2006 c 100 s 5 are each amended to read as follows:

(1) Except for health benefit plans covered under RCW 48.46.063, premium rates for health benefit plans for individuals shall be subject to the following provisions:

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

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

- (i) Geographic area;
- (ii) Family size;
- (iii) Age;
- (iv) Tenure discounts; and
- (v) Wellness activities.

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

(c) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.

(d) Except as provided in subsection (2) of this section, the permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

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

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

- (i) Changes to the family composition;
- (ii) Changes to the health benefit plan requested by the individual; or
- (iii) Changes in government requirements affecting the health benefit plan.

(g) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(h) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall pool the medical experience of all individuals purchasing coverage, except individuals purchasing coverage under RCW 48.46.063, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.46.066. Carriers may treat young adults and products developed specifically for them consistent with RCW 48.43.041(3) as a single banded experience pool for purposes of establishing rates. The rates established for this age group are not subject to subsection (1)(d) of this section.

(3) As used in this section and RCW 48.46.066, "health benefit plan," "adjusted community rate," "small employer," and "wellness activities" mean the same as defined in RCW 48.43.005.

Sec. 49. RCW 48.20.029 and 2006 c 100 s 2 are each amended to read as follows:

(1) Premiums for health benefit plans for individuals who purchase the plan as a member of a purchasing pool:

- (a) Consisting of five hundred or more individuals affiliated with a particular industry;
- (b) To whom care management services are provided as a benefit of pool membership; and
- (c) Which allows contributions from more than one

employer to be used towards the purchase of an individual's health benefit plan; shall be calculated using the adjusted community rating method that spreads financial risk across the entire purchasing pool of which the individual is a member. All such rates shall conform to the following:

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

- (A) Geographic area;
- (B) Family size;
- (C) Age;
- (D) Tenure discounts; and
- (E) Wellness activities.

(ii) The adjustment for age in (c)(i)(C) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(iii) The insurer shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer, and coverage for which medicare is not the primary payer. Both rates are subject to the requirements of this subsection.

(iv) Except as provided in subsection (2) of this section, the permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(v) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs not to exceed twenty percent.

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

- (A) Changes to the family composition;
- (B) Changes to the health benefit plan requested by the individual; or
- (C) Changes in government requirements affecting the health benefit plan.

(vii) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(viii) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.21.045. Carriers may treat young adults and products developed specifically for them consistent with RCW 48.43.041(3) as a single banded experience pool for purposes of establishing rates. The rates established for this age group are not subject to subsection (1)(c)(iv) of this section.

(3) As used in this section, "health benefit plan," "adjusted community rates," and "wellness activities" mean the same as defined in RCW 48.43.005.

NEW SECTION. Sec. 50. A new section is added to chapter 48.43 RCW to read as follows:

The office of the insurance commissioner shall make

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

available educational and outreach materials targeted to young adults aged nineteen to thirty-four, as funding becomes available. Education and outreach efforts shall focus on educating young consumers on the importance and value of health insurance, including educational materials, public service messages, and other outreach activities. The commissioner is authorized to fund these activities with grants, donations, in-kind contributions, or other funding that may be available."

On page 46, line 21 of the title amendment, after "41.05.075," strike "and 41.05.540" and insert "41.05.540, 48.43.041, 48.44.022, 48.46.064, and 48.20.029"

On page 46, beginning on line 26 of the title amendment, strike "a new section to chapter 48.43" and insert "new sections to chapter 48.43"

WITHDRAWAL OF AMENDMENT

On motion of Senator Parlette, the amendment by Senators Parlette and Haugen on page 45, line 33 to the striking amendment to Second Substitute Senate Bill No. 5930 was withdrawn.

MOTION

Senator Parlette moved that the following amendment by Senators Parlette and Haugen to the striking amendment be adopted.

On page 45, after line 33 of the amendment, insert the following:

"**NEW SECTION. Sec. 46.** The legislature finds that many small employers struggle with the cost of providing employer-sponsored health insurance coverage to their employees, while others are unable to offer coverage due to its high cost. It is the intent of the legislature to encourage the availability of less expensive health insurance plans, and expand the flexibility of small employers to purchase less expensive products.

Sec. 47. RCW 70.47A.040 and 2006 c 255 s 4 are each amended to read as follows:

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

(2) Premium subsidy payments may be provided to eligible employees ~~((f:))~~ or participating carriers on behalf of employees.

(a) The eligible employee ~~((s))~~ must be employed by a small employer((:)).

(b) ~~((The actuarial value of the health benefit plan offered by the small employer is at least equivalent to that of the basic health plan benefit offered under chapter 70.47 RCW. The office of the insurance commissioner under Title 48 RCW shall certify those small employer health benefit plans that are at least actuarially equivalent to the basic health plan benefit; and))~~ Small employers may offer any available health benefit plan including health savings accounts. Health savings account subsidy payments may be provided to eligible employees if the eligible employee participates in an employer-sponsored high deductible health plan and health savings account that conforms to the requirements of the United States internal revenue service.

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

(3) The amount of an eligible employee's premium subsidy shall be determined by applying the sliding scale subsidy

schedule developed for subsidized basic health plan enrollees under RCW 70.47.060 to the employee's premium obligation for his or her employer's health benefit plan.

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

(5) An eligible employee must agree to provide verification of continued enrollment in his or her small employer's health benefit plan on a semiannual basis or to notify the administrator whenever his or her enrollment status changes, whichever is earlier. Verification or notification may be made directly by the employee, or through his or her employer or the carrier providing the small employer health benefit plan. When necessary, the administrator has the authority to perform retrospective audits on premium subsidy accounts. The administrator may suspend or terminate an employee's participation in the program and seek repayment of any subsidy amounts paid due to the omission or misrepresentation of an applicant or enrolled employee. The administrator shall adopt rules to define the appropriate application of these sanctions and the processes to implement the sanctions provided in this subsection, within available resources.

Sec. 48. RCW 48.21.045 and 2004 c 244 s 1 are each amended to read as follows:

~~(1)((a))~~ An insurer offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer ~~((a))~~ no more than one health benefit plan featuring a limited schedule of covered health care services. ~~((Nothing in this subsection shall preclude an insurer from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. An insurer offering a health benefit plan under this subsection shall clearly disclose all covered benefits to the small employer in a brochure filed with the commissioner.~~

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

~~—(2))~~ (a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to, comply with: RCW 48.21.130 through 48.21.240, 48.21.244 through 48.21.280, 48.21.300 through 48.21.320, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

(b) In offering the plan under this subsection, the insurer must offer the small employer the option of permitting every category of health care provider to provide health services or care for conditions covered by the plan pursuant to RCW 48.43.045(1).

(2) An insurer offering the plan under subsection (1) of this section must also offer and actively market to the small employer at least one additional health benefit plan.

(3) Nothing in this section shall prohibit an insurer from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts

SIXTY-FIRST DAY, MARCH 9, 2007

shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

~~((3))~~ (4) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

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

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

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

(c) The insurer shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection ~~((3))~~ (4).

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

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

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

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

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

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

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account defined by the United States internal revenue service, adjusted community rates established under this section shall pool the medical experience of all small groups purchasing coverage. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus ~~((four))~~ eight percentage points from the overall adjustment of a carrier's entire small group pool, ~~((such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries~~

2007 REGULAR SESSION

~~that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal))~~ if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than eight percentage points are subject to review by the commissioner and must be approved or denied within thirty days of submittal. A variation that is not denied within ~~((sixty))~~ thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ~~((within thirty days))~~ at the time of the denial.

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

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

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

- (i) One hundred percent of eligible employees working for groups with three or less employees; and
- (ii) Seventy-five percent of eligible employees working for groups with more than three employees.

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

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

~~((6))~~ (7) An insurer must offer coverage to all eligible employees of a small employer and their dependents. An insurer may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. An insurer may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

~~((7))~~ (8) As used in this section, "health benefit plan," "small employer," "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005.

Sec. 49. RCW 48.44.023 and 2004 c 244 s 7 are each amended to read as follows:

(1)~~((a))~~ A health care services contractor offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer ~~((a))~~ no more than one health benefit plan featuring a limited schedule of covered health care services. ~~((Nothing in this subsection shall preclude~~

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

a contractor from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A contractor offering a health benefit plan under this subsection shall clearly disclose all covered benefits to the small employer in a brochure filed with the commissioner.

~~—(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460.~~

~~—(2)) (a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to, comply with: RCW 48.44.210, 48.44.212, 48.44.225, 48.44.240 through 48.44.245, 48.44.290 through 48.44.340, 48.44.344, 48.44.360 through 48.44.380, 48.44.400, 48.44.420, 48.44.440 through 48.44.460, 48.44.500, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.~~

~~(b) In offering the plan under this subsection, the health care service contractor must offer the small employer the option of permitting every category of health care provider to provide health services or care for conditions covered by the plan pursuant to RCW 48.43.045(1).~~

~~(2) A health care service contractor offering the plan under subsection (1) of this section must also offer and actively market to the small employer at least one additional health benefit plan.~~

~~(3) Nothing in this section shall prohibit a health care service contractor from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.~~

~~((3)) (4) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:~~

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

- ~~(i) Geographic area;~~
- ~~(ii) Family size;~~
- ~~(iii) Age; and~~
- ~~(iv) Wellness activities.~~

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

~~(c) The contractor shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection ((3)) (4).~~

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

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

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

- (i) Changes to the enrollment of the small employer;
- (ii) Changes to the family composition of the employee;
- (iii) Changes to the health benefit plan requested by the small employer; or

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

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

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

~~(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus ((four)) eight percentage points from the overall adjustment of a carrier's entire small group pool ((such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal)) if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than eight percentage points are subject to review by the commissioner and must be approved or denied within thirty days of submittal. A variation that is not denied within ((sixty)) thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ((within thirty days)) at the time of the denial.~~

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

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

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

- (i) One hundred percent of eligible employees working for

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

groups with three or less employees; and

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

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

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

~~((6))~~ (7) A contractor must offer coverage to all eligible employees of a small employer and their dependents. A contractor may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A contractor may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 50. RCW 48.46.066 and 2004 c 244 s 9 are each amended to read as follows:

~~(1)((a))~~ A health maintenance organization offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer ~~((a))~~ no more than one health benefit plan featuring a limited schedule of covered health care services. (Nothing in this subsection shall preclude a health maintenance organization from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A health maintenance organization offering a health benefit plan under this subsection shall clearly disclose all the covered benefits to the small employer in a brochure filed with the commissioner.

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

~~(2))~~ (a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to, comply with: RCW 48.46.250, 48.46.272 through 48.46.290, 48.46.320, 48.46.350, 48.46.375, 48.46.440 through 48.46.460, 48.46.480, 48.46.490, 48.46.510, 48.46.520, 48.46.530, 48.46.565, 48.46.570, 48.46.575, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

(b) In offering the plan under this subsection, the health maintenance organization must offer the small employer the option of permitting every category of health care provider to provide health services or care for conditions covered by the plan pursuant to RCW 48.43.045(1).

(2) A health maintenance organization offering the plan under subsection (1) of this section must also offer and actively market to the small employer at least one additional health benefit plan.

(3) Nothing in this section shall prohibit a health maintenance organization from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All

forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

~~((3))~~ (4) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

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

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

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

(c) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection ~~((3))~~ (4).

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

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

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

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

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

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

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus ~~((four))~~ eight percentage points from the overall adjustment of a carrier's entire small group pool ~~((such overall adjustment to be approved by the commissioner, upon a showing by the carrier,~~

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal)) if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the health maintenance organization's small group pool. Variations of greater than eight percentage points are subject to review by the commissioner and must be approved or denied within thirty days of submittal. A variation that is not denied within ((sixty)) thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ((within thirty days)) at the time of the denial.

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

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

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

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

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

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

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

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

Sec. 51. RCW 48.21.047 and 2005 c 223 s 11 are each amended to read as follows:

(1) An insurer may not offer any health benefit plan to any small employer without complying with RCW 48.21.045((4)) (4).

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and the plans are not subject to RCW 48.21.045((4)) (4).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

Sec. 52. RCW 48.43.028 and 2001 c 196 s 10 are each amended to read as follows:

To the extent required of the federal health insurance portability and accountability act of 1996, the eligibility of an employer or group to purchase a health benefit plan set forth in RCW 48.21.045(1)((b)), 48.44.023(1)((b)), and 48.46.066(1)((b)) must be extended to all small employers and small groups as defined in RCW 48.43.005.

Sec. 53. RCW 48.44.024 and 2003 c 248 s 15 are each amended to read as follows:

(1) A health care service contractor may not offer any health benefit plan to any small employer without complying with RCW 48.44.023((4)) (4).

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and the plans are not subject to RCW 48.44.023((4)) (4).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

Sec. 54. RCW 48.46.068 and 2003 c 248 s 16 are each amended to read as follows:

(1) A health maintenance organization may not offer any health benefit plan to any small employer without complying with RCW 48.46.066((4)) (4).

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and are not subject to RCW 48.46.066((4)) (4).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005."

Renumber the remaining sections consecutively.

Senators Parlette and Keiser spoke in favor of adoption of the amendment to the striking amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senators Parlette and Haugen on page 45, after line 33 to the striking amendment to Second Substitute Senate Bill No. 5930.

The motion by Senator Parlette carried and the amendment to the striking amendment was adopted by voice vote.

The President declared the question before the Senate to be the adoption of the striking amendment by Senator Keiser as amended to Second Substitute Senate Bill No. 5930.

The motion by Senator Keiser carried and the striking amendment as amended was adopted by voice vote.

MOTION

There being no objection, the following title amendments were adopted:

On page 1, line 3 of the title, after "access;" strike the remainder of the title and insert "amending RCW 7.70.060, 43.70.110, 41.05.220, 48.41.110, 48.41.160, 48.41.200, 48.41.037, 48.41.100, 48.43.005, 48.41.190, 41.05.075, and 41.05.540; reenacting and amending RCW 42.56.360; adding a new section to chapter 74.09 RCW; adding new sections to

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

chapter 43.70 RCW; adding new sections to chapter 41.05 RCW; adding a new section to chapter 48.20 RCW; adding a new section to chapter 48.21 RCW; adding a new section to chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; adding a new section to chapter 48.43 RCW; adding a new chapter to Title 69 RCW; creating new sections; prescribing penalties; providing an effective date; providing an expiration date; and declaring an emergency."

On page 46, line 21 of the title amendment, after "41.05.075," strike "and 41.05.540" and insert "41.05.540, 70.47A.040, 48.21.045, 48.44.023, 48.46.066, 48.21.047, 48.43.028, 48.44.024, and 48.46.068"

MOTION

On motion of Senator Keiser, the rules were suspended, Engrossed Second Substitute Senate Bill No. 5930 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators Keiser, Pflug and Parlette spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Engrossed Second Substitute Senate Bill No. 5930.

ROLL CALL

The Secretary called the roll on the final passage of Engrossed Second Substitute Senate Bill No. 5930 and the bill passed the Senate by the following vote: Yeas, 48; Nays, 0; Absent, 0; Excused, 1.

Voting yea: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Pflug, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 48

Excused: Senator Delvin - 1

ENGROSSED SECOND SUBSTITUTE SENATE BILL NO. 5930, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

SENATE BILL NO. 5813, by Senators McAuliffe, Hobbs, Weinstein, Kauffman, Eide, Tom, Rasmussen, Kohl-Welles, Murray, Shin, Marr, Oemig, Kilmer and Delvin

Improving mathematics and science education. Revised for 2nd Substitute: Creating educational opportunities.

MOTION

On motion of Senator McAuliffe, Second Substitute Senate Bill No. 5813 was substituted for Senate Bill No. 5813 and the second substitute bill was placed on the second reading and read the second time.

MOTION

Senator McAuliffe moved that the following amendment by Senators McAuliffe and Pflug be adopted.

On page 3, after line 24, strike all of section 2.

Renumber the sections consecutively and correct any internal references accordingly.

Senator McAuliffe spoke in favor of adoption of the amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senators McAuliffe and Pflug on page 3, after line 24 to Second Substitute Senate Bill No. 5813.

The motion by Senator McAuliffe carried and the amendment was adopted by voice vote.

MOTION

Senator McAuliffe moved that the following amendment by Senator McAuliffe be adopted.

On page 6, line 32, after "education," strike all material through "science" and insert "or English as a second language"

On page 7, beginning on line 5, strike all material through "endorsement." on line 18 and insert the following:

"(1) The retooling to teach mathematics and science conditional scholarship program is created. Participation is limited to current K-12 teachers and individuals having an elementary education certificate but who are not employed in positions requiring an elementary education certificate. It is anticipated that candidates enrolled in this program will complete the requirements for a mathematics or science endorsement, or both, in two years or less.

(2) Entry requirements for candidates include current K-12 teachers pursuing a middle level mathematics or science endorsement, or secondary mathematics or science endorsement."

On page 8, at the beginning of line 27, strike all material through "science" and insert "or English as a second language"

On page 8, beginning on line 35, after "mathematics" strike all material through "language," on line 36

Beginning on page 9, line 4, strike all material through "and" on line 19, and insert the following:

"(i) Individuals currently employed as teachers shall pursue a middle level mathematics or science, or secondary mathematics or science endorsement; or

(ii) Individuals who are certificated with an elementary education endorsement, but not employed in positions requiring an elementary education certificate, shall pursue an endorsement in middle level mathematics or science, or both; and

(iii) Individuals shall use one of the pathways to endorsement processes to receive a mathematics or science endorsement, or both, which shall include passing a mathematics or science endorsement test, or both tests, plus observation and completing applicable coursework to attain the proper endorsement; and"

Senator McAuliffe spoke in favor of adoption of the amendment.

The President declared the question before the Senate to be the adoption of the amendment by Senator McAuliffe on page 6, line 32 to Second Substitute Senate Bill No. 5813.

The motion by Senator McAuliffe carried and the amendment was adopted by voice vote.

MOTION

On motion of Senator McAuliffe, the rules were suspended,

SIXTY-FIRST DAY, MARCH 9, 2007

Engrossed Second Substitute Senate Bill No. 5813 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senator McAuliffe spoke in favor of passage of the bill.

MOTION

On motion of Senator Zarelli, Senator Pflug was excused.

Senator Holmquist spoke in favor of passage of the bill.

The President declared the question before the Senate to be the final passage of Engrossed Second Substitute Senate Bill No. 5813.

ROLL CALL

The Secretary called the roll on the final passage of Engrossed Second Substitute Senate Bill No. 5813 and the bill passed the Senate by the following vote: Yeas, 47; Nays, 0; Absent, 0; Excused, 2.

Voting yea: Senators Benton, Berkey, Brandland, Brown, Carrell, Clements, Eide, Fairley, Franklin, Fraser, Hargrove, Hatfield, Haugen, Hewitt, Hobbs, Holmquist, Honeyford, Jacobsen, Kastama, Kauffman, Keiser, Kilmer, Kline, Kohl-Welles, Marr, McAuliffe, McCaslin, Morton, Murray, Oemig, Parlette, Poulsen, Prentice, Pridemore, Rasmussen, Regala, Roach, Rockefeller, Schoesler, Sheldon, Shin, Spanel, Stevens, Swecker, Tom, Weinstein and Zarelli - 47

Excused: Senators Delvin and Pflug - 2

ENGROSSED SECOND SUBSTITUTE SENATE BILL NO. 5813, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

MOTION

At 6:38 p.m., on motion of Senator Eide, the Senate adjourned until 9:45 a.m. Saturday, March 10, 2007.

BRAD OWEN, President of the Senate

THOMAS HOEMANN, Secretary of the Senate

1008-S	Introduction & 1st Reading	1	Introduction & 1st Reading	2
1030-S	Messages	1	1147-S	Messages
1049	Introduction & 1st Reading	1	1148-S	Messages
1050-S	Messages	1	1178-S2	Messages
1076-S2	Introduction & 1st Reading	2	1189	Introduction & 1st Reading
1091-S	Messages	1	1226-S	Messages
1096-S2	Messages	1	1266-S	Introduction & 1st Reading
1106-S2	Messages	1	1276-S	Messages
1137	Messages	1	1277-S2	Messages
			1278-S	Messages

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

Introduction & 1st Reading	2	1887	Messages	16
1298		1923	Messages	16
Messages	1	1925	Introduction & 1st Reading	4
1313		1949	Introduction & 1st Reading	4
Messages	1	1955-S	Messages	16
1314-S		1965-S	Messages	1
Introduction & 1st Reading	2	1967	Messages	1
1337-S		1977-S	Introduction & 1st Reading	4
Messages	1	1987-S	Introduction & 1st Reading	4
1371		1988-S	Introduction & 1st Reading	4
Messages	16	2003-S	Introduction & 1st Reading	4
1430		2007-S	Messages	1
Introduction & 1st Reading	2	2026	Messages	1
1436		2032	Messages	1
Introduction & 1st Reading	2	2033	Messages	1
1443		2034	Introduction & 1st Reading	4
Introduction & 1st Reading	2	2070	Messages	1
1456-S		2073-S	Messages	1
Introduction & 1st Reading	2	2103-S	Messages	1
1458-S		2104	Introduction & 1st Reading	4
Introduction & 1st Reading	2	2129-S	Messages	1
1501		2137	Messages	1
Introduction & 1st Reading	3	2161	Messages	1
1512-S		2163	Messages	1
Messages	1	2170	Introduction & 1st Reading	5
1517		2171-S	Introduction & 1st Reading	5
Messages	1	2204	Introduction & 1st Reading	5
1566-S		2240	Introduction & 1st Reading	5
Messages	1	2263	Messages	1
1592		4017	Messages	1
Introduction & 1st Reading	3	5080-S	Other Action	32
1605-S		5114	Second Reading	27
Introduction & 1st Reading	3	5114-S2	Second Reading	27
1644			Third Reading Final Passage	28
Messages	16	5145	Second Reading	14
1671		5145-S	Second Reading	14
Introduction & 1st Reading	3			
1672				
Introduction & 1st Reading	3			
1675-S				
Messages	16			
1677-S2				
Messages	16			
1694-S				
Messages	16			
1706				
Introduction & 1st Reading	3			
1747				
Introduction & 1st Reading	3			
1755-S				
Introduction & 1st Reading	3			
1784-S				
Introduction & 1st Reading	3			
1789				
Introduction & 1st Reading	3			
1793				
Introduction & 1st Reading	3			
1820				
Introduction & 1st Reading	3			
1832-S				
Introduction & 1st Reading	3			
1836				
Introduction & 1st Reading	4			
1852				
Introduction & 1st Reading	4			
1865-S				
Introduction & 1st Reading	4			
1870				
Introduction & 1st Reading	4			
1880-S				
Introduction & 1st Reading	4			

SIXTY-FIRST DAY, MARCH 9, 2007

2007 REGULAR SESSION

Third Reading Final Passage	14	5930-S2	
5221		Other Action	45, 62, 66
Second Reading	14	Second Reading	33, 45, 58, 59, 60, 62
5221-S		Third Reading Final Passage	67
Second Reading	14	5952	
Third Reading Final Passage	15	Second Reading	8
5259		5952-S	
Second Reading	7	Second Reading	8
Third Reading Final Passage	7	Third Reading Final Passage	8
5261		5955	
Second Reading	9	Second Reading	12
Third Reading Final Passage	11	5955-S2	
5321		Second Reading	12, 30, 31
Second Reading	7	Third Reading Final Passage	32
5321-S		5958	
Second Reading	7	Second Reading	16
Third Reading Final Passage	7	5958-S2	
5332		Other Action	20
Second Reading	15	Second Reading	16, 18, 19, 20
Third Reading Final Passage	15	Third Reading Final Passage	20
5625		5964	
Second Reading	7	Second Reading	15
5625-S		5964-S	
Second Reading	7	Second Reading	15
Third Reading Final Passage	8	Third Reading Final Passage	15
5712		5969	
Second Reading	21	Second Reading	12
5712-S2		Third Reading Final Passage	12
Other Action	26	6107	
Second Reading	21	Second Reading	15
Third Reading Final Passage	26	Third Reading Final Passage	15
5714		8020	
Second Reading	13	Introduction & 1st Reading	1
5714-S		8626	
Second Reading	13	Adopted	5
Third Reading Final Passage	13	Introduced	5
5790		PRESIDENT OF THE SENATE	
Second Reading	11	Intro. Special Guest, members of Spain	5
5790-S2		Intro. Special Guests, Former Senator Oke	16
Second Reading	12	Remarks by the President	6, 28
Third Reading Final Passage	12	Reply by the President	12, 18
5813		Ruling by the President	32
Second Reading	67	WASHINGTON STATE SENATE	
5813-S2		Personal Privilege, Senator Benton	6
Second Reading	67	Personal Privilege, Senator Eide	6
Third Reading Final Passage	68	Personal Privilege, Senator Kohl-Welles	6
5828		Personal Privilege, Senator McAuliffe	6
Second Reading	13	Personal Privilege, Senator Rasmussen	8
5828-S2		Point of Inquiry, Senator Pflug	20
Second Reading	14	Point of Order, Senator Pflug	18
Third Reading Final Passage	14	Point of Order, Senator Sheldon	12
5841		Remarks by former Senator Oke	16
Second Reading	28		
5841-S2			
Other Action	29		
Second Reading	28, 29		
Third Reading Final Passage	30		
5842-S2			
Second Reading	30		
5843			
Second Reading	12		
5843-S2			
Second Reading	12, 13		
Third Reading Final Passage	13		
5855			
Second Reading	8		
5855-S			
Second Reading	8		
Third Reading Final Passage	8		
5930			
Second Reading	33		