In contrast to the approach proposed in section 2 of Substitute House Bill No. 1972, the state insurance code already provides the means by which such groups may form conventional insurance organizations with the appropriate financial and procedural safeguards.

With the exception of section 2, Substitute House Bill No. 1972 is approved."

CHAPTER 303

[Engrossed Substitute House Bill No. 2021]
MANAGED HEALTH CARE SYSTEMS

AN ACT Relating to managed health care; adding a new section to chapter 74.09 RCW; adding a new section to chapter 43.41 RCW; adding a new chapter to Title 70 RCW; creating new sections; making appropriations; and declaring an emergency.

Be it enacted by the Legislature of the State of Washington:

NEW SECTION. Sec. 1. (1) The legislature finds that:

(a) Good health care for indigent persons is of importance to the state;

(b) To ensure the availability of a good level of health care, efforts must be made to encourage cost consciousness on the part of providers and consumers, while maintaining medical assistance recipients within the mainstream of health care delivery;

(c) Managed health care systems have been found to be effective in controlling costs while providing good health care services;

(d) By enrolling medical assistance recipients within managed health care systems, the state's goal is to ensure that medical assistance recipients receive at least the same quality of care they currently receive.

(2) It is the intent of the legislature to develop and implement new strategies that promote the use of managed health care systems for medical assistance recipients by establishing prepaid capitated programs for both in-patient and out-patient services.

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

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

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

(a) Agreements shall be made within one class A county in the eastern part of the state for at least ten thousand recipients; and one class AA county for at least fifteen thousand recipients in the western part of the

state; and one first class county of at least five thousand recipients in the western part of the state;

(b) At least one of the agreements shall include enrollment of all recipients of aid to families with dependent children residing in a defined geographical area;

(c) The department shall, to the extent possible, ensure that recipients have a choice of systems in which to enroll and, if necessary and medically appropriate treatment for a recipient is not available from or through a participating managed health care system, the department shall exempt the recipient from any requirement to receive some or all of their medical services from such a system;

(d) To the extent possible, the department shall ensure that participating managed health care systems do not enroll a disproportionate number of medical assistance recipients within the total numbers of persons served by the managed health care systems;

(e) Prior to negotiating with any managed health care system, the department shall estimate, on an actuarially sound basis, the expected cost of providing the health care services expressed in terms of upper and lower limits, and recognizing variations in the cost of providing the services through the various systems and in different project areas. In negotiating with managed health care systems the department shall adopt a uniform procedure that includes at least request for proposals, including standards regarding the quality of services to be provided; and financial integrity of the responding system. The department may negotiate with respondents to the extent necessary to refine any proposals;

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

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

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

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

The department shall seek to obtain a large number of contracts with providers of health services to medicaid recipients. The department shall ensure that publicly supported community health centers and providers in rural areas, who show serious intent and apparent capability to participate in the project as managed health care systems are seriously considered as providers in the project.

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

NEW SECTION. Sec. 3. The department shall report to the legislature not later than January 1, 1987, on progress toward implementation of the requirements of this chapter, but shall not delay implementation on account of this reporting requirement.

The report shall also include an analysis of the possible expansion of the use of managed health care within other medical assistance programs, including making it available to certain recipients of general assistance and supplemental security income.

NEW SECTION. Sec. 4. There is created the Washington health care project commission composed of fifteen members; four members shall be state representatives, two from each political party appointed by the speaker of the house of representatives; four members shall be state senators, two from each political party appointed by the president of the senate.

The legislative members of the commission shall select seven public members, to serve on the commission, that are representative of health care professionals, health care providers, those directly involved in the purchase, provision, or delivery of health care services, industry, consumers, and those knowledgeable of the ethical issues involved with health care public policy.

The legislative members shall select from among the public members one to serve as chairman and from among the legislative members four to serve, together with the chairman, as an executive committee of the commission.

(1) The commission may hire staff or contract for professional assistance with funds made available for their activities. To the extent possible, the department of social and health services, the house of representatives, and the senate shall provide staff support. The commission may apply for and receive and accept grants, gifts, and other payments, including property and services, from any governmental or other public or private entity or person, and may make arrangements as to the use of these receipts, including the undertaking of special studies and other projects relating to health care costs or access to health care.

The public members of the commission shall receive no compensation for their service as members, but shall be reimbursed for their expenses while attending any meetings of the commission in the same manner as legislators engaged in interim committee business as specified in RCW 44.04.120.

The commission may establish ad hoc technical advisory committees to assist it with any particular matters deemed necessary and any person serving in such capacity may be reimbursed for their expenses while attending

any meetings of such committee or the commission in the same manner as public members of the commission.

(2) The commission shall have the following responsibilities:

(a) To review and estimate the following information about persons in the state of Washington who do not have health care coverage:

(i) The numbers of such persons;

(ii) Their age and geographic distribution;

(iii) Their employment status;

(iv) Their family size;

(v) Their economic status; and

(vi) Such other information as the commission deems relevant.

(b) To define basic health care coverage, using the following guidelines:

(i) The schedule of services shall emphasize preventive primary health care, including necessary physician services, and inpatient and outpatient hospital services;

(ii) The schedule of services shall include all services necessary for prenatal, postnatal, and well–child care;

(iii) The schedule of services shall include a separate schedule of basic health care services for children eighteen years of age and younger, for those who might choose to secure basic coverage only for their dependent children;

(iv) In designing the schedule of services, the commission shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.42.080; and

(v) The schedule of services shall be based upon an estimated cost not exceeding fifty dollars per month per person enrolled. The commission may develop alternative schedules of services based on higher or lower monthly costs as it deems appropriate.

(c) After establishing at least a tentative schedule of basic health care services, obtain the following information about persons identified in (a) of this subsection:

(i) An estimate of demand for basic health coverage expressed in terms of numbers of potential enrollees if such a program were made available to them, including the basis upon which such an offering should be made; and

(ii) The characteristics of likely enrollees including demographic and economic data, likely utilization and such other actuarial information as needed to estimate the likely cost of the benefit schedule defined by the commission.

(3) The commission shall then use the information obtained pursuant to this section to develop plans that includes:

(a) Methods of delivery for the schedule of basic health care services by managed health care systems;

(b) Methods of soliciting and accepting application for participation in the program to deliver such basic health care services on a demonstration

basis from managed health care systems, including payment methods, rates, and any risk sharing provisions;

(c) Methods whereby the delivery of such services could be integrated with the managed health care systems that may be participating in the medical assistance program of the department of social and health services;

(d) A structure of periodic payments, based upon gross family income, that would be the responsibility of any person or subscriber within the identified groups, or that might be made the responsibility of another private party;

(e) Establishing necessary eligibility standards and guidelines for person seeking such health care coverage, and whatever administrative structure may be needed to enroll such persons;

(f) Methods of monitoring the provision of services to enrollees and the quality of care provided; and

(g) Methods of funding the reasonably anticipated costs of such plans, collectively or individually.

(4) For the purposes of this section, "managed health care systems" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract the schedule of services by duly licensed providers, on a prepaid capitated basis.

(5) The commission shall submit a final report to the legislature no later than December 1, 1986. The report shall include plans that address the needs for such a basic health care program for any identified groups of persons and an analysis of any alternatives considered, but not adopted.

(6) The commission shall terminate upon the submission of their final report.

NEW SECTION. Sec. 5. The sum of one hundred fifty thousand dollars, of which ninety thousand is from the general fund——state and sixty thousand is from the general fund——federal, or so much thereof as may be necessary, is appropriated to the department of social and health services for the biennium ending June 30, 1987, for the purposes identified in sections 2 and 3 of this act.

The sum of one hundred twenty-five thousand dollars, or as much thereof as may be necessary, is appropriated for the biennium ending June 30, 1987, from the general fund to the Washington health care project commission for the purposes identified in this act: PROVIDED, That the house executive rules committee and senate facilities and operations committee may jointly authorize expenditures for necessary expenses directly related to commission activities or studies on health care issues conducted by any legislative committee during 1986 or 1987.

NEW SECTION. Sec. 6. The following state agencies are directed to cooperate with the office of financial management in order to establish appropriate health care information systems in their programs: The department of social and health services, the department of labor and industries, the state employees' insurance board, the department of veterans affairs, and the department of corrections.

The office of financial management, in conjunction with such agencies, shall determine:

(1) Definitions of health care services;

(2) Health care data elements common to all agencies;

(3) Health care data elements unique to each agency;

(4) A mechanism for program and budget review of health care data; and

(5) Executive review of health care data.

NEW SECTION. Sec. 7. Each of the agencies listed in section 6 of this act, with the exception of the department of labor and industries, which expends more than five hundred thousand dollars annually of state funds for purchase of health care shall identify the availability and costs of nonfee for service providers of health care, including preferred provider organizations, health maintenance organizations, managed health care or case management systems, or other nonfee for service alternatives. In each case where feasible in which an alternative health care provider arrangement, of similar scope and quality, is available at lower cost than fee for service providers, such state agencies shall make the services of the alternative provider available to clients, consumers, or employees for whom state dollars are spent to purchase health care. As consistent with other state and federal law, requirements for copayments, deductibles, the scope of available services, or other incentives shall be used to encourage clients, consumers, or employees to use the lowest cost providers, except that copayments or deductibles shall not be required where they might have the impact of denying access to necessary health care in a timely manner.

NEW SECTION. Sec. 8. Plans for establishing or improving utilization review procedures for purchased health care services shall be developed by each agency listed in section 6 of this act. The plans shall specifically address such utilization review procedures as prior authorization of services, hospital inpatient length of stay review, requirements for use of outpatient surgeries and the obtaining of second opinions for surgeries, review of invoices or claims submitted by service providers, and performance audit of providers.

NEW SECTION. Sec. 9. The state agencies listed in section 6 of this act shall review the feasibility of establishing prospective payment approaches within their health care programs. Work plans or timetables shall be prepared for the development of prospective rates. The agencies shall

identify legislative actions that may be necessary to facilitate the adoption of prospective rate setting methods.

NEW SECTION. Sec. 10. (1) Each agency listed in section 6 of this act shall individually or in cooperation with other agencies take any necessary actions to control costs without reducing the quality of care when reimbursing for or purchasing drugs. To accomplish this purpose, each agency shall investigate the feasibility of and may establish a drug formulary designating which drugs may be paid for through their health care programs. For purposes of this section, a drug formulary means a list of drugs, either inclusive or exclusive, that defines which drugs are eligible for reimbursement by the agency.

(2) In developing the drug formulary authorized by this section, agencies:

(a) Shall prohibit reimbursement for drugs that are determined to be ineffective by the United States food and drug administration;

(b) Shall adopt rules in order to ensure that less expensive generic drugs will be substituted for brand name drugs in those instances where the quality of care is not diminished;

(c) Where possible, may authorize reimbursement for drugs only in economical quantities;

(d) May limit the prices paid for drugs by such means as central purchasing, volume contracting, or setting maximum prices to be paid;

(e) Shall consider the approval of drugs with lower abuse potential in substitution for drugs with significant abuse potential; and

(f) May take other necessary measures to control costs of drugs without reducing the quality of care.

(3) Agencies may provide for reasonable exceptions to the drug formulary required by this section.

(4) Agencies may establish medical advisory committees, or utilize committees already established, to assist in the development of the drug formulary required by this section.

*NEW SECTION. Sec. 11. A new section is added to chapter 43.41 RCW to read as follows:

(1) It is the purpose of this section to ensure implementation and coordination of chapter 70.— RCW (sections 6 through 10 of this act) as well as other legislative and executive policies designed to contain the cost of health care that is purchased or provided by the state. In order to achieve that purpose, the director may:

(a) Establish within the office of financial management a health care cost containment program in cooperation with all state agencies;

(b) Implement lawful health care cost containment policies that have been adopted by the legislature or the governor, including appropriation provisos;

(c) Coordinate the activities of all state agencies with respect to health care cost containment policies;

(d) Study and make recommendations on health care cost containment policies;

(e) Monitor and report on the implementation of health care cost containment policies;

(f) Appoint a health care cost containment technical advisory committee that represents state agencies that are involved in the direct purchase, funding, or provision of health care; and

(g) Engage in other activities necessary to achieve the purposes of this section.

(2) All state agencies shall cooperate with the director in carrying out the purpose of this section.

(3) By December 15 of each even-numbered year, the office of financial management shall submit to the ways and means committees of the senate and house of representatives a report covering total expenditures over the past two years for the purchase or provision of health care services, together with an estimate of such future expenditures during the ensuing four years. The reports, together with any suitable recommendations, shall be consistent with the provisions of section 17, chapter 288, Laws of 1984 (uncodified).

***Sec. 11 was partially vetoed, see message at end of chapter.**

NEW SECTION. Sec. 12. Not later than January 1, 1988, the superintendent of public instruction shall report to the legislature on proposed methods of controlling school employee health care costs consistent with the policies and goals of this act.

NEW SECTION. Sec. 13. Sections 6 through 10 of this act shall constitute a new chapter in Title 70 RCW.

NEW SECTION. Sec. 14. This act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect immediately.

Passed the House March 12, 1986.
Passed the Senate March 12, 1986.
Approved by the Governor April 4, 1986, with the exception of certain items which were vetoed.
Filed in Office of Secretary of State April 4, 1986.

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

"I am returning herewith, without my approval as to section 11(3), Engrossed Substitute House Bill No. 2021, entitled:

"AN ACT Relating to managed health care."

Section 11 of this bill permits the Director of Financial Management to establish within the Office of Financial Management a health care cost containment program. The section also authorizes the Director to take other actions to control the cost of health care purchased by state agencies. I support wholeheartedly this effort

to control costs. The bill, however, does not provide any funds for the creation of the cost containment program. Most of section 11 is permissive, giving the Director of Financial Management the flexibility necessary to undertake those aspects of the program that can be accomplished without funding. Subsection (3), however, is a mandatory reporting requirement that involves significant amounts of staff time and other resources, which are not available. For this reason, I have vetoed section 11(3).

With the exception of section 11(3), Engrossed Substitute House Bill No. 2021 is approved."

CHAPTER 304

[Engrossed Substitute Senate Bill No. 3990]

SECURITIES——ACTIONS UNDER THE WASHINGTON STATE SECURITIES ACT——APPLICATION OF EXISTING LAW

AN ACT Relating to securities; and amending RCW 21.20.430.

Be it enacted by the Legislature of the State of Washington:

Sec. 1. Section 43, chapter 282, Laws of 1959 as last amended by section 1, chapter 171, Laws of 1985 and RCW 21.20.430 are each amended to read as follows:

(1) Any person, who offers or sells a security in violation of any provisions of RCW 21.20.010 or 21.20.140 through 21.20.230, is liable to the person buying the security from him or her, who may sue either at law or in equity to recover the consideration paid for the security, together with interest at eight percent per annum from the date of payment, costs, and reasonable attorneys' fees, less the amount of any income received on the security, upon the tender of the security, or for damages if he or she no longer owns the security. Damages are the amount that would be recoverable upon a tender less (a) the value of the security when the buyer disposed of it and (b) interest at eight percent per annum from the date of disposition.

(2) Any person who buys a security in violation of the provisions of RCW 21.20.010 is liable to the person selling the security to him or her, who may sue either at law or in equity to recover the security, together with any income received on the security, upon tender of the consideration received, costs, and reasonable attorneys' fees, or if the security cannot be recovered, for damages. Damages are the value of the security when the buyer disposed of it, and any income received on the security, less the consideration received for the security, plus interest at eight percent per annum from the date of disposition, costs, and reasonable attorneys' fees.

(3) Every person who directly or indirectly controls a seller or buyer liable under subsection (1) or (2) above, every partner, officer, director or person who occupies a similar status or performs a similar function of such seller or buyer, every employee of such a seller or buyer who materially aids in the transaction, and every broker-dealer, salesperson, or person exempt