THIRTY FOURTH DAY

House Chamber, Olympia, Saturday, February 11, 2012

The House was called to order at 10:00 a.m. by the Speaker (Representative Moeller presiding). The Clerk called the roll and a quorum was present.

The flags were escorted to the rostrum by a Sergeant at Arms Color Guard, Pages Mike Christensen and Holly Pope. The Speaker (Representative Moeller presiding) led the Chamber in the Pledge of Allegiance. The prayer was offered by Dottie Lehuta, Christian Science Practitioner, Christian Science Church Olympia, Washington.

Reading of the Journal of the previous day was dispensed with and it was ordered to stand approved.

MESSAGE FROM THE SENATE

February 10, 2012

MR. SPEAKER:

The Senate has passed:

ENGROSSED SUBSTITUTE SENATE BILL NO. 5556
ENGROSSED SUBSTITUTE SENATE BILL NO. 5697
ENGROSSED SECOND SUBSTITUTE SENATE BILL NO. 6023
ENGROSSED SUBSTITUTE SENATE BILL NO. 6147
ENGROSSED SENATE BILL NO. 6162
ENGROSSED SECOND SUBSTITUTE SENATE BILL NO. 6232
ENGROSSED SUBSTITUTE SENATE BILL NO. 6260

and the same are herewith transmitted.

Thomas Hoemann, Secretary

INTRODUCTION & FIRST READING

HB 2782 by Representatives Liias, Moeller, Pettigrew and Dickerson

AN ACT Relating to establishing volumetric taxes imposed upon liquor sales; amending RCW 82.08.150; adding a new section to chapter 82.04 RCW; and providing an effective date.

Referred to Committee on Ways & Means.

2SSB 5355 by Senate Committee on Government Operations, Tribal Relations & Elections (originally sponsored by Senators Morton, Swecker and Honeyford)

AN ACT Relating to special meetings; and amending RCW 42.30.080.

Referred to Committee on State Government & Tribal Affairs.

SB 5365 by Senators Nelson and Kohl-Welles

AN ACT Relating to the purchase of retirement pension coverage by certain volunteer firefighters and reserve officers; and adding a new section to chapter 41.24 RCW.

Referred to Committee on Ways & Means.

SB 5401 by Senators Chase, Kastama and McAuliffe

AN ACT Relating to authorizing use of sales and use tax proceeds for certain public facilities in innovation partnership zones for economic development purposes; and amending RCW 82.14.370.

Referred to Committee on Community & Economic Development & Housing.

SB 5404 by Senators Chase, Kastama, Hatfield, Shin, Prentice, McAuliffe, Kohl-Welles, Conway and Keiser

AN ACT Relating to authorizing community economic revitalization board funding to benefit innovation partnership zones; and amending RCW 43.160.010 and 43.160.020.

Referred to Committee on Community & Economic Development & Housing.

ESSB 5715 by Senate Committee on Early Learning & K-12 Education (originally sponsored by Senators Kohl-Welles, McAuliffe, Litzow, Harper and Kline)

AN ACT Relating to adopting core competencies for early care and education professionals and child and youth development professionals; adding a new section to chapter 43.215 RCW; and creating a new section.

Referred to Committee on Early Learning & Human Services.

SB 5913 by Senators Prentice, Hobbs and Benton

AN ACT Relating to increasing the permissible deposit of public funds with credit unions and authorizing the deposit of public funds at federally chartered credit unions; and amending RCW 39.58.240.

Referred to Committee on Business & Financial Services.

SSB 5984 by Senate Committee on Ways & Means (originally sponsored by Senators Murray, Zarelli, Parlette, Kilmer, Fraser, Harper, Kohl-Welles and Chase)

AN ACT Relating to local government financial soundness; amending RCW 82.14.048; adding new sections to chapter 35.57 RCW; adding new sections to chapter 36.100 RCW; creating a new section; and declaring an emergency.

Referred to Committee on Ways & Means.

SSB 6038 by Senate Committee on Early Learning & K-12 Education (originally sponsored by Senators Delvin and McAuliffe)

AN ACT Relating to school construction assistance rules; and adding a new section to chapter 28A.300 RCW.

Referred to Committee on Education.

SSB 6041 by Senate Committee on Early Learning & K-12 Education (originally sponsored by Senators McAuliffe, Litzow, Rolfes and Hobbs)

AN ACT Relating to lighthouse schools; amending RCW 28A.630.065; and adding a new section to chapter 28A.630 RCW.

Referred to Committee on Education.

SSB 6068 by Senate Committee on Judiciary (originally sponsored by Senators Kline, Zarelli and Frockt)

AN ACT Relating to religious objection to autopsy; adding a new section to chapter 36.24 RCW; and creating a new section.

Referred to Committee on Judiciary.

ESSB 6078 by Senate Committee on Energy, Natural Resources & Marine Waters (originally sponsored by Senators Ranker, Swecker, Regala, Kline, Schoesler, Fain, Kilmer, Harper, Shin, Litzow, Fraser, Keiser, Conway, Hargrove and Rolfes)

AN ACT Relating to implementing efficiencies in the management of the state's natural resources; adding a new chapter to Title 43 RCW; and creating new sections.

Referred to Committee on State Government & Tribal Affairs.

SB 6134 by Senators Delvin, Conway, Sheldon and Hewitt

AN ACT Relating to allowing department of fish and wildlife enforcement officers to transfer service credit; and amending RCW 41.26.435.

Referred to Committee on Ways & Means.

SSB 6142 by Senate Committee on Economic Development, Trade & Innovation (originally sponsored by Senators Kilmer, Becker, Rolfes, Hatfield, Kastama, Baumgartner, Eide, Fain, Hobbs, Shin, Parlette, Chase and Frockt)

AN ACT Relating to changing agency regulatory practices; amending RCW 34.05.110, 43.05.030, and 43.42.010; adding a new section to chapter 43.05 RCW; adding a new section to chapter 43.42 RCW; and creating a new section.

Referred to Committee on State Government & Tribal Affairs

SSB 6197 by Senate Committee on Health & Long-Term Care (originally sponsored by Senators Conway, Parlette, Keiser and Becker)

AN ACT Relating to including pharmacists in the legend drug act; and reenacting and amending RCW 69.41.030.

Referred to Committee on Health Care & Wellness.

SSB 6216 by Senate Committee on Health & Long-Term Care (originally sponsored by Senators Padden, Regala, Hargrove, Baumgartner, Kohl-Welles and Roach)

AN ACT Relating to liability of nonprofit and charitable corporations; amending RCW 43.20A.800; and adding a new section to chapter 43.20A RCW.

Referred to Committee on Judiciary.

SSB 6226 by Senate Committee on Human Services & Corrections (originally sponsored by Senators Frockt, Harper, Regala, Zarelli, Fain, Hargrove, Kohl-Welles and Keiser)

AN ACT Relating to authorization periods for subsidized child care; amending RCW 43.215.135; adding a new section to chapter 43.215 RCW; and providing an effective date.

Referred to Committee on Early Learning & Human Services.

ESSB 6237 by Senate Committee on Health & Long-Term Care (originally sponsored by Senators Keiser, Conway, Kline, Frockt and Becker)

AN ACT Relating to creating a career pathway for medical assistants; amending RCW 18.135.030, 18.135.040, 18.135.060, 18.135.070, 18.135.090, 18.135.110, 18.135.120, 18.120.020, 18.130.040, and 46.61.506; reenacting and amending RCW 18.135.020; adding new sections to chapter 18.135 RCW; creating a new section; and repealing RCW 18.135.010, 18.135.025, 18.135.050, 18.135.055, and 18.135.062.

Referred to Committee on Health Care & Wellness.

ESB 6296 by Senators Harper, Carrell and Shin

AN ACT Relating to background checks; amending RCW 10.97.030, 10.97.050, 10.97.080, 43.43.730, and 43.43.8321; and repealing RCW 43.43.565.

Referred to Committee on Public Safety & Emergency Preparedness.

SB 6324 by Senators Fain and Hobbs

AN ACT Relating to the obligations of landlords and tenants with respect to carbon monoxide alarms and the disclosure of certain health- related information; and amending RCW 59.18.060 and 59.18.130.

Referred to Committee on Judiciary.

SSB 6354 by Senate Committee on Economic Development, Trade & Innovation (originally sponsored by Senators Rolfes, Kastama, Chase, Tom, Frockt and McAuliffe)

AN ACT Relating to filing of business forms with state agencies; and adding a new section to chapter 43.17 RCW.

Referred to Committee on State Government & Tribal Affairs.

SB 6412 by Senators Rolfes and Harper

AN ACT Relating to applying for health insurance coverage when an insurance carrier discontinues all individual health benefit plan coverage; amending RCW 48.43.018; and declaring an emergency.

Referred to Committee on Health Care & Wellness.

SSB 6493 by Senate Committee on Human Services & Corrections (originally sponsored by Senators Regala, Hargrove, Stevens, Harper, Kline, Carrell and Shin)

AN ACT Relating to sexually violent predator civil commitment cases; amending RCW 2.70.020, 71.09.040, 71.09.050, 71.09.080, 71.09.090, 71.09.110, 71.09.120, and 71.09.140; adding a new section to chapter 2.70 RCW; adding new sections to chapter 71.09 RCW; creating new sections; and providing an effective date.

Referred to Committee on Public Safety & Emergency Preparedness.

There being no objection, the bills listed on the day's introduction sheet under the fourth order of business were referred to the committees so designated.

SECOND READING

HOUSE BILL NO. 2152, by Representatives Angel, Takko, Dammeier, Rivers, Kristiansen, Springer, Buys, Tharinger and Liias

Clarifying timelines associated with plats.

The bill was read the second time.

With the consent of the house, amendments (953) and (954) were withdrawn.

Representative Springer moved the adoption of amendment (1051).

On page 2, line 1, after "within" insert "nine years of the date of preliminary plat approval if the project is within city limits, not subject to requirements adopted under chapter 90.58 RCW, and the date of preliminary plat approval is on or before December 31, 2007, within"

On page 2, line 2, after "or" insert "after January 1, 2008, and on or"

On page 2, line 24, after "period of" insert "nine years from the date of filing if the project is within city limits, not subject to requirements adopted under chapter 90.58 RCW, and the date of filing is on or before December 31, 2007, for a period of"

On page 2, line 25, after "on or" insert "after January 1, 2008, and on or"

On page 2, line 29, after "period of" insert "nine years after final plat approval if the project is within city limits, not subject to requirements adopted under chapter 90.58 RCW, and the date of final plat approval is on or before December 31, 2007, for a period of"

On page 2, line 31, after "on or" insert "after January 1, 2008, and on or"

Representatives Springer and Angel spoke in favor of the adoption of the amendment.

Amendment (1051) was adopted.

The bill was ordered engrossed.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Angel and Takko spoke in favor of the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Engrossed House Bill No. 2152.

MOTIONS

On motion of Representative Van De Wege, Representatives Kelley and Liias were excused. On motion of Representative Hinkle, Representatives Dammeier, Rodne, Wilcox and Zeiger were excused.

ROLL CALL

The Clerk called the roll on the final passage of Engrossed House Bill No. 2152, and the bill passed the House by the following vote: Yeas, 92; Nays, 0; Absent, 0; Excused, 6.

Voting yea: Representatives Ahern, Alexander, Anderson, Angel, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Chandler, Clibborn, Cody, Condotta, Crouse, Dahlquist, Darneille, DeBolt, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Hargrove, Harris, Hasegawa, Hinkle, Hope, Hudgins, Hunt, Hunter, Hurst, Jinkins, Johnson, Kagi, Kenney, Kirby, Klippert, Kretz, Kristiansen, Ladenburg, Lytton, Maxwell, McCoy, McCune, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Overstreet, Parker, Pearson, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ross, Ryu, Santos, Schmick, Seaquist, Sells, Shea, Short, Smith, Springer, Stanford, Sullivan, Takko, Taylor, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wylie and Mr. Speaker.

Excused: Representatives Dammeier, Kelley, Liias, Rodne, Wilcox and Zeiger.

ENGROSSED HOUSE BILL NO. 2152, having received the necessary constitutional majority, was declared passed.

HOUSE BILL NO. 2407, by Representatives Roberts, Green, Ormsby, Reykdal, Moeller, Upthegrove and Maxwell

Restricting the use of information related to claims resolution structured settlement agreements.

The bill was read the second time.

There being no objection, Substitute House Bill No. 2407 was substituted for House Bill No. 2407 and the substitute bill was placed on the second reading calendar.

SUBSTITUTE HOUSE BILL NO. 2407 was read the second time.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Roberts spoke in favor of the passage of the bill.

Representative Condotta spoke against passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Substitute House Bill No. 2407.

ROLL CALL

The Clerk called the roll on the final passage of Substitute House Bill No. 2407, and the bill passed the House by the following vote: Yeas, 53; Nays, 39; Absent, 0; Excused, 6.

Voting yea: Representatives Appleton, Armstrong, Billig, Blake, Carlyle, Clibborn, Cody, Darneille, Dickerson, Dunshee, Finn, Fitzgibbon, Goodman, Green, Haigh, Hansen, Hasegawa, Hudgins, Hunt, Hunter, Hurst, Jinkins, Kagi, Kenney, Kirby, Ladenburg, Lytton, Maxwell, McCoy, Miloscia, Moeller, Morris, Moscoso, Ormsby, Orwall, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Roberts, Ryu, Santos, Seaquist, Sells, Stanford, Sullivan, Takko, Tharinger, Upthegrove, Van De Wege, Wylie and Mr. Speaker.

Voting nay: Representatives Ahern, Alexander, Anderson, Angel, Asay, Bailey, Buys, Chandler, Condotta, Crouse, Dahlquist, DeBolt, Eddy, Fagan, Haler, Hargrove, Harris, Hinkle, Hope, Johnson, Klippert, Kretz, Kristiansen, McCune, Nealey, Orcutt, Overstreet, Parker, Pearson, Rivers, Ross, Schmick, Shea, Short, Smith, Springer, Taylor, Walsh and Warnick.

Excused: Representatives Dammeier, Kelley, Liias, Rodne, Wilcox and Zeiger.

SUBSTITUTE HOUSE BILL NO. 2407, having received the necessary constitutional majority, was declared passed.

HOUSE BILL NO. 2586, by Representatives Kagi, Maxwell, Ladenburg, Dammeier, Kenney and Tharinger

Phasing-in statewide implementation of the Washington kindergarten inventory of developing skills.

The bill was read the second time.

There being no objection, Substitute House Bill No. 2586 was substituted for House Bill No. 2586 and the substitute bill was placed on the second reading calendar.

SUBSTITUTE HOUSE BILL NO. 2586 was read the second time.

Representative Kagi moved the adoption of amendment (1041).

On page 4, line 21, after "(2)" insert "Time spent by certificated staff meeting with students and families as part of the Washington kindergarten inventory of developing skills may be considered instructional hours under RCW 28A.150.205.

(2) Up to five school days used by certificated staff to meet with students and families or otherwise administer the Washington kindergarten inventory of developing skills may be considered school days under RCW 28A.150.203 and RCW 28A.150.220.

(3) To the extent funds are available, additional support in the form of implementation grants shall be offered to schools on a schedule to be determined by the office of superintendent of public instruction, in consultation with the department of early learning.

(4)"

Representatives Kagi and Walsh spoke in favor of the adoption of the amendment.

Amendment (1041) was adopted.

There being no objection, the House deferred action on. SUBSTITUTE HOUSE BILL NO. 2586, and the bill held its place on the second reading calendar.

HOUSE BILL NO. 2747, by Representative Hansen

Modifying the use of funds in the fire service training account.

The bill was read the second time.

There being no objection, Substitute House Bill No. 2747 was substituted for House Bill No. 2747 and the substitute bill was placed on the second reading calendar.

SUBSTITUTE HOUSE BILL NO. 2747 was read the second time.

Representative Hansen moved the adoption of amendment (1040).

On page 1, line 7, after “state treasury.” insert “The primary purpose of the account is firefighter training for both volunteer and career firefighters.”

On page 1, line 19, after "academy." insert "However, expenditures for purposes of (b) and (c) of this subsection may only be made to the extent that these expenditures do not adversely affect expenditures for the purpose of (a) of this subsection."

Representative Hansen spoke in favor of the adoption of the amendment.

Amendment (1040) was adopted.

The bill was ordered engrossed.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Hansen and Warnick spoke in favor of the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Engrossed Substitute House Bill No. 2747.

ROLL CALL

The Clerk called the roll on the final passage of Engrossed Substitute House Bill No. 2747, and the bill passed the House by the following vote: Yeas, 92; Nays, 0; Absent, 0; Excused, 6.

Voting yea: Representatives Ahern, Alexander, Anderson, Angel, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Chandler, Clibborn, Cody, Condotta, Crouse, Dahlquist,

Darneille, DeBolt, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Hargrove, Harris, Hasegawa, Hinkle, Hope, Hudgins, Hunt, Hunter, Hurst, Jinkins, Johnson, Kagi, Kenney, Kirby, Klippert, Kretz, Kristiansen, Ladenburg, Lytton, Maxwell, McCoy, McCune, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Overstreet, Parker, Pearson, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ross, Ryu, Santos, Schmick, Seaquist, Sells, Shea, Short, Smith, Springer, Stanford, Sullivan, Takko, Taylor, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wylie and Mr. Speaker.

Excused: Representatives Dammeier, Kelley, Liias, Rodne, Wilcox and Zeiger.

ENGROSSED SUBSTITUTE HOUSE BILL NO. 2747, having received the necessary constitutional majority, was declared passed.

HOUSE BILL NO. 2177, by Representatives Ladenburg, Dammeier, Jinkins, Zeiger, Darneille, Dahlquist, Seaquist, Angel, Kelley, Wilcox, Hurst, McCune, Kirby, Appleton, Green, Ryu, Warnick and Finn

Protecting children from sexual exploitation.

The bill was read the second time.

There being no objection, Substitute House Bill No. 2177 was substituted for House Bill No. 2177 and the substitute bill was placed on the second reading calendar.

SUBSTITUTE HOUSE BILL NO. 2177 was read the second time.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Ladenburg and Pearson spoke in favor of the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Substitute House Bill No. 2177.

ROLL CALL

The Clerk called the roll on the final passage of Substitute House Bill No. 2177, and the bill passed the House by the following vote: Yeas, 92; Nays, 0; Absent, 0; Excused, 6.

Voting yea: Representatives Ahern, Alexander, Anderson, Angel, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Chandler, Clibborn, Cody, Condotta, Crouse, Dahlquist, Darneille, DeBolt, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Hargrove, Harris, Hasegawa, Hinkle, Hope, Hudgins, Hunt, Hunter, Hurst, Jinkins, Johnson, Kagi, Kenney, Kirby, Klippert, Kretz, Kristiansen, Ladenburg, Lytton, Maxwell, McCoy, McCune, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Overstreet, Parker, Pearson, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ross, Ryu, Santos, Schmick, Seaquist, Sells, Shea, Short, Smith, Springer, Stanford, Sullivan, Takko, Taylor, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wylie and Mr. Speaker.

Excused: Representatives Dammeier, Kelley, Liias, Rodne, Wilcox and Zeiger.

SUBSTITUTE HOUSE BILL NO. 2177, having received the necessary constitutional majority, was declared passed.

HOUSE BILL NO. 2179, by Representatives Morris, Lytton and Kenney

Concerning objections to liquor licenses by local governments.

The bill was read the second time.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Morris and Angel spoke in favor of the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of House Bill No. 2179.

ROLL CALL

The Clerk called the roll on the final passage of House Bill No. 2179, and the bill passed the House by the following vote: Yeas, 92; Nays, 0; Absent, 0; Excused, 6.

Voting yea: Representatives Ahern, Alexander, Anderson, Angel, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Chandler, Clibborn, Cody, Condotta, Crouse, Dahlquist, Darneille, DeBolt, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Hargrove, Harris, Hasegawa, Hinkle, Hope, Hudgins, Hunt, Hunter, Hurst, Jinkins, Johnson, Kagi, Kenney, Kirby, Klippert, Kretz, Kristiansen, Ladenburg, Lytton, Maxwell, McCoy, McCune, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Overstreet, Parker, Pearson, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ross, Ryu, Santos, Schmick, Seaquist, Sells, Shea, Short, Smith, Springer, Stanford, Sullivan, Takko, Taylor, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wylie and Mr. Speaker.

Excused: Representatives Dammeier, Kelley, Liias, Rodne, Wilcox and Zeiger.

HOUSE BILL NO. 2179, having received the necessary constitutional majority, was declared passed.

HOUSE BILL NO. 2421, by Representatives Orwall, Rodne, Ladenburg, Upthegrove, Tharinger, Maxwell, Kelley, Kenney, Kagi, Moscoso and Jinkins

Modifying the foreclosure fairness act.

The bill was read the second time.

There being no objection, Substitute House Bill No. 2421 was substituted for House Bill No. 2421 and the substitute bill was placed on the second reading calendar.

SUBSTITUTE HOUSE BILL NO. 2421 was read the second time.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Orwall and Shea spoke in favor of the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Substitute House Bill No. 2421.

ROLL CALL

The Clerk called the roll on the final passage of Substitute House Bill No. 2421, and the bill passed the House by the following vote: Yeas, 91; Nays, 1; Absent, 0; Excused, 6.

Voting yea: Representatives Ahern, Alexander, Anderson, Angel, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Chandler, Clibborn, Cody, Condotta, Crouse, Dahlquist, Darneille, DeBolt, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Hargrove, Harris, Hasegawa, Hope, Hudgins, Hunt, Hunter, Hurst, Jinkins, Johnson, Kagi, Kenney, Kirby, Klippert, Kretz, Kristiansen, Ladenburg, Lytton, Maxwell, McCoy, McCune, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Overstreet, Parker, Pearson, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ross, Ryu, Santos, Schmick, Seaquist, Sells, Shea, Short, Smith, Springer, Stanford, Sullivan, Takko, Taylor, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wylie and Mr. Speaker.

Voting nay: Representative Hinkle.

Excused: Representatives Dammeier, Kelley, Liias, Rodne, Wilcox and Zeiger.

SUBSTITUTE HOUSE BILL NO. 2421, having received the necessary constitutional majority, was declared passed.

RECONSIDERATION

The House resumed consideration of SUBSTITUTE HOUSE BILL NO. 2586.

There being no objection, the House immediately reconsidered the vote by which amendment (1041) to ENGROSSED SUBSTITUTE HOUSE BILL NO. 2586 was adopted.

There being no objection, amendment (1041) was not adopted.

Representative Kagi moved the adoption of amendment (1047).

On page 4, line 21, after "(2)" insert "Time spent by certificated staff meeting with students and families as part of the Washington kindergarten inventory of developing skills may be considered instructional hours under RCW 28A.150.205.

(2) Up to three school days used by certificated staff to meet with students and families or otherwise administer the Washington kindergarten inventory of developing skills may be considered school days under RCW 28A.150.203 and RCW 28A.150.220.

(3) To the extent funds are available, additional support in the form of implementation grants shall be offered to schools on a schedule to be determined by the office of superintendent of public instruction, in consultation with the department of early learning.

(4)"

Representatives Kagi and Dammeier spoke in favor of the adoption of the amendment.

Amendment (1047) was adopted.

The bill was ordered engrossed.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Kagi, Dammeier and Alexander spoke in favor of the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Engrossed Substitute House Bill No. 2586.

ROLL CALL

The Clerk called the roll on the final passage of Engrossed Substitute House Bill No. 2586, and the bill passed the House by the following vote: Yeas, 84; Nays, 11; Absent, 0; Excused, 3.

Voting yea: Representatives Alexander, Anderson, Angel, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Chandler, Clibborn, Cody, Condotta, Dahlquist, Dammeier, Darneille, DeBolt, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Harris, Hasegawa, Hinkle, Hudgins, Hunt, Hunter, Hurst, Jinkins, Johnson, Kagi, Kenney, Kirby, Klippert, Ladenburg, Lytton, Maxwell, McCoy, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Parker, Pearson, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ross, Ryu, Santos, Schmick, Seaquist, Sells, Smith, Springer, Stanford, Sullivan, Takko, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wilcox, Wylie, Zeiger and Mr. Speaker.

Voting nay: Representatives Ahern, Crouse, Hargrove, Hope, Kretz, Kristiansen, McCune, Overstreet, Shea, Short and Taylor.

Excused: Representatives Kelley, Liias and Rodne.

ENGROSSED SUBSTITUTE HOUSE BILL NO. 2586, having received the necessary constitutional majority, was declared passed.

STATEMENT FOR THE JOURNAL

I intended to vote YEA on Engrossed Substitute House Bill No. 2586.

Representative Hope, 44th District

HOUSE BILL NO. 2170, by Representatives Probst, Rivers, Hansen, Sells, Jinkins, Ryu, Ladenburg, Tharinger, Warnick, Maxwell, McCoy, Goodman, Springer, Appleton, Kenney, Roberts, Kirby, Green, Wylie, Ormsby and Orwall

Enacting the career pathways act.

The bill was read the second time.

There being no objection, Second Substitute House Bill No. 2170 was substituted for House Bill No. 2170 and the second substitute bill was placed on the second reading calendar.

SECOND SUBSTITUTE HOUSE BILL NO. 2170 was read the second time.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Probst, Fagan, Hansen and Rivers spoke in favor of the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Second Substitute House Bill No. 2170.

ROLL CALL

The Clerk called the roll on the final passage of Second Substitute House Bill No. 2170, and the bill passed the House by the following vote: Yeas, 88; Nays, 7; Absent, 0; Excused, 3.

Voting yea: Representatives Ahern, Alexander, Anderson, Angel, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Clibborn, Cody, Condotta, Dahlquist, Dammeier, Darneille, DeBolt, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Hargrove, Harris, Hasegawa, Hinkle, Hope, Hudgins, Hunt, Hunter, Hurst, Jinkins, Johnson, Kagi, Kenney, Kirby, Klippert, Kretz, Kristiansen, Ladenburg, Lytton, Maxwell, McCoy, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Parker, Pearson, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ross, Ryu, Santos, Schmick, Seaquist, Sells, Short, Springer, Stanford, Sullivan, Takko, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wilcox, Wylie, Zeiger and Mr. Speaker.

Voting nay: Representatives Chandler, Crouse, McCune, Overstreet, Shea, Smith and Taylor.

Excused: Representatives Kelley, Liias and Rodne.

SECOND SUBSTITUTE HOUSE BILL NO. 2170, having received the necessary constitutional majority, was declared passed.

SECOND READING SUSPENSION

HOUSE BILL NO. 2211, by House Committee on Health & Human Services Appropriations & Oversight (originally sponsored by Representatives Orwall, Ormsby, Upthegrove and Hunt)

Regarding adoptees' access to information, including original birth certificates.

The bill was read the second time.

There being no objection, Second Substitute House Bill No. 2211 was substituted for House Bill No. 2211 and the second substitute bill was placed on the second reading calendar.

SECOND SUBSTITUTE HOUSE BILL NO. 2211 was read the second time.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Orwall and Rivers spoke in favor of the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Second Substitute House Bill No. 2211.

ROLL CALL

The Clerk called the roll on the final passage of Second Substitute House Bill No. 2211, and the bill passed the House by the following vote: Yeas, 95; Nays, 0; Absent, 0; Excused, 3.

Voting yea: Representatives Ahern, Alexander, Anderson, Angel, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Chandler, Clibborn, Cody, Condotta, Crouse, Dahlquist, Dammeier, Darneille, DeBolt, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Hargrove, Harris, Hasegawa, Hinkle, Hope, Hudgins, Hunt, Hunter, Hurst, Jinkins, Johnson, Kagi, Kenney, Kirby, Klippert, Kretz, Kristiansen, Ladenburg, Lytton, Maxwell, McCoy, McCune, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Overstreet, Parker, Pearson, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ross, Ryu, Santos, Schmick, Seaquist, Sells, Shea, Short, Smith, Springer, Stanford, Sullivan, Takko, Taylor, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wilcox, Wylie, Zeiger and Mr. Speaker.

Excused: Representatives Kelley, Liias and Rodne.

SECOND SUBSTITUTE HOUSE BILL NO. 2211, having received the necessary constitutional majority, was declared passed.

HOUSE BILL NO. 2736, by Representative Hansen

Concerning commercial vehicle regulations for texting while driving and projecting loads.

The bill was read the second time.

There being no objection, Substitute House Bill No. 2736 was substituted for House Bill No. 2736 and the substitute bill was placed on the second reading calendar.

SUBSTITUTE HOUSE BILL NO. 2736 was read the second time.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Hansen and Hargrove spoke in favor of the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Substitute House Bill No. 2736.

ROLL CALL

The Clerk called the roll on the final passage of Substitute House Bill No. 2736, and the bill passed the House by the following vote: Yeas, 95; Nays, 0; Absent, 0; Excused, 3.

Voting yea: Representatives Ahern, Alexander, Anderson, Angel, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Chandler, Clibborn, Cody, Condotta, Crouse, Dahlquist, Dammeier, Darneille, DeBolt, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Hargrove, Harris, Hasegawa, Hinkle, Hope, Hudgins, Hunt, Hunter, Hurst, Jinkins, Johnson, Kagi, Kenney, Kirby, Klippert, Kretz, Kristiansen, Ladenburg, Lytton, Maxwell, McCoy, McCune, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Overstreet, Parker, Pearson, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ross, Ryu, Santos, Schmick, Seaquist, Sells, Shea, Short, Smith, Springer, Stanford,

Sullivan, Takko, Taylor, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wilcox, Wylie, Zeiger and Mr. Speaker.

Excused: Representatives Kelley, Liias and Rodne.

SUBSTITUTE HOUSE BILL NO. 2736, having received the necessary constitutional majority, was declared passed.

SECOND READING

HOUSE BILL NO. 2254, by Representatives Carlyle, Kagi, Reykdal, Darneille, Maxwell, Jinkins, Pedersen, Seaquist, Roberts, Dickerson and Kenney

Enacting the educational success for youth and alumni of foster care act.

The bill was read the second time.

There being no objection, Substitute House Bill No. 2254 was substituted for House Bill No. 2254 and the substitute bill was placed on the second reading calendar.

SUBSTITUTE HOUSE BILL NO. 2254 was read the second time.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representative Carlyle spoke in favor of the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Substitute House Bill No. 2254.

ROLL CALL

The Clerk called the roll on the final passage of Substitute House Bill No. 2254, and the bill passed the House by the following vote: Yeas, 88; Nays, 7; Absent, 0; Excused, 3.

Voting yea: Representatives Alexander, Anderson, Angel, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Chandler, Clibborn, Cody, Condotta, Dahlquist, Dammeier, Darneille, DeBolt, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Hargrove, Harris, Hasegawa, Hinkle, Hope, Hudgins, Hunt, Hunter, Hurst, Jinkins, Johnson, Kagi, Kenney, Kirby, Kretz, Ladenburg, Lytton, Maxwell, McCoy, McCune, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Parker, Pearson, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ross, Ryu, Santos, Schmick, Seaquist, Sells, Short, Smith, Springer, Stanford, Sullivan, Takko, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wilcox, Wylie, Zeiger and Mr. Speaker.

Voting nay: Representatives Ahern, Crouse, Klippert, Kristiansen, Overstreet, Shea and Taylor.

Excused: Representatives Kelley, Liias and Rodne.

SUBSTITUTE HOUSE BILL NO. 2254, having received the necessary constitutional majority, was declared passed.

HOUSE BILL NO. 2452, by Representatives Wylie, Alexander, Kenney, Haigh, Hunt, Hudgins, Harris, McCoy, Ryu, Hasegawa, Springer, Billig, Maxwell, Upthegrove and Ormsby

Centralizing the authority and responsibility for the development, process, and oversight of state procurement of goods and services.

The bill was read the second time.

There being no objection, Second Substitute House Bill No. 2452 was substituted for House Bill No. 2452 and the second substitute bill was placed on the second reading calendar.

SECOND SUBSTITUTE HOUSE BILL NO. 2452 was read the second time.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Wylie and Seaquist spoke in favor of the passage of the bill.

Representative Alexander spoke against the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Second Substitute House Bill No. 2452.

ROLL CALL

The Clerk called the roll on the final passage of Second Substitute House Bill No. 2452, and the bill passed the House by the following vote: Yeas, 55; Nays, 40; Absent, 0; Excused, 3.

Voting yea: Representatives Appleton, Billig, Blake, Carlyle, Clibborn, Cody, Darneille, Dickerson, Dunshee, Eddy, Finn, Fitzgibbon, Goodman, Green, Haigh, Hansen, Harris, Hasegawa, Hudgins, Hunt, Hunter, Hurst, Jinkins, Kagi, Kenney, Kirby, Ladenburg, Lytton, Maxwell, McCoy, Miloscia, Moeller, Morris, Moscoso, Ormsby, Orwall, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Roberts, Ryu, Santos, Seaquist, Sells, Springer, Stanford, Sullivan, Takko, Tharinger, Upthegrove, Van De Wege, Wylie and Mr. Speaker.

Voting nay: Representatives Ahern, Alexander, Anderson, Angel, Armstrong, Asay, Bailey, Buys, Chandler, Condotta, Crouse, Dahlquist, Dammeier, DeBolt, Fagan, Haler, Hargrove, Hinkle, Hope, Johnson, Klippert, Kretz, Kristiansen, McCune, Nealey, Orcutt, Overstreet, Parker, Pearson, Rivers, Ross, Schmick, Shea, Short, Smith, Taylor, Walsh, Warnick, Wilcox and Zeiger.

Excused: Representatives Kelley, Liias and Rodne.

SECOND SUBSTITUTE HOUSE BILL NO. 2452, having received the necessary constitutional majority, was declared passed.

POINT OF PERSONAL PRIVILEGE

Representative Green congratulated Representative Wylie on the passage of her first bill through the House, and asked the Chamber to acknowledge her accomplishment.

HOUSE BILL NO. 2474, by Representatives Springer, Van De Wege and Fitzgibbon

Adjusting voting requirements for the renewal of emergency medical service levies.

The bill was read the second time.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representative Springer spoke in favor of the passage of the bill.

Representative Orcutt spoke against the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of House Bill No. 2474.

ROLL CALL

The Clerk called the roll on the final passage of House Bill No. 2474, and the bill passed the House by the following vote: Yeas, 70; Nays, 25; Absent, 0; Excused, 3.

Voting yea: Representatives Anderson, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Carlyle, Clibborn, Cody, Dahlquist, Dammeier, Darneille, Dickerson, Dunshee, Eddy, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Harris, Hasegawa, Hinkle, Hope, Hudgins, Hunt, Hunter, Hurst, Jinkins, Kagi, Kenney, Kirby, Klippert, Ladenburg, Lytton, Maxwell, McCoy, Miloscia, Moeller, Morris, Moscoso, Ormsby, Orwall, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ryu, Santos, Seaquist, Sells, Smith, Springer, Stanford, Sullivan, Takko, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wylie, Zeiger and Mr. Speaker.

Voting nay: Representatives Ahern, Alexander, Angel, Buys, Chandler, Condotta, Crouse, DeBolt, Fagan, Hargrove, Johnson, Kretz, Kristiansen, McCune, Nealey, Orcutt, Overstreet, Parker, Pearson, Ross, Schmick, Shea, Short, Taylor and Wilcox.

Excused: Representatives Kelley, Liias and Rodne.

HOUSE BILL NO. 2474, having received the necessary constitutional majority, was declared passed.

HOUSE BILL NO. 2503, by Representatives Hansen, McCoy, Moscoso, Appleton, Kelley, Springer, Green, Van De Wege, Finn, Hudgins and Maxwell

Requiring institutions of higher education to provide early registration for eligible veterans and national guard members. Revised for 1st Substitute: Requiring institutions of higher education that offer an early course registration period to provide early registration for eligible veterans and national guard members.

The bill was read the second time.

There being no objection, Substitute House Bill No. 2503 was substituted for House Bill No. 2503 and the substitute bill was placed on the second reading calendar.

SUBSTITUTE HOUSE BILL NO. 2503 was read the second time.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Hansen, Haler, Shea and Angel spoke in favor of the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Substitute House Bill No. 2503.

ROLL CALL

The Clerk called the roll on the final passage of Substitute House Bill No. 2503, and the bill passed the House by the following vote: Yeas, 95; Nays, 0; Absent, 0; Excused, 3.

Voting yea: Representatives Ahern, Alexander, Anderson, Angel, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Chandler, Clibborn, Cody, Condotta, Crouse, Dahlquist, Dammeier, Darneille, DeBolt, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Hargrove, Harris, Hasegawa, Hinkle, Hope, Hudgins, Hunt, Hunter, Hurst, Jinkins, Johnson, Kagi, Kenney, Kirby, Klippert, Kretz, Kristiansen, Ladenburg, Lytton, Maxwell, McCoy, McCune, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Overstreet, Parker, Pearson, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ross, Ryu, Santos, Schmick, Seaquist, Sells, Shea, Short, Smith, Springer, Stanford, Sullivan, Takko, Taylor, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wilcox, Wylie, Zeiger and Mr. Speaker.

Excused: Representatives Kelley, Liias and Rodne.

SUBSTITUTE HOUSE BILL NO. 2503, having received the necessary constitutional majority, was declared passed.

HOUSE BILL NO. 2640, by Representatives Smith, Kenney, Warnick, Finn, Walsh, Orcutt and Kelley

Emphasizing cost-effectiveness in the housing trust fund.

The bill was read the second time.

There being no objection, Substitute House Bill No. 2640 was substituted for House Bill No. 2640 and the substitute bill was placed on the second reading calendar.

SUBSTITUTE HOUSE BILL NO. 2640 was read the second time.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Smith, Finn and Kenney spoke in favor of the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Substitute House Bill No. 2640.

ROLL CALL

The Clerk called the roll on the final passage of Substitute House Bill No. 2640, and the bill passed the House by the following vote: Yeas, 95; Nays, 0; Absent, 0; Excused, 3.

Voting yea: Representatives Ahern, Alexander, Anderson, Angel, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Chandler, Clibborn, Cody, Condotta, Crouse, Dahlquist, Dammeier, Darneille, DeBolt, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Hargrove, Harris, Hasegawa, Hinkle, Hope, Hudgins, Hunt, Hunter, Hurst, Jinkins, Johnson, Kagi, Kenney, Kirby, Klippert, Kretz, Kristiansen, Ladenburg, Lytton, Maxwell, McCoy,

McCune, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Overstreet, Parker, Pearson, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ross, Ryu, Santos, Schmick, Seaquist, Sells, Shea, Short, Smith, Springer, Stanford, Sullivan, Takko, Taylor, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wilcox, Wylie, Zeiger and Mr. Speaker.

Excused: Representatives Kelley, Liias and Rodne.

SUBSTITUTE HOUSE BILL NO. 2640, having received the necessary constitutional majority, was declared passed.

HOUSE BILL NO. 2346, by Representatives Walsh, Reykdal, Pearson, Hurst, Kristiansen, Nealey, McCune, Appleton, Orwall, Moscoso, Goodman, DeBolt, Rivers, Shea, Armstrong, Maxwell, Johnson, Springer, Darneille, Sells, Fitzgibbon, Eddy, Angel, Upthegrove, Kelley, Ryu, Stanford, Hudgins, Seaquist and Ormsby

Removing the requirement that correctional officers of the department of corrections purchase uniforms from correctional industries. Revised for 1st Substitute: Concerning the procurement of correctional officer uniforms.

The bill was read the second time.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Walsh, Hudgins, Pearson and Hurst spoke in favor of the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of House Bill No. 2346.

ROLL CALL

The Clerk called the roll on the final passage of House Bill No. 2346, and the bill passed the House by the following vote: Yeas, 92; Nays, 3; Absent, 0; Excused, 3.

Voting yea: Representatives Ahern, Alexander, Anderson, Angel, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Chandler, Clibborn, Cody, Condotta, Crouse, Dahlquist, Dammeier, Darneille, DeBolt, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Hargrove, Harris, Hasegawa, Hinkle, Hope, Hudgins, Hunter, Hurst, Jinkins, Johnson, Kagi, Kenney, Kirby, Klippert, Kretz, Kristiansen, Ladenburg, Lytton, Maxwell, McCoy, McCune, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Overstreet, Parker, Pearson, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Ross, Ryu, Santos, Schmick, Seaquist, Sells, Shea, Short, Smith, Springer, Stanford, Sullivan, Takko, Taylor, Tharinger, Upthegrove, Van De Wege, Walsh, Wilcox, Wylie, Zeiger and Mr. Speaker.

Voting nay: Representatives Hunt, Roberts and Warnick.

Excused: Representatives Kelley, Liias and Rodne.

HOUSE BILL NO. 2346, having received the necessary constitutional majority, was declared passed.

HOUSE BILL NO. 2717, by Representatives Seaquist and Pollet

Creating innovations in higher education.

The bill was read the second time.

There being no objection, Second Substitute House Bill No. 2717 was substituted for House Bill No. 2717 and the second substitute bill was placed on the second reading calendar.

SECOND SUBSTITUTE HOUSE BILL NO. 2717 was read the second time.

Representative Anderson moved the adoption of amendment (1092).

On page 3, after line 30, insert the following:

"NEW SECTION. **Sec. 4.** RCW 28B.15.067 and 2011 1st sp.s. c 10 s 3 are each amended to read as follows:

(1) Tuition fees shall be established under the provisions of this chapter.

(2) Beginning in the 2011-12 academic year, reductions or increases in full-time tuition fees shall be as provided in the omnibus appropriations act for resident undergraduate students at community and technical colleges. The governing boards of the state universities, regional universities, and The Evergreen State College; and the state board for community and technical colleges may reduce or increase full-time tuition fees for all students other than resident undergraduates, including nonresident students, summer school students, and students in other self-supporting degree programs. Percentage increases in full-time tuition may exceed the fiscal growth factor. The state board for community and technical colleges may pilot or institute differential tuition models. The board may define scale, scope, and rationale for the models.

(3)(a) Beginning with the 2011-12 academic year and through the end of the 2014-15 academic year, the governing boards of the state universities, the regional universities, and The Evergreen State College may reduce or increase full-time tuition fees for all students, including summer school students and students in other self-supporting degree programs, except that for at least four consecutive academic years following initial full-time enrollment, a student shall be guaranteed that there will be no increase in the tuition fees paid by that student. Percentage increases in full-time tuition fees may exceed the fiscal growth factor. Reductions or increases may be made for all or portions of an institution's programs, campuses, courses, or students.

(b) Prior to reducing or increasing tuition for each academic year, the governing boards of the state universities, the regional universities, and The Evergreen State College shall consult with existing student associations or organizations with student undergraduate and graduate representatives regarding the impacts of potential tuition increases. Governing boards shall be required to provide data regarding the percentage of students receiving financial aid, the sources of aid, and the percentage of total costs of attendance paid for by aid.

(c) Prior to reducing or increasing tuition for each academic year, the state board for community and technical college system shall consult with existing student associations or organizations with undergraduate student representation regarding the impacts of potential tuition increases. The state board for community and technical colleges shall provide data regarding the percentage of students receiving financial aid, the sources of aid, and the percentage of total costs of attendance paid for by aid.

(4) Beginning with the 2015-16 academic year through the 2018-19 academic year, the governing boards of the state universities, regional universities, and The Evergreen State College may set tuition for resident undergraduates as follows:

(a) If state funding for a college or university falls below the state funding provided in the operating budget for fiscal year 2011, the governing board may increase tuition up to the limits set in (d) of this subsection, reduce enrollments, or both;

(b) If state funding for a college or university is at least at the level of state funding provided in the operating budget for fiscal year 2011, the governing board may increase tuition up to the limits set in (d) of this subsection and shall continue to at least maintain the actual enrollment levels for fiscal year 2011 or increase enrollments as required in the omnibus appropriations act; and

(c) If state funding is increased so that combined with resident undergraduate tuition the sixtieth percentile of the total per-student funding at similar public institutions of higher education in the global challenge states under RCW 28B.15.068 is exceeded, the governing board shall decrease tuition by the amount needed for the total per-student funding to be at the sixtieth percentile under RCW 28B.15.068;

(d) The amount of tuition set by the governing board for an institution under this subsection (4) may not exceed the sixtieth percentile of the resident undergraduate tuition of similar public institutions of higher education in the global challenge states((.)):

(e) In subsections (a) through (c) a student shall be guaranteed that there will be no increase in the tuition fees paid by that student for at least four consecutive academic years following initial full-time enrollment.

(5) The tuition fees established under this chapter shall not apply to high school students enrolling in participating institutions of higher education under RCW 28A.600.300 through 28A.600.400.

(6) The tuition fees established under this chapter shall not apply to eligible students enrolling in a dropout reengagement program through an interlocal agreement between a school district and a community or technical college under RCW 28A.175.100 through 28A.175.110.

(7) The tuition fees established under this chapter shall not apply to eligible students enrolling in a community or technical college participating in the pilot program under RCW 28B.50.534 for the purpose of obtaining a high school diploma.

(8) Beginning in the 2019-20 academic year, reductions or increases in full-time tuition fees for resident undergraduates at four-year institutions of higher education shall be as provided in the omnibus appropriations act."

Correct the title.

Representative Anderson spoke in favor of the adoption of the amendment.

Representative Seaquist spoke against the adoption of the amendment.

Amendment (1092) was not adopted.

Representative Anderson moved the adoption of amendment (1093).

On page 3, after line 30, insert the following:

"NEW SECTION. **Sec. 4.** RCW 28B.76.310 and 2011 1st sp.s. c 11 s 105 are each amended to read as follows:

(1) The board, or successor agency, in consultation with the house of representatives and senate committees responsible for higher education, the respective fiscal committees of the house of representatives and senate, the office of financial management, the state board for community and technical colleges, and the state institutions of higher education, shall develop standardized methods and protocols for measuring the undergraduate and graduate educational costs for the state universities, regional universities, and community colleges, including but not limited to the costs of instruction, costs to provide degrees in specific fields, and costs for precollege remediation. When reporting accountability data, the board shall require that the institutions of higher education do so in accordance with the standardized methods and protocols.

(2) By December 1, 2012, and every four years, the board, or successor agency, shall complete studies of the costs of instruction, the costs of degrees in specific fields, the costs of precollege remediation, and the costs of attendance, and shall report the same to the governor and the appropriate committees of the legislature.

(3) The institutions of higher education shall participate in the development of cost study methods and shall provide all necessary data in a timely fashion consistent with the protocols developed."

Correct the title.

Representative Anderson and Anderson (again) spoke in favor of the adoption of the amendment.

Representative Seaquist spoke against the adoption of the amendment.

An electronic roll call was requested.

ROLL CALL

The Clerk called the roll on the adoption of amendment (1093) to Second Substitute House Bill No. 2717 and the amendment was not adopted by the following vote: Yeas, 41; Nays, 54; Absent, 0; Excused, 3.

Voting yea: Representatives Ahern, Alexander, Anderson, Angel, Armstrong, Asay, Bailey, Buys, Chandler, Condotta, Crouse, Dahlquist, Dammeier, DeBolt, Fagan, Haler, Hargrove, Harris, Hinkle, Hope, Johnson, Kirby, Klippert, Kretz, Kristiansen, McCune, Nealey, Orcutt, Overstreet, Parker, Pearson, Rivers, Ross, Schmick, Shea, Short, Smith, Taylor, Walsh, Warnick and Zeiger.

Voting nay: Representatives Appleton, Billig, Blake, Carlyle, Clibborn, Cody, Darneille, Dickerson, Dunshee, Eddy, Finn, Fitzgibbon, Goodman, Green, Haigh, Hansen, Hasegawa, Hudgins, Hunt, Hunter, Hurst, Jinkins, Kagi, Kenney, Ladenburg, Lytton, Maxwell, McCoy, Miloscia, Moeller, Morris, Moscoso, Ormsby, Orwall, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Roberts, Ryu, Santos, Seaquist, Sells, Springer, Stanford, Sullivan, Takko, Tharinger, Upthegrove, Van De Wege, Wilcox, Wylie and Mr. Speaker.

Excused: Representatives Kelley, Liias and Rodne.

Representative Anderson moved the adoption of amendment (1094).

On page 3, after line 30, insert the following:

"**Sec. 4.** RCW 28B.76.270 and 2011 1st sp.s. c 10 s 8 are each amended to read as follows:

(1) The board, or its successor, shall establish an accountability monitoring and reporting system as part of a continuing effort to make meaningful and substantial progress towards the achievement of long-term performance goals in higher education.

(2) To provide consistent, easily understood data among the public four-year institutions of higher education within Washington and in other states, the following data must be reported annually by December 1st, and at a minimum include data recommended by a national organization representing state chief executives. The board, or its successor, may change the data requirements to be consistent with best practices across the country. This data must, to the maximum extent possible, be disaggregated by race and ethnicity, gender, state and county of origin, age, and socioeconomic status, and include the following for the four-year institutions of higher education:

(a) Bachelor's degrees awarded;

(b) Graduate and professional degrees awarded;

(c) Graduation rates: The number and percentage of students who graduate within four years for bachelor's degrees and within the extended time, which is six years for bachelor's degrees;

(d) Transfer rates: The annual number and percentage of students who transfer from a two-year to a four-year institution of higher education;

(e) Time and credits to degree: The average length of time in years and average number of credits that graduating students took to earn a bachelor's degree;

(f) Enrollment in remedial education: The number and percentage of entering first-time undergraduate students who place into and enroll in remedial mathematics, English, or both;

(g) Success beyond remedial education: The number and percentage of entering first-time undergraduate students who complete entry college-level math and English courses within the first two consecutive academic years;

(h) Credit accumulation: The number and percentage of first-time undergraduate students completing two quarters or one semester worth of credit during their first academic year;

(i) Retention rates: The number and percentage of entering undergraduate students who enroll consecutively from fall-to-spring and fall-to-fall at an institution of higher education;

(j) Course completion: The percentage of credit hours completed out of those attempted during an academic year;

(k) Program participation and degree completion rates in bachelor and advanced degree programs in the sciences, which includes agriculture and natural resources, biology and biomedical sciences, computer and information sciences, engineering and engineering technologies, health professions and clinical sciences, mathematics and statistics, and physical sciences and science technologies, including participation and degree completion rates for students from traditionally underrepresented populations;

(l) Annual enrollment: Annual unduplicated number of students enrolled over a twelve-month period at institutions of higher education including by student level;

(m) Annual first-time enrollment: Total first-time students enrolled in a four-year institution of higher education;

(n) Completion ratio: Annual ratio of undergraduate and graduate degrees and certificates, of at least one year in expected length, awarded per one hundred full-time equivalent undergraduate students at the state level;

(o) Market penetration: Annual ratio of undergraduate and graduate degrees and certificates, of at least one year in program length, awarded relative to the state's population age eighteen to twenty-four years old with a high school diploma;

(p) Student debt load: Median three-year distribution of debt load, excluding private loans or debts incurred before coming to the institution;

(q) Data related to enrollment, completion rates, participation rates, and debt load shall be disaggregated for students in the following income brackets to the maximum extent possible:

(i) Up to seventy percent of the median family income;

(ii) Between seventy-one percent and one hundred twenty-five percent of the median family income; and

(iii) Above one hundred twenty-five percent of the median family income; and

(r) Yearly percentage increases in the average cost of undergraduate instruction.

(3) Four-year institutions of higher education must count all students when collecting data, not only first-time, full-time freshmen.

(4) Based on guidelines prepared by the board, or its successor, each four-year institution and the state board for community and technical colleges shall submit a biennial plan to achieve measurable and specific improvements each academic year on statewide and institution-specific performance measures. Plans shall be submitted to the board, or its successor, along with the biennial budget requests from the institutions and the state board for community and technical colleges. Performance measures established for the community and technical colleges shall reflect the role and mission of the colleges. Performance measures established for the research universities, the regional universities, and The Evergreen State College shall include, but are not limited to, measures for instruction, research, and public service.

(5) The board, or its successor, shall approve biennial performance targets for each four-year institution and for the community and technical college system and shall review actual achievements annually. The state board for community and technical colleges shall set biennial performance targets for each college or district, where appropriate.

(6) The board, or its successor, shall submit a report on progress towards the statewide goals, with recommendations for the ensuing biennium, to the fiscal and higher education committees of the legislature along with the board's, or its successor's, biennial budget recommendations.

(7) The board, or its successor, in collaboration with the four-year institutions and the state board for community and technical colleges, shall periodically review and update the accountability monitoring and reporting system.

(8) The board, or its successor, shall develop measurable indicators and benchmarks for its own performance regarding cost, quantity, quality, and timeliness and including the performance of committees and advisory groups convened under this chapter to accomplish such tasks as improving transfer and articulation, improving articulation with the K-12 education system, measuring educational costs, or developing data protocols. The board, or its successor, shall submit its accountability plan to the legislature concurrently with the biennial report on institution progress.

(9) In conjunction with the office of financial management, all four-year institutions of higher education must display the data described in subsection (2) of this section in a uniform dashboard format on the office of financial management's web site no later than December 1, 2011, and updated thereafter annually by December 1st. To the maximum extent possible, the information must be viewable by race and ethnicity, gender, state and county of origin, age, and socioeconomic status. The information may be tailored to meet the needs of various target audiences such as students, researchers, and the general public."

Representative Anderson spoke in favor of the adoption of the amendment.

Representative Seaquist spoke against the adoption of the amendment.

Amendment (1094) was not adopted.

Representative Anderson moved the adoption of amendment (1095).

On page 3, after line 30, insert the following:

"**Sec. 4.** RCW 28B.15.0681 and 2011 1st sp.s. c 10 s 4 are each amended to read as follows:

(1) ((~~In addition to the requirement in RCW 28B.76.300(4),~~)) Institutions of higher education shall disclose to their undergraduate resident students on the tuition billing statement, in dollar figures for a full-time equivalent student:

(a) The full cost of instruction;

(b) The amount collected from student tuition and fees; and

(c) The difference between the amounts for the full cost of instruction and the student tuition and fees.

(2) The tuition billing statement shall note that the difference between the cost and tuition under subsection (1)(c) of this section was paid by state tax funds and other moneys.

(3) Beginning in the 2010-11 academic year, the amount determined in subsection (1)(c) of this section shall be labeled an "opportunity pathway" on the tuition billing statement.

(4) Beginning in the 2010-11 academic year, institutions of higher education shall label financial aid awarded to resident undergraduate students as an "opportunity pathway" on the tuition billing statement or financial aid award notification. Aid granted to students outside of the financial aid package provided through the institution of higher education and loans provided by the federal government are not subject to the labeling provisions in this subsection. All other aid from all sources including federal, state, and local governments, local communities, nonprofit and for-profit organizations, and institutions of higher education must be included. The disclosure requirements specified in this section do not change the source, award amount, student eligibility, or student obligations associated with each award. Institutions of higher education retain the ability to customize their tuition billing statements to inform students of the assistance source, amount, and type so long as provisions of this section are also fulfilled.

(5) Institutions of higher education shall provide the following information to all undergraduate resident students either on the tuition billing statement or via a link to a web site detailing the following information:

(a) The sources of all institutional revenue received during the prior academic or fiscal year, including but not limited to state, federal, local, and private sources;

(b) The uses of tuition revenue collected during the prior academic or fiscal year by program category as determined by the office of financial management; and

(c) The accountability and performance data under RCW 28B.76.270.

(6) The tuition billing statement disclosures shall be in twelve-point type and boldface type where appropriate.

(7) All tuition billing statements or financial aid award notifications at institutions of higher education must notify resident undergraduate students of federal tax credits related to higher education for which they may be eligible.

(8) The higher education coordinating board, or its successor board, the state board for community and technical colleges, and the institutions of higher education shall develop a uniform billing statement that uses a uniform format and definitions. Institutions of higher education must use the uniform billing statement no later than the beginning of the 2012-13 academic year."

Representative Anderson spoke in favor of the adoption of the amendment.

Representative Seaquist spoke against the adoption of the amendment.

Amendment (1095) was not adopted.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Seaquist, Haler and Anderson spoke in favor of the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Second Substitute House Bill No. 2717.

ROLL CALL

The Clerk called the roll on the final passage of Second Substitute House Bill No. 2717, and the bill passed the House by the following vote: Yeas, 70; Nays, 25; Absent, 0; Excused, 3.

Voting yea: Representatives Anderson, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Clibborn, Cody, Darneille, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Hasegawa, Hinkle, Hope, Hudgins, Hunt, Hunter, Hurst, Jinkins, Kagi, Kenney, Kirby, Ladenburg, Lytton, Maxwell, McCoy, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ryu, Santos, Seaquist, Sells, Smith, Springer, Stanford, Sullivan, Takko, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wylie, Zeiger and Mr. Speaker.

Voting nay: Representatives Ahern, Alexander, Angel, Chandler, Condotta, Crouse, Dahlquist, Dammeier, DeBolt, Hargrove, Harris, Johnson, Klippert, Kretz, Kristiansen, McCune, Overstreet, Parker, Pearson, Ross, Schmick, Shea, Short, Taylor and Wilcox.

Excused: Representatives Kelley, Liias and Rodne.

SECOND SUBSTITUTE HOUSE BILL NO. 2717, having received the necessary constitutional majority, was declared passed.

HOUSE BILL NO. 2395, by Representatives Sells, Reykdal, Upthegrove, Ryu, Moscoso, Ormsby, Hasegawa, Fitzgibbon, Hudgins, Darneille, Cody, Kenney, Santos, Roberts, Green, Miloscia, Pettigrew, Dickerson, Moeller, Appleton, Liias, Jinkins, Dunshee, Van De Wege, Goodman, Orwall, Hunt, Wylie, Billig and Probst

Regulating drayage truck operators.

The bill was read the second time.

There being no objection, Substitute House Bill No. 2395 was substituted for House Bill No. 2395 and the substitute bill was placed on the second reading calendar.

SUBSTITUTE HOUSE BILL NO. 2395 was read the second time.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Sells, Sullivan Hasegawa and Sells (again) spoke in favor of the passage of the bill.

Representatives Condotta, Orcutt, Harris, Nealey and Ross spoke against the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Substitute House Bill No. 2395.

ROLL CALL

The Clerk called the roll on the final passage of Substitute House Bill No. 2395, and the bill passed the House by the following vote: Yeas, 52; Nays, 43; Absent, 0; Excused, 3.

Voting yea: Representatives Appleton, Billig, Blake, Carlyle, Clibborn, Cody, Darneille, Dickerson, Dunshee, Eddy, Finn,

Fitzgibbon, Goodman, Green, Haigh, Hansen, Hasegawa, Hudgins, Hunt, Hunter, Jinkins, Kagi, Kenney, Kirby, Ladenburg, Lytton, Maxwell, McCoy, Miloscia, Moeller, Morris, Moscoso, Ormsby, Orwall, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Roberts, Ryu, Santos, Seaquist, Sells, Springer, Stanford, Sullivan, Tharinger, Upthegrove, Van De Wege, Wylie and Mr. Speaker.

Voting nay: Representatives Ahern, Alexander, Anderson, Angel, Armstrong, Asay, Bailey, Buys, Chandler, Condotta, Crouse, Dahlquist, Dammeier, DeBolt, Fagan, Haler, Hargrove, Harris, Hinkle, Hope, Hurst, Johnson, Klippert, Kretz, Kristiansen, McCune, Nealey, Orcutt, Overstreet, Parker, Pearson, Rivers, Ross, Schmick, Shea, Short, Smith, Takko, Taylor, Walsh, Warnick, Wilcox and Zeiger.

Excused: Representatives Kelley, Liias and Rodne.

SUBSTITUTE HOUSE BILL NO. 2395, having received the necessary constitutional majority, was declared passed.

HOUSE BILL NO. 2319, by Representatives Cody, Jinkins and Ormsby

Implementing the affordable care act. Revised for 2nd Substitute: Implementing the federal patient and protection affordable care act.

The bill was read the second time.

There being no objection, Second Substitute House Bill No. 2319 was substituted for House Bill No. 2319 and the second substitute bill was placed on the second reading calendar.

SECOND SUBSTITUTE HOUSE BILL NO. 2319 was read the second time.

Representative Cody moved the adoption of amendment (1068).

Strike everything after the enacting clause and insert the following:

"**PART I**

DEFINITIONS

Sec. 1. RCW 48.43.005 and 2011 c 315 s 2 and 2011 c 314 s 3 are each reenacted and 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) "Adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(3) "Applicant" means a person who applies for enrollment in an individual health plan as the subscriber or an enrollee, or the dependent or spouse of a subscriber or enrollee.

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

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

(6) "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.

(7) "Board" means the governing board of the Washington health benefit exchange established in chapter 43.71 RCW.

(8)(a) For grandfathered health benefit plans issued before January 1, 2014, and renewed thereafter, "catastrophic health plan" means:

((~~(a)~~)) (i) 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 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, both amounts to be adjusted annually by the insurance commissioner; and

((~~(b)~~)) (ii) 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 six thousand dollars, both amounts to be adjusted annually by the insurance commissioner((~~; 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~~)).

(b) In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding twelve months, as determined by the United States department of labor. The adjusted amount shall apply on the following January 1st.

(c) For health benefit plans issued on or after January 1, 2014, "catastrophic health plan" means:

(i) A health benefit plan that meets the definition of catastrophic plan set forth in section 1302(e) of P.L. 111-148 of 2010, as amended; or

(ii) A health benefit plan offered outside the exchange marketplace that requires a calendar year deductible or out-of-pocket expenses under the plan, other than for premiums, for covered benefits, that meets or exceeds the commissioner's annual adjustment under (b) of this subsection.

((~~(8)~~)) (9) "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.

((~~(9)~~)) (10) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

((~~(10)~~)) (11) "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.

((~~(11)~~)) (12) "Dependent" means, at a minimum, the enrollee's legal spouse and dependent children who qualify for coverage under the enrollee's health benefit plan.

((~~(12)~~)) (13) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

((~~(13)~~)) (14) "Emergency services" means a medical screening examination, as required under section 1867 of the social security act (42 U.S.C. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. 1395dd(e)(3)).

((~~(14)~~)) (15) "Employee" has the same meaning given to the term, as of January 1, 2008, under section 3(6) of the federal employee retirement income security act of 1974.

((~~(15)~~)) (16) "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.

((~~(16)~~)) (17) "Exchange" means the Washington health benefit exchange established under chapter 43.71 RCW.

(18) "Final external review decision" means a determination by an independent review organization at the conclusion of an external review.

((~~(17)~~)) (19) "Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a health plan or carrier at the completion of the internal appeals process, or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the exhaustion rules described in RCW 48.43.530 and 48.43.535.

((~~(18)~~)) (20) "Grandfathered health plan" means a group health plan or an individual health plan that under section 1251 of the patient protection and affordable care act, P.L. 111-148 (2010) and as amended by the health care and education reconciliation act, P.L. 111-152 (2010) is not subject to subtitles A or C of the act as amended.

((~~(19)~~)) (21) "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.

((~~(20)~~)) (22) "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.

((~~(21)~~)) (23) "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.

((~~(22)~~)) (24) "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.

((~~(23)~~)) (25) "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, and includes "issuers" as that term is used in the patient protection and affordable care act (P.L. 111-148).

((~~(24)~~)) (26) "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 or 48.83 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 or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit;

(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.

((~~(25)~~)) (27) "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.

((~~(26)~~)) (28) "Open enrollment" means a period of time as defined in rule to be held at the same time each year, during which applicants may enroll in a carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

((~~(27)~~)) (29) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(28)~~)) (30) "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.

(((~~(29)~~))) (31) "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.

(((~~(30)~~))) (32) "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 employed an average of at least one but no more than fifty employees, during the previous calendar year and employed at least one employee on the first day of the plan year, 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 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 who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived 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 a self-employed individual or sole proprietor in an agricultural trade or business, must have derived 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.

(((~~(31)~~))) (33) "Special enrollment" means a defined period of time of not less than thirty-one days, triggered by a specific qualifying event experienced by the applicant, during which applicants may enroll in the carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(((~~(32)~~))) (34) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

(((~~(33)~~))) (35) "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.

(((~~(34)~~))) (36) "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.

PART II

THE WASHINGTON HEALTH BENEFIT EXCHANGE

Sec. 2. RCW 43.71.020 and 2011 c 317 s 3 are each amended to read as follows:

(1) The Washington health benefit exchange is established and constitutes a self-sustaining public-private partnership separate and distinct from the state, exercising functions delineated in chapter 317, Laws of 2011. The exchange shall be known as the evergreen health marketplace. By January 1, 2014, the exchange shall operate consistent with the affordable care act subject to statutory authorization. The exchange shall have a governing board consisting of persons with expertise in the Washington health care system and private and public health care coverage. The initial membership of the board shall be appointed as follows:

(a) By October 1, 2011, each of the two largest caucuses in both the house of representatives and the senate shall submit to the governor a list of five nominees who are not legislators or employees of the state or its political subdivisions, with no caucus submitting the same nominee.

(i) The nominations from the largest caucus in the house of representatives must include at least one employee benefit specialist;

(ii) The nominations from the second largest caucus in the house of representatives must include at least one health economist or actuary;

(iii) The nominations from the largest caucus in the senate must include at least one representative of health consumer advocates;

(iv) The nominations from the second largest caucus in the senate must include at least one representative of small business;

(v) The remaining nominees must have demonstrated and acknowledged expertise in at least one of the following areas: Individual health care coverage, small employer health care coverage, health benefits plan administration, health care finance and economics, actuarial science, or administering a public or private health care delivery system.

(b) By December 15, 2011, the governor shall appoint two members from each list submitted by the caucuses under (a) of this subsection. The appointments made under this subsection (1)(b) must include at least one employee benefits specialist, one health economist or actuary, one representative of small business, and one representative of health consumer advocates. The remaining four members must have a demonstrated and acknowledged expertise in at least one of the following areas: Individual health care coverage, small employer health care coverage, health benefits plan administration, health care finance and economics, actuarial science, or administering a public or private health care delivery system.

(c) By December 15, 2011, the governor shall appoint a ninth member to serve as chair. The chair may not be an employee of the state or its political subdivisions. The chair shall serve as a nonvoting member except in the case of a tie. Beginning on December 1, 2013, the chair shall serve at the pleasure of the governor.

(d) The following members shall serve as nonvoting, ex officio members of the board:

(i) The insurance commissioner or his or her designee; and

(ii) The administrator of the health care authority, or his or her designee.

(2) Initial members of the board shall serve staggered terms not to exceed four years. Members appointed thereafter shall serve two-year terms.

(3) A member of the board whose term has expired or who otherwise leaves the board shall be replaced by gubernatorial appointment. When the person leaving was nominated by one of the caucuses of the house of representatives or the senate, his or her replacement shall be appointed from a list of five nominees submitted by that caucus within thirty days after the person leaves. If the member to be replaced is the chair, the governor shall appoint a new chair within thirty days after the vacancy occurs. A person appointed to replace a member who leaves the board prior to the expiration of

his or her term shall serve only the duration of the unexpired term. Members of the board may be reappointed to multiple terms.

(4)(a) No board member may be appointed if his or her participation in the decisions of the board could benefit his or her own financial interests or the financial interests of an entity he or she represents. A board member who develops such a conflict of interest shall resign or be removed from the board.

(b) A voting board member may lobby on issues related to the exchange or the state's implementation of the affordable care act, but only to: (i) Provide information or communicating on matters pertaining to official board business to any elected official; or (ii) advocate the official position or interests of the board to any elected official. A voting board member may communicate with a member of the legislature, on issues related to the exchange or the state's implementation of the affordable care act, on the request of that member or communicate to the legislature, through proper board-approved channels, requests for legislative action or appropriations deemed necessary for the efficient conduct of the exchange or actually made in the proper performance of his or her duties as a voting board member. For purposes of this subsection, "lobby" has the same meaning as in RCW 42.17A.005.

(5) Members of the board must be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060. The board shall prescribe rules for the conduct of its business. Meetings of the board are at the call of the chair.

(6) The exchange and the board are subject only to the provisions of chapter 42.30 RCW, the open public meetings act, and chapter 42.56 RCW, the public records act, and not to any other law or regulation generally applicable to state agencies. Consistent with the open public meetings act, the board may hold executive sessions to consider proprietary or confidential nonpublished information.

(7)(a) The board shall establish an advisory committee to allow for the views of the health care industry and other stakeholders to be heard in the operation of the health benefit exchange.

(b) The board may establish technical advisory committees or seek the advice of technical experts when necessary to execute the powers and duties included in chapter 317, Laws of 2011.

(8) Members of the board are not civilly or criminally liable and may 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 chapter 317, Laws of 2011. Nothing in this section prohibits legal actions against the board to enforce the board's statutory or contractual duties or obligations.

(9) In recognition of the government-to-government relationship between the state of Washington and the federally recognized tribes in the state of Washington, the board shall consult with the American Indian health commission.

Sec. 3. RCW 43.71.030 and 2011 c 317 s 4 are each amended to read as follows:

(1) The exchange may, consistent with the purposes of this chapter: (a) Sue and be sued in its own name; (b) make and execute agreements, contracts, and other instruments, with any public or private person or entity; (c) employ, contract with, or engage personnel; (d) pay administrative costs; ((~~and~~)) (e) accept grants, donations, loans of funds, and contributions in money, services, materials or otherwise, from the United States or any of its agencies, from the state of Washington and its agencies or from any other source, and use or expend those moneys, services, materials, or other contributions; (f) aggregate or delegate the aggregation of funds that comprise the premium for a health plan; and (g) complete other duties necessary to begin open enrollment in qualified health plans through the exchange beginning October 2, 2013.

(2) ((~~The powers and duties of the exchange and the board are limited to those necessary to apply for and administer grants, establish information technology infrastructure, and undertake additional administrative functions necessary to begin operation of the exchange by January 1, 2014. Any actions relating to substantive issues included in RCW 43.71.040 must be consistent with statutory direction on those issues.~~)) The exchange may charge and equitably apportion among participating carriers the administrative costs and expenses incurred consistent with the provisions of this chapter, and must develop the methodology to ensure the exchange is self-sustaining.

(3) The board shall establish rules or policies that permit city and county governments, Indian tribes, tribal organizations, urban Indian organizations, private foundations, and other entities to pay premiums on behalf of qualified individuals.

(4) The exchange shall report its activities and status to the governor and the legislature as requested, and no less often than annually.

Sec. 4. RCW 43.71.060 and 2011 c 317 s 7 are each amended to read as follows:

(1) The health benefit exchange account is created in the custody of the state treasurer. All receipts from federal grants received under the affordable care act shall be deposited into the account. Expenditures from the account may be used only for purposes consistent with the grants. Until March 15, 2012, only the administrator of the health care authority, or his or her designee, may authorize expenditures from the account. ((~~Beginning March 15, 2012, only the board of the Washington health benefit exchange may authorize expenditures from the account.~~)) The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

(2) This section expires January 1, 2014.

PART III

MARKET RULES

NEW SECTION. **Sec. 5.** A new section is added to chapter 48.43 RCW to read as follows:

(1) For plan or policy years beginning January 1, 2014, a carrier must offer individual or small group health benefit plans outside the exchange that meet the definition of silver and gold level plans in section 1302 of P.L. 111-148 of 2010, as amended, if the carrier offers an individual or small group plan outside the exchange that meets the bronze level definition in section 1302 of P.L. 111-148 of 2010, as amended.

(2) A health benefit plan meeting the definition of a catastrophic plan in RCW 48.43.005(8)(c)(i) may only be sold through the exchange.

(3)(a) The commissioner shall adopt rules prohibiting a carrier from offering outside the exchange a health benefit plan that meets the definition of a bronze level qualified health plan under section 1302 of P.L. 111-148 of 2010, as amended, unless the carrier offers the same plan inside the exchange, if:

(i) The exchange is experiencing adverse selection or, based upon current and projected health plan enrollment patterns, the exchange is likely to experience adverse selection within the next twelve months; or

(ii) Consumers do not have an adequate choice of health plan options among the actuarial value tiers specified in section 1302 of P.L. 111-148 in the exchange.

(b) Any rules adopted under this subsection (3) may not go into effect until one full regular session of the legislature has passed following their adoption.

(4) The commissioner shall evaluate plans offered at each actuarial value defined in section 1302 of P.L. 111-148 of 2010, as amended, and determine whether variation in prescription drug benefits, including cost-sharing, both inside and outside the exchange in both the individual and small group markets results in adverse selection. If so, the commissioner may adopt rules to assure substantial equivalence of prescription drug benefits.

NEW SECTION. **Sec. 6.** A new section is added to chapter 48.43 RCW to read as follows:

All health plans, other than catastrophic health plans, offered outside of the exchange must conform with the actuarial value tiers specified in section 1302 of P.L. 111-148 of 2010, as amended, as bronze, silver, gold, or platinum.

PART IV

QUALIFIED HEALTH PLANS

NEW SECTION. **Sec. 7.** A new section is added to chapter 43.71 RCW to read as follows:

(1) The board shall certify a plan as a qualified health plan to be offered through the exchange if the plan:

(a) Is determined by the insurance commissioner to meet the requirements of Title 48 RCW and rules adopted by the commissioner pursuant to chapter 34.05 RCW;

(b) Is determined by the board to meet the requirements of the affordable care act for certification as a qualified health plan; and

(c) Is determined by the board to include tribal clinics and urban Indian clinics as essential community providers in the plan's provider network consistent with federal law. If consistent with federal law, integrated delivery systems may be exempt from the requirement to include all essential community providers in the provider network.

(2) Consistent with section 1311 of P.L. 111-148 of 2010, as amended, the board shall allow stand-alone dental plans to offer coverage in the exchange beginning January 1, 2014. Dental benefits offered in the exchange must be offered and priced separately to assure transparency for consumers.

(3) Upon request by the board, a state agency shall provide information to the board for its use in determining if the requirements under subsection (1)(b) or (c) of this section have been met. Unless the agency and the board agree to a later date, the agency shall provide the information within sixty days of the request. The exchange shall reimburse the agency for the cost of compiling and providing the requested information within one hundred eighty days of its receipt.

(4) A decision by the board denying a request to certify or recertify a plan as a qualified health plan may be appealed according to procedures adopted by the board.

NEW SECTION. **Sec. 8.** A new section is added to chapter 43.71 RCW to read as follows:

The board shall establish a rating system for qualified health plans to assist consumers in evaluating plan choices in the exchange. Rating factors established by the board must include, but are not limited to:

(1) Affordability with respect to premiums, deductibles, and point- of-service cost-sharing;

(2) Enrollee satisfaction;

(3) Provider reimbursement methods that incentivize health homes or chronic care management or care coordination for enrollees with complex, high-cost, or multiple chronic conditions;

(4) Promotion of appropriate primary care and preventive services utilization;

(5) High standards for provider network adequacy, including consumer choice of providers and service locations and robust provider participation intended to improve access to underserved populations through participation of essential community providers, family planning providers and pediatric providers;

(6) Protection of the privacy of patients' personal health information;

(7) High standards for covered services, including languages spoken or transportation assistance; and

(8) Coverage of benefits for spiritual care services that are deductible under section 213(d) of the internal revenue code.

Sec. 9. RCW 48.42.010 and 1985 c 264 s 15 are each amended to read as follows:

(1) Notwithstanding any other provision of law, and except as provided in this chapter, any person or other entity which provides coverage in this state for life insurance, annuities, loss of time, medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether the coverage is by direct payment, reimbursement, the providing of services, or otherwise, shall be subject to the authority of the state insurance commissioner, unless the person or other entity shows that while providing the services it is subject to the jurisdiction and regulation of another agency of this state, any subdivisions thereof, or the federal government.

(2) "Another agency of this state, any subdivision thereof, or the federal government" does not include the Washington health benefit exchange under chapter 43.71 RCW or P.L. 111-148 of 2010, as amended.

Sec. 10. RCW 48.42.020 and 1983 c 36 s 2 are each amended to read as follows:

(1) A person or entity may show that it is subject to the jurisdiction and regulation of another agency of this state, any subdivision thereof, or the federal government, by providing to the insurance commissioner the appropriate certificate, license, or other document issued by the other governmental agency which permits or qualifies it to provide the coverage as defined in RCW 48.42.010.

(2) "Another agency of this state, any subdivision thereof, or the federal government" does not include the Washington health benefit exchange under chapter 43.71 RCW or P.L. 111-148 of 2010, as amended.

NEW SECTION. **Sec. 11.** A new section is added to chapter 48.43 RCW to read as follows:

Certification by the Washington health benefit exchange of a plan as a qualified health plan, or of a carrier as a qualified issuer, does not exempt the plan or carrier from any of the requirements of this title or rules adopted by the commissioner pursuant to chapter 34.05 RCW.

PART V

ESSENTIAL HEALTH BENEFITS

NEW SECTION. **Sec. 12.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Consistent with federal law, the commissioner, in consultation with the board and the health care authority, shall, by rule, select the largest small group plan in the state by enrollment as the benchmark plan for purposes of establishing the essential health benefits in Washington state under P.L. 111-148 of 2010, as amended.

(2) If the essential health benefits benchmark plan does not include all of the ten benefit categories specified by section 1302 of P.L. 111-148, as amended, the commissioner, in consultation with the board and the health care authority, shall, by rule, supplement the benchmark plan benefits as needed to meet the requirements of section 1302.

(3) A health plan required to offer the essential health benefits, other than a health plan offered through the federal basic health

program or medicaid, under P.L. 111-148 of 2010, as amended, may not be offered in the state unless the commissioner finds that it is substantially equal to the benchmark plan. When making this determination, the commissioner must ensure that the plan:

(a) Covers the ten essential health benefits categories specified in section 1302 of P.L. 111-148 of 2010, as amended;

(b) Does not have a plan benefits design that would create a risk of biased selection based on health status; and

(c) Contains meaningful scope and level of benefits in each of the ten essential health benefits categories specified by section 1302 of P.L. 111-148 of 2010, as amended.

(4) Beginning December 15, 2012, and every year thereafter, the commissioner shall submit to the legislature a list of state-mandated health benefits, the enforcement of which will result in federally imposed costs to the state related to the plans sold through the exchange because the benefits are not included in the essential health benefits designated under federal law. The list must include the anticipated costs to the state of each state-mandated health benefit on the list. The commissioner may enforce a mandate on the list for the entire market only if funds are appropriated in an omnibus appropriations act specifically to pay for the identified costs. During any period of time such funds are not appropriated, the mandate must be suspended for the entire market and may not be enforced by the commissioner.

NEW SECTION. **Sec. 13.** Nothing in this act prohibits the offering of benefits for spiritual care services deductible under section 213(d) of the internal revenue code in health plans inside and outside of the exchange.

PART VI

THE BASIC HEALTH OPTION

NEW SECTION. **Sec. 14.** A new section is added to chapter 70.47 RCW to read as follows:

(1) The director of the health care authority shall provide the necessary certifications to the secretary of the federal department of health and human services under section 1331 of P.L. 111-148 of 2010, as amended, for the purposes of Washington state's adoption of the federal basic health program option, unless, by September 1, 2012, the governor finds that:

(a) Anticipated federal funding under section 1331 will be insufficient, absent any additional funding from the state, to provide at least the essential health benefits to eligible individuals under section 1331 during the period of calendar years 2014 through 2019:

(i) At enrollee premium levels below the levels that would be applicable to persons with income between one hundred thirty-four and two hundred percent of the federal poverty level through the Washington health benefits exchange;

(ii) Using health plan payment rates that exceed 2012 medicaid payment rates for the same services and are sufficient to ensure access to care for enrollees and incentivize an adequate provider network, in conjunction with innovative payment methodologies and standard health plan performance measures that will create incentives for the use of effective cost containment and health care quality strategies; and

(iii) Assuming reasonable basic health program administrative costs and the potential impact of federal basic health plan program funding reconciliation under section 1331(d) of the affordable care act; and

(b) Sufficient funds are not available to support the design and development work necessary for the program to begin providing health coverage to enrollees beginning January 1, 2014.

(2) Prior to making this finding, the director shall:

(a) Actively consult with the board of the Washington health benefit exchange, the office of the insurance commissioner, consumer advocates, provider organizations, carriers, and other interested organizations;

(b) Consider any available objective analysis specific to Washington state, by an independent nationally recognized consultant that has been actively engaged in analysis and economic modeling of the federal basic health program option for multiple states.

(3) The director shall report any findings and supporting analysis made under this section to the relevant policy and fiscal committees of the legislature.

(4) If implemented, the federal basic health program must be guided by the following principles:

(a) Meeting the minimum state certification standards in section 1331 of the federal patient protection and affordable care act;

(b) To the extent allowed by the federal department of health and human services, twelve-month continuous eligibility for the basic health program, and corresponding twelve-month continuous enrollment in standard health plans by enrollees; or, in lieu of twelve-month continuous eligibility, financing mechanisms that enable enrollees to remain with a plan for the entire plan year;

(c) Achieving an appropriate balance between:

(i) Premiums and cost-sharing minimized to increase the affordability of insurance coverage;

(ii) Standard health plan contracting requirements that minimize plan and provider administrative costs, while holding standard health plans accountable for performance and enrollee health outcomes, and ensuring adequate enrollee notice and appeal rights; and

(iii) Health plan payment rates that exceed the 2012 medicaid payment rates for the same services and are sufficient to ensure access to care for enrollees and incentivize an adequate provider network, in conjunction with innovative payment methodologies and standard health plan performance measures that will create incentives for the use of effective cost containment and health care quality; and

(d) Transparency in program administration, including active and ongoing consultation with basic health program enrollees and interested organizations.

PART VII

RISK ADJUSTMENT AND REINSURANCE

NEW SECTION. **Sec. 15.** A new section is added to chapter 48.43 RCW to read as follows:

(1) The commissioner, in consultation with the board, shall adopt rules establishing the reinsurance and risk adjustment programs required by P.L. 111-148 of 2010, as amended.

(2) Consistent with federal law, the rules for the reinsurance program must, at a minimum, establish:

(a) A mechanism to collect reinsurance contribution funds;

(b) A reinsurance payment formula; and

(c) A mechanism to disburse reinsurance payments.

(3)(a) The rules for the reinsurance program may compensate carriers offering health plans in the exchange for the possibility of increased risk in the exchange and incentivize carrier participation in the exchange by making any or all of the following modifications to the reinsurance payment formula established by federal law:

(i) Establishing a lower attachment point inside the exchange than outside the exchange;

(ii) Establishing a higher reinsurance cap inside the exchange than outside the exchange or eliminating the reinsurance cap inside the exchange; or

(iii) Establishing a higher coinsurance rate inside the exchange than outside the exchange.

(b) The commissioner may adjust the rules adopted under this subsection (3) as needed to preserve a healthy market both inside and outside of the exchange.

(c) The rules for the reinsurance program may also include requirements to encourage appropriate cost management measures by carriers, such as care management or care coordination, for persons with chronic illness or other health conditions that present a risk of incurring high claims cost.

(4) The commissioner shall contract with one or more nonprofit entities to administer the risk adjustment and reinsurance programs.

(5) The commissioner must identify by rule the data needed to support operation of the reinsurance program established under this section, the sources of the data, and other requirements related to their collection, validation, interpretation, and retention.

PART VIII

THE WASHINGTON STATE HEALTH INSURANCE POOL

NEW SECTION. **Sec. 16.** A new section is added to chapter 48.41 RCW to read as follows:

(1) The board shall evaluate the populations that may need ongoing access to the pool coverage with specific attention to those persons who may be excluded from coverage in 2014, such as persons with end- stage renal disease or HIV/AIDS, or persons not eligible for coverage in the exchange.

(2) The board shall evaluate the eligibility requirements for the purchase of health care coverage through the pool and submit recommendations regarding any modifications to pool eligibility requirements that might allow new enrollees on or after January 1, 2014. The recommendations must address any needed modifications to the standard health questionnaire or other eligibility screening tool that could be used in a manner consistent with federal law to determine eligibility for enrollment in the pool.

(3) The board shall complete an analysis of the pool assessments in relation to the assessments for the reinsurance program and recommend changes for the assessment or any credits that may be considered for the reinsurance program.

(4) The board shall report its recommendations to the governor and the legislature by December 1, 2012.

NEW SECTION. **Sec. 17.** A new section is added to chapter 48.41 RCW to read as follows:

For policies renewed beginning January 1, 2014:

(1) Rates for pool coverage may be no more than 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, rates for pool coverage may be no more than the standard risk rate established using reasonable actuarial techniques and must reflect anticipated experience and expenses for such coverage in the individual market.

(2) The pool shall reduce the premium obligation of an enrollee in the pool on or after January 1, 2014, as needed to provide the enrollee with premium subsidies equivalent to what he or she would have received in the exchange if the enrollee:

(a) Has a modified adjusted gross income below four hundred percent of federal poverty level;

(b) Is not enrolled in medicare; and

(c) Does not have an offer of minimum essential coverage.

(3) Premium subsidies provided under this subsection shall be funded through member assessments.

PART IX

EXCHANGE EMPLOYEES

NEW SECTION. **Sec. 18.** A new section is added to chapter 41.04 RCW to read as follows:

Except for chapters 41.05 and 41.40 RCW, this title does not apply to any position in or employee of the Washington health benefit exchange established in chapter 43.71 RCW.

NEW SECTION. **Sec. 19.** A new section is added to chapter 43.01 RCW to read as follows:

This chapter does not apply to any position in or employee of the Washington health benefit exchange established in chapter 43.71 RCW.

NEW SECTION. **Sec. 20.** A new section is added to chapter 43.03 RCW to read as follows:

This chapter does not apply to any position in or employee of the Washington health benefit exchange established in chapter 43.71 RCW.

Sec. 21. RCW 41.05.011 and 2011 1st sp.s. c 15 s 54 are each reenacted and amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Authority" means the Washington state health care authority.

(2) "Board" means the public employees' benefits board established under RCW 41.05.055.

(3) "Dependent care assistance program" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under this chapter pursuant to 26 U.S.C. Sec. 129 or other sections of the internal revenue code.

(4) "Director" means the director of the authority.

(5) "Emergency service personnel killed in the line of duty" means law enforcement officers and firefighters as defined in RCW 41.26.030, members of the Washington state patrol retirement fund as defined in RCW 43.43.120, and reserve officers and firefighters as defined in RCW 41.24.010 who die as a result of injuries sustained in the course of employment as determined consistent with Title 51 RCW by the department of labor and industries.

(6) "Employee" includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021(1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; ((~~and~~)) (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW

41.05.021(1) (f) and (g); and (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021(1) (g) and (n). "Employee" does not include: Adult family homeowners; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under this chapter or by the authority under this chapter.

(7) "Employer" means the state of Washington.

(8) "Employing agency" means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; and a tribal government covered by this chapter.

(9) "Faculty" means an academic employee of an institution of higher education whose workload is not defined by work hours but whose appointment, workload, and duties directly serve the institution's academic mission, as determined under the authority of its enabling statutes, its governing body, and any applicable collective bargaining agreement.

(10) "Flexible benefit plan" means a benefit plan that allows employees to choose the level of health care coverage provided and the amount of employee contributions from among a range of choices offered by the authority.

(11) "Insuring entity" means an insurer as defined in chapter 48.01 RCW, a health care service contractor as defined in chapter 48.44 RCW, or a health maintenance organization as defined in chapter 48.46 RCW.

(12) "Medical flexible spending arrangement" means a benefit plan whereby state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan under this chapter pursuant to 26 U.S.C. Sec. 125 or other sections of the internal revenue code.

(13) "Participant" means an individual who fulfills the eligibility and enrollment requirements under the salary reduction plan.

(14) "Plan year" means the time period established by the authority.

(15) "Premium payment plan" means a benefit plan whereby state and public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under this chapter pursuant to 26 U.S.C. Sec. 125 or other sections of the internal revenue code.

(16) "Retired or disabled school employee" means:

(a) Persons who separated from employment with a school district or educational service district and are receiving a retirement allowance under chapter 41.32 or 41.40 RCW as of September 30, 1993;

(b) Persons who separate from employment with a school district or educational service district on or after October 1, 1993, and immediately upon separation receive a retirement allowance under chapter 41.32, 41.35, or 41.40 RCW;

(c) Persons who separate from employment with a school district or educational service district due to a total and permanent disability, and are eligible to receive a deferred retirement allowance under chapter 41.32, 41.35, or 41.40 RCW.

(17) "Salary" means a state employee's monthly salary or wages.

(18) "Salary reduction plan" means a benefit plan whereby state and public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the internal revenue code.

(19) "Seasonal employee" means an employee hired to work during a recurring, annual season with a duration of three months or more, and anticipated to return each season to perform similar work.

(20) "Separated employees" means persons who separate from employment with an employer as defined in:

(a) RCW 41.32.010(17) on or after July 1, 1996; or

(b) RCW 41.35.010 on or after September 1, 2000; or

(c) RCW 41.40.010 on or after March 1, 2002;

and who are at least age fifty-five and have at least ten years of service under the teachers' retirement system plan 3 as defined in RCW 41.32.010(33), the Washington school employees' retirement system plan 3 as defined in RCW 41.35.010, or the public employees' retirement system plan 3 as defined in RCW 41.40.010.

(21) "State purchased health care" or "health care" means medical and health care, pharmaceuticals, and medical equipment purchased with state and federal funds by the department of social and health services, the department of health, the basic health plan, the state health care authority, the department of labor and industries, the department of corrections, the department of veterans affairs, and local school districts.

(22) "Tribal government" means an Indian tribal government as defined in section 3(32) of the employee retirement income security act of 1974, as amended, or an agency or instrumentality of the tribal government, that has government offices principally located in this state.

Sec. 22. RCW 41.05.021 and 2011 1st sp.s. c 15 s 56 are each amended to read as follows:

(1) The Washington state health care authority is created within the executive branch. The authority shall have a director appointed by the governor, with the consent of the senate. The director shall serve at the pleasure of the governor. The director may employ a deputy director, and such assistant directors and special assistants as may be needed to administer the authority, who shall be exempt from chapter 41.06 RCW, and any additional staff members as are necessary to administer this chapter. The director may delegate any power or duty vested in him or her by law, including authority to make final decisions and enter final orders in hearings conducted under chapter 34.05 RCW. The primary duties of the authority shall be to: Administer state employees' insurance benefits and retired or disabled school employees' insurance benefits; administer the basic health plan pursuant to chapter 70.47 RCW; administer the children's health program pursuant to chapter 74.09 RCW; study state-purchased health care programs in order to maximize cost containment in these programs while ensuring access to quality health care; implement state initiatives, joint purchasing strategies, and techniques for efficient administration that have potential application to all state-purchased health services; and administer grants that further the mission and goals of the authority. The authority's duties include, but are not limited to, the following:

(a) To administer health care benefit programs for employees and retired or disabled school employees as specifically authorized in RCW 41.05.065 and in accordance with the methods described in RCW 41.05.075, 41.05.140, and other provisions of this chapter;

(b) To analyze state-purchased health care programs and to explore options for cost containment and delivery alternatives for those programs that are consistent with the purposes of those programs, including, but not limited to:

(i) Creation of economic incentives for the persons for whom the state purchases health care to appropriately utilize and purchase health care services, including the development of flexible benefit plans to offset increases in individual financial responsibility;

(ii) Utilization of provider arrangements that encourage cost containment, including but not limited to prepaid delivery systems, utilization review, and prospective payment methods, and that ensure access to quality care, including assuring reasonable access to local providers, especially for employees residing in rural areas;

(iii) Coordination of state agency efforts to purchase drugs effectively as provided in RCW 70.14.050;

(iv) Development of recommendations and methods for purchasing medical equipment and supporting services on a volume discount basis;

(v) Development of data systems to obtain utilization data from state-purchased health care programs in order to identify cost centers, utilization patterns, provider and hospital practice patterns, and procedure costs, utilizing the information obtained pursuant to RCW 41.05.031; and

(vi) 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;

(c) To analyze areas of public and private health care interaction;

(d) To provide information and technical and administrative assistance to the board;

(e) To review and approve or deny applications from counties, municipalities, and other political subdivisions of the state to provide state-sponsored insurance or self-insurance programs to their employees in accordance with the provisions of RCW 41.04.205 and (g) of this subsection, setting the premium contribution for approved groups as outlined in RCW 41.05.050;

(f) To review and approve or deny the application when the governing body of a tribal government applies to transfer their employees to an insurance or self-insurance program administered under this chapter. In the event of an employee transfer pursuant to this subsection (1)(f), members of the governing body are eligible to be included in such a transfer if the members are authorized by the tribal government to participate in the insurance program being transferred from and subject to payment by the members of all costs of insurance for the members. The authority shall: (i) Establish the conditions for participation; (ii) have the sole right to reject the application; and (iii) set the premium contribution for approved groups as outlined in RCW 41.05.050. Approval of the application by the authority transfers the employees and dependents involved to the insurance, self-insurance, or health care program approved by the authority;

(g) To ensure the continued status of the employee insurance or self-insurance programs administered under this chapter as a governmental plan under section 3(32) of the employee retirement income security act of 1974, as amended, the authority shall limit the participation of employees of a county, municipal, school district, educational service district, or other political subdivision, the Washington health benefit exchange, or a tribal government, including providing for the participation of those employees whose services are substantially all in the performance of essential governmental functions, but not in the performance of commercial activities;

(h) To establish billing procedures and collect funds from school districts in a way that minimizes the administrative burden on districts;

(i) To publish and distribute to nonparticipating school districts and educational service districts by October 1st of each year a description of health care benefit plans available through the authority and the estimated cost if school districts and educational service district employees were enrolled;

(j) To apply for, receive, and accept grants, gifts, and other payments, including property and service, from any governmental or other public or private entity or person, and make arrangements as to the use of these receipts to implement initiatives and strategies developed under this section;

(k) To issue, distribute, and administer grants that further the mission and goals of the authority;

(l) To adopt rules consistent with this chapter as described in RCW 41.05.160 including, but not limited to:

(i) Setting forth the criteria established by the board under RCW 41.05.065 for determining whether an employee is eligible for benefits;

(ii) Establishing an appeal process in accordance with chapter 34.05 RCW by which an employee may appeal an eligibility determination;

(iii) Establishing a process to assure that the eligibility determinations of an employing agency comply with the criteria under this chapter, including the imposition of penalties as may be authorized by the board;

(m)(i) To administer the medical services programs established under chapter 74.09 RCW as the designated single state agency for purposes of Title XIX of the federal social security act;

(ii) To administer the state children's health insurance program under chapter 74.09 RCW for purposes of Title XXI of the federal social security act;

(iii) To enter into agreements with the department of social and health services for administration of medical care services programs under Titles XIX and XXI of the social security act. The agreements shall establish the division of responsibilities between the authority and the department with respect to mental health, chemical dependency, and long-term care services, including services for persons with developmental disabilities. The agreements shall be revised as necessary, to comply with the final implementation plan adopted under section 116, chapter 15, Laws of 2011 1st sp. sess.;

(iv) To adopt rules to carry out the purposes of chapter 74.09 RCW;

(v) To appoint such advisory committees or councils as may be required by any federal statute or regulation as a condition to the receipt of federal funds by the authority. The director may appoint statewide committees or councils in the following subject areas: (A) Health facilities; (B) children and youth services; (C) blind services; (D) medical and health care; (E) drug abuse and alcoholism; (F) rehabilitative services; and (G) such other subject matters as are or come within the authority's responsibilities. The statewide councils shall have representation from both major political parties and shall have substantial consumer representation. Such committees or councils shall be constituted as required by federal law or as the director in his or her discretion may determine. The members of the committees or councils shall hold office for three years except in the case of a vacancy, in which event appointment shall be only for the

remainder of the unexpired term for which the vacancy occurs. No member shall serve more than two consecutive terms. Members of such state advisory committees or councils may be paid their travel expenses in accordance with RCW 43.03.050 and 43.03.060 as now existing or hereafter amended;

(n) To review and approve or deny the application from the governing board of the Washington health benefit exchange to provide state-sponsored insurance or self-insurance programs to employees of the exchange. The authority shall (i) establish the conditions for participation; (ii) have the sole right to reject an application; and (iii) set the premium contribution for approved groups as outlined in RCW 41.05.050.

(2) On and after January 1, 1996, the public employees' benefits board may implement strategies to promote managed competition among employee health benefit plans. Strategies may include but are not limited to:

(a) Standardizing the benefit package;

(b) Soliciting competitive bids for the benefit package;

(c) Limiting the state's contribution to a percent of the lowest priced qualified plan within a geographical area;

(d) Monitoring the impact of the approach under this subsection with regards to: Efficiencies in health service delivery, cost shifts to subscribers, access to and choice of managed care plans statewide, and quality of health services. The health care authority shall also advise on the value of administering a benchmark employer-managed plan to promote competition among managed care plans.

PART X

MISCELLANEOUS

NEW SECTION. **Sec. 23.** The health care authority shall pursue an application for the state to participate in the individual market wellness program demonstration as described in section 2705 of P.L. 111-148 of 2010, as amended. The health care authority shall pursue activities that will prepare the state to apply for the demonstration project once announced by the United States department of health and human services.

NEW SECTION. **Sec. 24.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 25.** Section 3 of 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."

Representative Schmick moved the adoption of amendment (1080) to the striking amendment (1068).

On page 1 of the striking amendment, strike all material after line 2 and insert the following:

"**PART I**

DEFINITIONS

Sec. 1. RCW 48.43.005 and 2011 c 315 s 2 and 2011 c 314 s 3 are each reenacted and 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) "Adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(3) "Applicant" means a person who applies for enrollment in an individual health plan as the subscriber or an enrollee, or the dependent or spouse of a subscriber or enrollee.

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

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

(6) "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.

(7)(a) For grandfathered health benefit plans issued before January 1, 2014, and renewed thereafter, "catastrophic health plan" means:

(((~~(a)~~))) (i) 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 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, both amounts to be adjusted annually by the insurance commissioner; and

(((~~(b)~~))) (ii) 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 six thousand dollars, both amounts to be adjusted annually by the insurance commissioner((~~; 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~~)).

(b) In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding twelve months, as determined by the United States department of labor. The adjusted amount shall apply on the following January 1st.

(c) For health benefit plans issued on or after January 1, 2014, "catastrophic health plan" means:

(i) A health benefit plan that meets the definition of catastrophic plan set forth in section 1302(e) of P.L. 111-148 of 2010, as amended; or

(ii) A health benefit plan offered outside the exchange marketplace that requires a calendar year deductible or out-of-pocket expenses under the plan, other than for premiums, for covered benefits, that meets or exceeds the commissioner's annual adjustment under (b) of this subsection.

(8) "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.

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

(10) "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.

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

(12) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

(13) "Emergency services" means a medical screening examination, as required under section 1867 of the social security act (42 U.S.C. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. 1395dd(e)(3)).

(14) "Employee" has the same meaning given to the term, as of January 1, 2008, under section 3(6) of the federal employee retirement income security act of 1974.

(15) "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.

(16) "Final external review decision" means a determination by an independent review organization at the conclusion of an external review.

(17) "Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a health plan or carrier at the completion of the internal appeals process, or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the exhaustion rules described in RCW 48.43.530 and 48.43.535.

(18) "Grandfathered health plan" means a group health plan or an individual health plan that under section 1251 of the patient protection and affordable care act, P.L. 111-148 (2010) and as amended by the health care and education reconciliation act, P.L. 111-152 (2010) is not subject to subtitles A or C of the act as amended.

(19) "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.

(20) "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.

(21) "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.

(22) "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.

(23) "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, and includes "issuers" as that term is used in the patient protection and affordable care act (P.L. 111-148).

(24) "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 or 48.83 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 or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit;

(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.

(25) "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.

(26) "Open enrollment" means a period of time as defined in rule to be held at the same time each year, during which applicants may enroll in a carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

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

(28) "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.

(29) "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.

(30) "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 employed an average of at least one but no more than fifty employees, during the previous calendar year and employed at least one employee on the first day of the plan year, 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 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 who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived 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 a self-employed individual or sole proprietor in an agricultural trade or business, must have derived 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.

(31) "Special enrollment" means a defined period of time of not less than thirty-one days, triggered by a specific qualifying event experienced by the applicant, during which applicants may enroll in the carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(32) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

(33) "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.

(34) "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.

PART II

THE WASHINGTON HEALTH BENEFIT EXCHANGE

Sec. 2. RCW 43.71.020 and 2011 c 317 s 3 are each amended to read as follows:

(1) The Washington health benefit exchange is established and constitutes a public-private partnership separate and distinct from the state, exercising functions delineated in chapter 317, Laws of 2011. By January 1, 2014, the exchange shall operate consistent with the affordable care act subject to statutory authorization. The exchange shall have a governing board consisting of persons with expertise in the Washington health care system and private and public health care coverage. The initial membership of the board shall be appointed as follows:

(a) By October 1, 2011, each of the two largest caucuses in both the house of representatives and the senate shall submit to the governor a list of five nominees who are not legislators or employees of the state or its political subdivisions, with no caucus submitting the same nominee.

(i) The nominations from the largest caucus in the house of representatives must include at least one employee benefit specialist;

(ii) The nominations from the second largest caucus in the house of representatives must include at least one health economist or actuary;

(iii) The nominations from the largest caucus in the senate must include at least one representative of health consumer advocates;

(iv) The nominations from the second largest caucus in the senate must include at least one representative of small business;

(v) The remaining nominees must have demonstrated and acknowledged expertise in at least one of the following areas: Individual health care coverage, small employer health care coverage, health benefits plan administration, health care finance and economics, actuarial science, or administering a public or private health care delivery system.

(b) By December 15, 2011, the governor shall appoint two members from each list submitted by the caucuses under (a) of this subsection. The appointments made under this subsection (1)(b) must include at least one employee benefits specialist, one health economist or actuary, one representative of small business, and one representative of health consumer advocates. The remaining four members must have a demonstrated and acknowledged expertise in at least one of the following areas: Individual health care coverage, small employer health care coverage, health benefits plan administration, health care finance and economics, actuarial science, or administering a public or private health care delivery system.

(c) By December 15, 2011, the governor shall appoint a ninth member to serve as chair. The chair may not be an employee of the state or its political subdivisions. The chair shall serve as a nonvoting member except in the case of a tie. <u>The chair shall serve at the pleasure of the governor.</u>

(d) The following members shall serve as nonvoting, ex officio members of the board:

(i) The insurance commissioner or his or her designee; and

(ii) The administrator of the health care authority, or his or her designee.

(2) Initial members of the board shall serve staggered terms not to exceed four years. Members appointed thereafter shall serve two-year terms.

(3) A member of the board whose term has expired or who otherwise leaves the board shall be replaced by gubernatorial

appointment. When the person leaving was nominated by one of the caucuses of the house of representatives or the senate, his or her replacement shall be appointed from a list of five nominees submitted by that caucus within thirty days after the person leaves. If the member to be replaced is the chair, the governor shall appoint a new chair within thirty days after the vacancy occurs. A person appointed to replace a member who leaves the board prior to the expiration of his or her term shall serve only the duration of the unexpired term. Members of the board may be reappointed to multiple terms.

(4) No board member may be appointed if his or her participation in the decisions of the board could benefit his or her own financial interests or the financial interests of an entity he or she represents. No board member may be a lobbyist registered under RCW 42.17A.600. A board member who develops such a conflict of interest or who is a registered lobbyist shall resign or be removed from the board.

(5) Members of the board must be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060. The board shall prescribe rules for the conduct of its business. Meetings of the board are at the call of the chair.

(6) The exchange and the board are subject only to the provisions of chapter 42.30 RCW, the open public meetings act, and chapter 42.56 RCW, the public records act, and not to any other law or regulation generally applicable to state agencies. Consistent with the open public meetings act, the board may hold executive sessions to consider proprietary or confidential nonpublished information.

(7)(a) The board shall establish an advisory committee to allow for the views of the health care industry and other stakeholders to be heard in the operation of the health benefit exchange.

(b) The board may establish technical advisory committees or seek the advice of technical experts when necessary to execute the powers and duties included in chapter 317, Laws of 2011.

(8) Members of the board are not civilly or criminally liable and may 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 chapter 317, Laws of 2011. Nothing in this section prohibits legal actions against the board to enforce the board's statutory or contractual duties or obligations.

(9) In recognition of the government-to-government relationship between the state of Washington and the federally recognized tribes in the state of Washington, the board shall consult with the American Indian health commission.

Sec. 3. RCW 43.71.030 and 2011 c 317 s 4 are each amended to read as follows:

(1) The exchange may, consistent with the purposes of this chapter: (a) Sue and be sued in its own name; (b) make and execute agreements, contracts, and other instruments, with any public or private person or entity; (c) employ, contract with, or engage personnel; (d) pay administrative costs; and (e) accept grants, donations, loans of funds, and contributions in money, services, materials or otherwise, from the United States or any of its agencies, from the state of Washington and its agencies or from any other source, and use or expend those moneys, services, materials, or other contributions.

(2) The powers and duties of the exchange and the board are limited to those necessary to apply for and administer grants, establish information technology infrastructure, and undertake additional ((~~administrative~~)) functions necessary to begin operation of the exchange by January 1, 2014, in a manner consistent with, and not exceeding, the minimum requirements for American health benefit exchanges specified in section 1311(d) of P.L. 111-148 of 2010, as amended. Any actions relating to substantive issues ((~~included in RCW 43.71.040~~)) must be consistent with statutory direction on those issues.

NEW SECTION. **Sec. 4.** A new section is added to chapter 43.71 RCW to read as follows:

(1) A person or entity functioning as a navigator under section 1311(i) of P.L. 111-148 of 2010, as amended, may not sell, solicit, or negotiate insurance in this state for any line or lines of insurance unless the person or entity is licensed for that line of authority under RCW 48.17.060.

(2) The exchange shall permit producers licensed under RCW 48.17.060 to enroll qualified individuals, qualified employers, or qualified employees in qualified health plans in the exchange.

(3) Producers licensed under RCW 48.17.060 shall be compensated by qualified health plan issuers in the same manner and amount as the qualified health plan issuer compensates producers for comparable health plan outside of the exchange. The exchange shall have no role in developing or determining the manner or amount of compensation producers receive from qualified health plans for individuals or employers enrolled in health plans through the exchange.

PART III

QUALIFIED HEALTH PLANS

NEW SECTION. **Sec. 5.** A new section is added to chapter 43.71 RCW to read as follows:

(1) The board shall certify a plan as a qualified health plan to be offered through the exchange if the plan:

(a) Is determined by the insurance commissioner to meet the requirements of Title 48 RCW and rules adopted by the commissioner pursuant to chapter 34.05 RCW; and

(b) Meets the requirements for qualified health plans under section 1311(c) of P.L. 111-148 of 2010, as amended.

(2) The board may not impose requirements on qualified health plans other than the requirements in subsection (1) of this section.

(3) A decision by the board denying a request to certify or recertify a plan as a qualified health plan may be appealed pursuant to chapter 34.05 RCW.

Sec. 6. RCW 48.42.010 and 1985 c 264 s 15 are each amended to read as follows:

(1) Notwithstanding any other provision of law, and except as provided in this chapter, any person or other entity which provides coverage in this state for life insurance, annuities, loss of time, medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether the coverage is by direct payment, reimbursement, the providing of services, or otherwise, shall be subject to the authority of the state insurance commissioner, unless the person or other entity shows that while providing the services it is subject to the jurisdiction and regulation of another agency of this state, any subdivisions thereof, or the federal government.

(2) "Another agency of this state, any subdivision thereof, or the federal government" does not include the Washington health benefit exchange under chapter 43.71 RCW or P.L. 111-148 of 2010, as amended.

Sec. 7. RCW 48.42.020 and 1983 c 36 s 2 are each amended to read as follows:

(1) A person or entity may show that it is subject to the jurisdiction and regulation of another agency of this state, any subdivision thereof, or the federal government, by providing to the insurance commissioner the appropriate certificate, license, or other document issued by the other governmental agency which permits or qualifies it to provide the coverage as defined in RCW 48.42.010.

(2) "Another agency of this state, any subdivision thereof, or the federal government" does not include the Washington health benefit

exchange under chapter 43.71 RCW or P.L. 111-148 of 2010, as amended.

NEW SECTION. **Sec. 8.** A new section is added to chapter 48.43 RCW to read as follows:

Certification by the Washington health benefit exchange of a plan as a qualified health plan, or of a carrier as a qualified issuer, does not exempt the plan or carrier from any of the requirements of this title or rules adopted by the commissioner pursuant to chapter 34.05 RCW.

PART IV

ESSENTIAL HEALTH BENEFITS

NEW SECTION. **Sec. 9.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Consistent with federal law, the commissioner shall, by rule, select the largest small group plan in the state by enrollment, as determined by an independent actuarial analysis, as the benchmark plan for purposes of establishing the essential health benefits in Washington state under P.L. 111-148 of 2010, as amended.

(2) If the essential health benefits benchmark plan does not include all of the ten benefit categories specified by section 1302 of P.L. 111-148 of 2010, as amended, the commissioner shall, by rule, supplement the benchmark plan benefits as needed, but no more than the extent necessary to comply with the minimum standards in federal law.

(3) Any health plan required to offer the essential health benefits under P.L. 111-148 of 2010, as amended, may be offered in the state unless the commissioner finds that:

(a) It is not substantially equal to the benchmark plan; or

(b) It does not cover the ten essential health benefits categories specified in section 1302 of P.L. 111-148 of 2010, as amended.

(4) A finding by the commissioner under subsection (3) of this section may be appealed pursuant to chapter 34.05 RCW. In any such proceeding, the insurance commissioner shall have the burden to prove, by clear and convincing evidence, that the plan is not substantially equal to the benchmark plan or does not cover the ten essential health benefits categories.

PART V

THE WASHINGTON STATE HEALTH INSURANCE POOL

Sec. 10. RCW 48.41.060 and 2011 c 314 s 13 are each amended to read as follows:

(1) The board shall have the general powers and authority granted under the laws of this state to insurance companies, health care service contractors, and health maintenance organizations, licensed or registered to offer or provide the kinds of health coverage defined under this title. In addition thereto, the board shall:

(a) ((~~Designate or establish the standard health questionnaire to be used under RCW 48.41.100 and 48.43.018, including the form and content of the standard health questionnaire and the method of its application. The questionnaire must provide for an objective evaluation of an individual's health status by assigning a discreet measure, such as a system of point scoring to each individual. The questionnaire must not contain any questions related to pregnancy, and pregnancy shall not be a basis for coverage by the pool. The questionnaire shall be designed such that it is reasonably expected to identify the eight percent of persons who are the most costly to treat who are under individual coverage in health benefit plans, as defined in RCW 48.43.005, in Washington state or are covered by the pool, if applied to all such persons;~~

~~(b) Obtain from a member of the American academy of actuaries, who is independent of the board, a certification that the standard health questionnaire meets the requirements of (a) of this subsection;~~

~~(c) Approve the standard health questionnaire and any modifications needed to comply with this chapter. The standard health questionnaire shall be submitted to an actuary for certification, modified as necessary, and approved at least every thirty-six months unless at the time when certification is required the pool will be discontinued before the end of the succeeding thirty-six month period. The designation and approval of the standard health questionnaire by the board shall not be subject to review and approval by the commissioner. The standard health questionnaire or any modification thereto shall not be used until ninety days after public notice of the approval of the questionnaire or any modification thereto, except that the initial standard health questionnaire approved for use by the board after March 23, 2000, may be used immediately following public notice of such approval;~~

~~(d)~~)) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, claim reserve formulas and any other actuarial functions appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience, and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial underwriting practices consistent with Washington state individual plan rating requirements under RCW 48.44.022 and 48.46.064;

((~~(e)~~)) (b)(i) Assess members of the pool in accordance with the provisions of this chapter, and make advance interim assessments as may be reasonable and necessary for the organizational or interim operating expenses. Any interim assessments will be credited as offsets against any regular assessments due following the close of the year.

(ii) Self-funded multiple employer welfare arrangements are subject to assessment under this subsection only in the event that assessments 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 assessments on these arrangements before imposing the assessment. Once the legality of the assessments has been determined, the multiple employer welfare arrangement certified by the insurance commissioner must begin payment of these assessments.

(iii) If there has not been a final determination of the legality of these assessments, then beginning on the earlier of (A) the date the fourth multiple employer welfare arrangement has been certified by the insurance commissioner, or (B) April 1, 2006, the arrangement shall deposit the assessments imposed by this subsection into an interest bearing escrow account maintained by the arrangement. Upon a final determination that the assessments are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq., all funds in the interest bearing escrow account shall be transferred to the board;

((~~(f)~~)) (c) Issue policies of health coverage in accordance with the requirements of this chapter; and

(((~~g) Establish procedures for the administration of the premium discount provided under RCW 48.41.200(3)(a)(iii);~~

~~(h) Contract with the Washington state health care authority for the administration of the premium discounts provided under RCW 48.41.200(3)(a) (i) and (ii);~~

~~(i) Set a reasonable fee to be paid to an insurance producer licensed in Washington state for submitting an acceptable application for enrollment in the pool; and~~

~~(j)~~)) (d) Provide certification to the commissioner when

assessments will exceed the threshold level established in RCW 48.41.037.

(2) In addition thereto, the board may:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter including the authority, with the approval of the commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(c) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the pool, policy, and other contract design, and any other function within the authority of the pool; and

(d) Conduct periodic audits to assure the general accuracy of the financial data submitted to the pool, and the board shall cause the pool to have an annual audit of its operations by an independent certified public accountant.

(3) Nothing in this section shall be construed to require or authorize the adoption of rules under chapter 34.05 RCW.

Sec. 11. RCW 48.41.110 and 2011 c 315 s 6 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. The pool may incorporate managed care features into existing plans.

(2) The administrator shall prepare a brochure outlining the benefits and exclusions of pool 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 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. Eligible expenses are the reasonable amounts for the health care services and items for which benefits are extended under a pool policy.

(4) The pool shall offer at least two policies, one of which will be a comprehensive policy that must comply with RCW 48.41.120 and must at a minimum include 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, including no less than a total of one hundred eighty inpatient days in a calendar year, and no less than thirty days inpatient care for 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) No less than twenty outpatient professional visits for the diagnosis or treatment of alcohol, drug, or chemical dependency or abuse rendered during a calendar year by a state-certified chemical dependency program approved under chapter 70.96A RCW, or 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;

(d) Drugs and contraceptive devices requiring a prescription;

(e) Services of a skilled nursing facility, excluding custodial and convalescent care, for not less 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 including at least 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;

(r) Mental health services pursuant to RCW 48.41.220; and

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

(5) 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.

(6) 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. No limitation, exception, or reduction may be used that would exclude coverage for any disease, illness, or injury.

(7)(a) 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 or extend beyond December 31, 2013. 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 (8) of this section.

(b) The pool shall not impose any preexisting condition waiting period for any person under the age of nineteen.

(8)(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)).

(9) 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.

(10) 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. The pool may encourage the use of shared decision making and certified decision aids for preference-sensitive care areas.

Sec. 12. RCW 48.41.170 and 1987 c 431 s 17 are each amended to read as follows:

The commissioner shall adopt rules pursuant to chapter 34.05 RCW that((: ~~(1) Provide for disclosure by the member of the availability of insurance coverage from the pool; and (2)~~)) implement this chapter.

NEW SECTION. **Sec. 13.** A new section is added to chapter 48.41 RCW to read as follows:

For policies renewed beginning January 1, 2014, rates for pool coverage may be no more than 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, rates for pool coverage may be no more than the standard risk rate established using reasonable actuarial techniques and must reflect anticipated experience and expenses for such coverage in the individual market.

NEW SECTION. **Sec. 14.** A new section is added to chapter 48.41 RCW to read as follows:

Only persons enrolled in a health benefit plan through the pool on December 31, 2013, who do not disenroll after December 31, 2013, are eligible for pool coverage.

NEW SECTION. **Sec. 15.** A new section is added to chapter 48.41 RCW to read as follows:

(1) The pool may perform all or part of the risk management functions in the federal patient protection and affordable care act pursuant to a state contract providing funding.

(2) To further timely state implementation of the federal patient protection and affordable care act in the state, the pool is authorized to conduct preoperational and planning activities related to these programs, including defining and implementing an appropriate legal structure or structures to administer and coordinate these programs.

(3) Funding for the transitional reinsurance program as provided by assessments pursuant to section 1341 of the federal patient protection and affordable care act may be increased in this state by inclusion of additional assessment amounts to cover the administrative costs of operation of the reinsurance program including reimbursement of the reasonable costs incurred by the pool for preoperational activities undertaken pursuant to this section.

(4) The pool shall report on these activities to the appropriate committees of the senate and house of representatives by December 15, 2012, and December 15, 2013. The reports shall also include recommendations on additional mechanisms to address high-risk individuals both inside and outside of the exchange.

NEW SECTION. **Sec. 16.** The following acts or parts of acts, as now existing or hereafter amended, are each repealed, effective January 1, 2014:

(1) RCW 48.43.018 (Requirement to complete the standard health questionnaire--Exemptions--Results) and 2010 c 277 s 1 & 2009 c 42 s 1;

(2) RCW 48.41.020 (Intent) and 2000 c 79 s 5 & 1987 c 431 s 2;

(3) RCW 48.41.100 (Eligibility for coverage) and 2011 c 315 s 5, 2011 c 314 s 15, 2009 c 555 s 3, 2007 c 259 s 30, 2001 c 196 s 3, 2000 c 79 s 12, 1995 c 34 s 5, 1989 c 121 s 7, & 1987 c 431 s 10; and

(4) RCW 48.41.200 (Rates--Standard risk and maximum) and 2007 c 259 s 28, 2000 c 79 s 17, 1997 c 231 s 214, & 1987 c 431 s 20.

PART VI

MISCELLANEOUS

NEW SECTION. **Sec. 17.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 18.** Sections 10, 12, and 14 of this act take effect January 1, 2014.

NEW SECTION. **Sec. 19.** Sections 2, 3, and 4 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.

NEW SECTION. **Sec. 20.** Upon a finding by the United States supreme court that any part of P.L. 111-148, as amended, is unconstitutional, or if federal funding is not provided for the premium subsidies in the exchange, the following acts or parts of acts are each repealed:

(1) RCW 43.71.005 (Finding--Intent) and 2011 c 317 s 1;

(2) RCW 43.71.010 (Definitions) and 2011 c 317 s 2;

(3) RCW 43.71.020 (Washington health benefit exchange) and 2012 c ... s 2 (section 2 of this act) & 2011 c 317 s 3;

(4) RCW 43.71.030 (Exchange--Powers and duties) and 2012 c ... s 3 (section 3 of this act) & 2011 c 317 s 4;

(5) RCW 43.71.040 (Authority, joint select committee on health reform, and board--Collaboration--Report--Responsibilities and duties) and 2011 c 317 s 5;

(6) RCW 43.71.050 (Authority--Powers and duties) and 2011 c 317 s 6;

(7) RCW 43.71.060 (Health benefit exchange account) and 2011 c 317 s 7; and

(8) RCW 43.71.900 (Conflict with federal requirements--2011 c 317) and 2011 c 317 s 9."

Representatives Schmick, Hinkle and Bailey spoke in favor of the adoption of the amendment to the striking amendment.

Representative Cody spoke against the adoption of the amendment to the striking amendment.

An electronic roll call was requested.

ROLL CALL

The Clerk called the roll on the adoption of amendment (1080) to the striking amendment (1068) and the amendment was not adopted by the following vote: Yeas, 41; Nays, 54; Absent, 0; Excused, 3.

Voting yea: Representatives Ahern, Alexander, Anderson, Angel, Armstrong, Asay, Bailey, Buys, Chandler, Condotta, Crouse, Dahlquist, Dammeier, DeBolt, Fagan, Haler, Hargrove, Harris, Hinkle, Hope, Johnson, Kirby, Klippert, Kretz, Kristiansen, McCune, Nealey, Orcutt, Overstreet, Parker, Pearson, Rivers, Ross, Schmick, Shea, Short, Smith, Taylor, Walsh, Warnick and Zeiger.

Voting nay: Representatives Appleton, Billig, Blake, Carlyle, Clibborn, Cody, Darneille, Dickerson, Dunshee, Eddy, Finn, Fitzgibbon, Goodman, Green, Haigh, Hansen, Hasegawa, Hudgins, Hunt, Hunter, Hurst, Jinkins, Kagi, Kenney, Ladenburg, Lytton, Maxwell, McCoy, Miloscia, Moeller, Morris, Moscoso, Ormsby, Orwall, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Roberts, Ryu, Santos, Seaquist, Sells, Springer, Stanford, Sullivan, Takko, Tharinger, Upthegrove, Van De Wege, Wilcox, Wylie and Mr. Speaker.

Excused: Representatives Kelley, Liias and Rodne.

Representative Hinkle moved the adoption of amendment (1079) to the striking amendment.

On page 14, beginning on line 15 of the striking amendment, after "include" strike "tribal clinics and urban Indian clinics as"

On page 14, line 17 of the striking amendment, after "network" strike "consistent" and insert "to the extent required by"

Representatives Hinkle, Schmick and Bailey spoke in favor of the adoption of the amendment to the striking amendment.

Representative Cody spoke against the adoption of the amendment to the striking amendment.

Amendment (1079) to the striking amendment was not adopted.

Representative Cody spoke in favor of the adoption of the striking amendment.

Division was demanded and the demand was sustained. The Speaker (Representative Moeller presiding) divided the House. The result was 51 - YEAS; 44 – NAYS.

Amendment (1068) was adopted.

The bill was ordered engrossed.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Cody, Jinkins and Green spoke in favor of the passage of the bill.

Representatives Schmick, Hinkle, Bailey, Shea, Overstreet and Ross spoke against the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Engrossed Second Substitute House Bill No. 2319.

ROLL CALL

The Clerk called the roll on the final passage of Engrossed Second Substitute House Bill No. 2319, and the bill passed the House by the following vote: Yeas, 52; Nays, 43; Absent, 0; Excused, 3.

Voting yea: Representatives Appleton, Billig, Blake, Carlyle, Clibborn, Cody, Darneille, Dickerson, Dunshee, Eddy, Finn, Fitzgibbon, Goodman, Green, Haigh, Hansen, Hasegawa, Hudgins, Hunt, Hunter, Jinkins, Kagi, Kenney, Kirby, Ladenburg, Lytton, Maxwell, McCoy, Miloscia, Moeller, Morris, Moscoso, Ormsby, Orwall, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Roberts, Ryu, Santos, Sells, Springer, Stanford, Sullivan, Takko, Tharinger, Upthegrove, Van De Wege, Wylie and Mr. Speaker.

Voting nay: Representatives Ahern, Alexander, Anderson, Angel, Armstrong, Asay, Bailey, Buys, Chandler, Condotta, Crouse, Dahlquist, Dammeier, DeBolt, Fagan, Haler, Hargrove, Harris, Hinkle, Hope, Hurst, Johnson, Klippert, Kretz, Kristiansen, McCune, Nealey, Orcutt, Overstreet, Parker, Pearson, Rivers, Ross, Schmick, Seaquist, Shea, Short, Smith, Taylor, Walsh, Warnick, Wilcox and Zeiger.

Excused: Representatives Kelley, Liias and Rodne.

ENGROSSED SECOND SUBSTITUTE HOUSE BILL NO. 2319, having received the necessary constitutional majority, was declared passed.

HOUSE BILL NO. 2337, by Representatives Carlyle, Orwall, Sullivan, Maxwell, Lytton, Zeiger, Reykdal, Pettigrew, Liias, Dammeier, Fitzgibbon, Pedersen, Hunt and Hudgins

Regarding open educational resources in K-12 education.

The bill was read the second time.

There being no objection, Second Substitute House Bill No. 2337 was substituted for House Bill No. 2337 and the second substitute bill was placed on the second reading calendar.

SECOND SUBSTITUTE HOUSE BILL NO. 2337 was read the second time.

With the consent of the house, amendment (1088) was withdrawn.

Representative Carlyle moved the adoption of amendment (1008).

On page 1, beginning on line 15, after "up-to-date." strike all material through "courseware." on line 19

On page 2, line 6, after "under" strike "a Creative Commons" and insert "an"

On page 2, line 7, after "attribution" strike "license" and insert "license, registered by a non-profit organization with domain expertise in open courseware,"

On page 2, line 16, after "funding" insert "by actively partnering with private organizations"

On page 2, line 16, after "funding;" strike "and"

On page 2, line 18, after "share" strike "results." and insert "results; and"

On page 2, after line 18, insert the following:

"(v) Must include input from classroom practitioners, including librarians, in the results reported under subsection (2)(d) of this act."

On page 2, beginning on line 34, after "under" strike "a Creative Commons" and insert "an"

Representatives Carlyle and Anderson spoke in favor of the adoption of the amendment.

Amendment (1008) was adopted.

Representative McCune moved the adoption of amendment (1089).

On page 2, after line 15, insert the following:

"(iii) Before adopting or adapting material referenced in subsection (1)(b)(ii), the Office of the Superintendent of Public

Instruction must submit the open source material to the legislature for review and approval;"

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

Representative McCune and McCune (again) spoke in favor of the adoption of the amendment.

Representative Carlyle and Anderson spoke against the adoption of the amendment.

Amendment (1089) was not adopted.

The bill was ordered engrossed.

There being no objection, the rules were suspended, the second reading considered the third and the bill was placed on final passage.

Representatives Carlyle and Anderson spoke in favor of the passage of the bill.

Representatives Ahern and McCune spoke against the passage of the bill.

The Speaker (Representative Moeller presiding) stated the question before the House to be the final passage of Engrossed Second Substitute House Bill No. 2337.

ROLL CALL

The Clerk called the roll on the final passage of Engrossed Second Substitute House Bill No. 2337, and the bill passed the House by the following vote: Yeas, 88; Nays, 7; Absent, 0; Excused, 3.

Voting yea: Representatives Alexander, Anderson, Angel, Appleton, Armstrong, Asay, Bailey, Billig, Blake, Buys, Carlyle, Chandler, Clibborn, Cody, Condotta, Dahlquist, Dammeier, Darneille, DeBolt, Dickerson, Dunshee, Eddy, Fagan, Finn, Fitzgibbon, Goodman, Green, Haigh, Haler, Hansen, Hargrove, Harris, Hasegawa, Hinkle, Hope, Hudgins, Hunt, Hunter, Hurst, Jinkins, Johnson, Kagi, Kenney, Kirby, Klippert, Kretz, Ladenburg, Lytton, Maxwell, McCoy, Miloscia, Moeller, Morris, Moscoso, Nealey, Orcutt, Ormsby, Orwall, Parker, Pearson, Pedersen, Pettigrew, Pollet, Probst, Reykdal, Rivers, Roberts, Ross, Ryu, Santos, Schmick, Seaquist, Sells, Short, Smith, Springer, Stanford, Sullivan, Takko, Tharinger, Upthegrove, Van De Wege, Walsh, Warnick, Wilcox, Wylie, Zeiger and Mr. Speaker.

Voting nay: Representatives Ahern, Crouse, Kristiansen, McCune, Overstreet, Shea and Taylor.

Excused: Representatives Kelley, Liias and Rodne.

ENGROSSED SECOND SUBSTITUTE HOUSE BILL NO. 2337, having received the necessary constitutional majority, was declared passed.

There being no objection, the House advanced to the eighth order of business.

There being no objection House Bill No. 2571 was placed on the Second Reading Calendar.

There being no objection, the Committee on Rules was relieved of House Bill 1860 and the bill was placed on the second reading calendar:

There being no objection, the House advanced to the eleventh order of business.

There being no objection, the House adjourned until 9:00 a.m., February 13, 2012, the 36th Day of the Regular Session.

FRANK CHOPP, Speaker

BARBARA BAKER, Chief Clerk