

Initiative Measure No. 1045

Filed

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SECRETARY OF STATE

AN ACT Relating to the creation of an affordable Washington basic health care program; adding a new chapter to Title 48 RCW; creating a new section; and providing an effective date.

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

NEW SECTION. **Sec. 1.** Existing law does not provide a system of universal health care coverage for Washington residents. Existing law provides for the creation of various programs to provide health care services to persons who have limited incomes and meet various eligibility requirements.

This initiative would establish the Washington state affordable health insurance system to be administered by the newly created Washington health insurance agency under the control of a health insurance commissioner appointed by the governor and subject to confirmation by the senate. This initiative would make all Washington residents eligible for specified health care benefits under the Washington health insurance system, which would, negotiate for or set fees for health care services provided through the system and pay claims for those services. This initiative would require the commissioner to seek all necessary waivers, exemptions, agreements, or legislation to allow various existing federal, state, and local health care payments to be paid to the Washington health insurance system, which would then assume responsibility for all benefits and services previously paid for with those funds.

This initiative would create a health insurance policy board to establish policy on medical issues and various other matters relating to the health care system. This initiative would create the office of

patient advocacy within the agency to represent the interests of health care consumers relative to the health care system. This initiative would create within the agency the office of health planning to plan for the health care needs of the population, and the office of health care quality, headed by the chief medical officer, to support the delivery of high quality care and promote provider and patient satisfaction. This initiative would create the office of inspector general for the Washington health insurance system within the attorney general's office, which would have various oversight powers. This initiative would prohibit health care service plan contracts or health insurance policies from being issued for services covered by the Washington health insurance system. This initiative would create the health insurance fund and the payments board to administer the finances of the Washington health insurance system. The initiative would create the Washington health insurance premium commission to determine the cost of the Washington health insurance system and to develop a premium structure for the system that complies with specified standards. The bill would require the premium commission to recommend a premium structure to the governor and legislature on or before January 1, 2011, and to make a draft recommendation to the governor, the legislature, and the public ninety days before submitting its final premium structure recommendation. This initiative would specify that only its provisions relating to the premium commission would become operative on January 1, 2010, with its remaining provisions becoming operative on the date the secretary of health and human services notifies the legislature, as specified, that sufficient funding exists to implement the Washington health insurance system. This initiative would require that system to be operative within two years of that date and would provide for various transition processes for that period. This initiative would extend the application of certain insurance fraud laws to providers of services and products under the health care system, thereby imposing a state-mandated local program by revising the definition of a crime. This initiative would enact other related provisions relative to budgeting, regional entities, federal preemption, subrogation, collective

bargaining agreements, compensation of health care providers, conflict of interest, patient grievances, independent medical review, and associated matters.

NEW SECTION. **Sec. 2.** (1) There is hereby established in state government the Washington health insurance system, which shall be administered by the Washington health insurance agency, an independent agency under the control of the health insurance commissioner.

(2) No health care service plan contract or health insurance policy, except for the Washington health insurance system plan, may be sold in Washington for services provided by the system.

(3) This act shall be known as and may be cited as the Washington affordable health insurance act.

(4) This act shall be liberally construed to accomplish its purposes.

(5) The Washington health insurance agency is hereby created and designated as the single state agency with full power to supervise every phase of the administration of the Washington health insurance system and to receive grants-in-aid made by the United States government, by the state, or by other sources in order to secure full compliance with the applicable provisions of state and federal law.

(6) The Washington health insurance agency shall be comprised of the following entities:

- (a) The health insurance policy board.
- (b) The office of patient advocacy.
- (c) The office of health planning.
- (d) The office of health care quality.
- (e) The health insurance fund.
- (f) The public advisory committee.
- (g) The payments board.
- (h) Partnerships for health.

(7) The proponents of this initiative find and declare all of the following:

(a) Health care issues deeply impact each and every one of us. It is generally agreed that we need an affordable health care plan

that covers everyone. Given the current health care crisis throughout Washington state, this proposal is designed to revise health care insurance for the residents of Washington state.

(b) Currently, we are paying for four types of medical coverage which are:

- (i) Medicare.
- (ii) Medicaid.
- (iii) Workers' compensation.
- (iv) Private or personal medical insurance.

(c) By seeking to combine medicare, medicaid, workers' compensation, and private medical insurance into one agency, governmental bureaucracy and overhead is reduced. In addition, we eliminate the private insurance companies that seek to deny claims and cap medical claims in the interest of profit.

(d) With this system, people continue to choose their physicians, doctors' clinics, and hospitals as they always have. The major difference is the billing process. Creation of a health care system in which all the citizens of Washington state are insured through the state will provide adequate and affordable health care for our residents.

(e) According to the institute of medicine, 18,000 people in the United States die every year from a lack of health insurance--that's two people every hour. This concept saves time and money. By having one organization that handles the administration of the health care system (mostly consisting of paperwork and payments) we dramatically reduce the overhead costs. More of each of our dollars that go toward health care would actually be used to care for people's health, instead of going toward managers and forms. We eliminate the bulk of paperwork duplication and, in the process, could potentially save millions of dollars.

(f) Affordable health care is possible. Not only is it possible, this affordable health care program will save Washington state corporations millions of dollars each year. We are competing in a global society and, as it is right now, businesses are at an economic disadvantage, because their health costs are so much higher than in

other countries. With the current sad state of the economy, and the need to be competitive in the global economy, this could be a tremendous boost to the industries of Washington state.

(g) From a business perspective, there are repeated cases in which employed individuals work one day and claim an injury that in fact was preexisting. Employers know that the injury is not job-related but cannot prove otherwise. Individuals make these claims because they do not have health care insurance. As a result, we, as employers, are penalized for labor and industry claims that are submitted through rate increases.

(h) Health care spending continues to grow much faster than the economy, and efforts to control health care costs and the growth of health care spending have been unsuccessful.

(i) On average, the United States spends more than twice as much as all other industrial nations on health care, both per person and as a percentage of its gross domestic product.

(j) A majority of Washington residents and businesses support a system of affordable publicly financed health care.

(k) Consumers can no longer rely on traditional health care coverage due to a continuous decline of employer-offered coverage, unstable employment trends, and uncontrolled increases in the amount of premiums and cost sharing, and increases in benefit gaps.

(l) As a result, one-half of all bankruptcies in the United States now relate to medical costs, though three-fourths of bankrupted families had health care coverage at the time of sustaining the injury or illness.

(m) Health insurance companies have no business motive to provide comprehensive and affordable health care coverage to residents who are likely to require health care services, including seniors, disabled residents, residents with or at risk of developing a chronic illness, and women of child-bearing age.

(n) Health care quality is rapidly declining, and the United States institute of medicine has declared an epidemic of substandard health care throughout the nation.

(o) The world health organization ranks the United States below all other industrial nations and 37th overall in population-based health outcomes.

(p) Growing epidemics of chronic diseases such as diabetes, obesity, and asthma require a system of universal health care and a continuous source of health care for all residents in order to adequately address the health care needs of all residents.

(q) Severe health access disparities exist by region, ethnicity, income, and gender. These disparities destabilize the overall health care system throughout the state and reflect a lack of effective health care planning.

(r) Inadequate access to a regular source of care has caused uninsured patients to seek treatment in emergency facilities for conditions that could have been treated more appropriately in a nonemergency setting.

(s) Emergency departments and trauma centers face growing financial losses, and uncompensated hospital care. The burden for providing uncompensated care falls disproportionately on a minority of hospitals in Washington and leads to significant financial instability for the overall health care system.

(t) Multiple quantitative analyses indicate that, under a single payer health insurance system, the amount currently spent for health care is more than adequate to finance comprehensive high-quality health care coverage for every resident of the state while guaranteeing the right of every resident to choose his or her own physician.

(u) By simplifying administration, achieving bulk purchase discounts on pharmaceuticals, reducing the use of emergency facilities for primary care, and carefully managing health care capital investment, Washington could divert billions of dollars toward providing direct health care and improve the quality of, and access to, that care.

NEW SECTION. **Sec. 3.** (1) It is the intent of this initiative to establish a system of affordable health insurance in this state that

covers all residents with comprehensive health insurance benefits, guarantees a single standard of care for all residents, stabilizes the growth in health care spending, and improves the quality of health care for all residents.

(2) It is the intent of this initiative that, in order to ensure an adequate supply and distribution of direct care providers in the state, a just and fair return for providers electing to be compensated by the health care system, and a uniform system of payments, the state shall actively supervise and regulate a system of payments whereby groups of fee-for-service physicians are authorized to select representatives of their specialties to negotiate with the health care system. Nothing in this act shall be construed to allow collective action against the health care system.

(3) This act shall have all of the following purposes:

(a) To provide affordable and comprehensive health insurance coverage with a single standard of care for all Washington residents.

(b) To control health care costs and the growth of health care spending.

(c) To achieve measurable improvement in the quality of care and the efficiency of care delivery.

(d) To prevent disease and disability and to maintain or improve health and functionality.

(e) To increase health care provider, consumer, employee, and employer satisfaction with the health care system.

(f) To implement policies that strengthen and improve culturally and linguistically sensitive care.

(g) To develop an integrated population-based health care database to support health care planning.

(4) As used in this act, the following terms have the following meanings:

(a) "Agency" means the Washington health insurance agency.

(b) "Clinic" means an organized outpatient health facility that provides direct medical, surgical, dental, optometric, or podiatric advice, services, or treatment to patients who remain less than 24 hours, and that may also provide diagnostic or therapeutic services to

patients in the home as an alternative to care provided at the clinic facility.

(c) "Commissioner" means the health insurance commissioner.

(d) "Direct care provider" means any licensed health care professional that provides health care services through direct contact with the patient, either in person or using approved telemedicine modalities.

(e) "Essential community provider" means a health facility that has served as part of the state's health care safety net for low-income and traditionally underserved populations in Washington and that is one of the following:

(i) A "community clinic."

(ii) A "free clinic."

(iii) A "federally qualified health center."

(iv) A "rural health clinic."

(v) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization.

(vi) Any clinic exempt from licensure.

(f) "Health care provider" means any professional person, medical group, independent practice association, organization, health facility, or other person or institution licensed or authorized by the state to deliver or furnish health care services.

(g) "Health facility" means any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, and includes those facilities.

(h) "Hospital" means all health facilities to which persons may be admitted for a 24-hour stay or longer, with the exception of nursing, skilled nursing, intermediate care, and congregate living health facilities.

(i) "Integrated health care delivery system" means a provider organization that meets all of the following criteria:

(i) Is fully integrated operationally and clinically to provide a broad range of health care services, including preventative care, prenatal and well-baby care, immunizations, screening diagnostics, emergency services, hospital and medical services, surgical services, and ancillary services.

(ii) Is compensated using capitation or facility budgets, except for copayments, for the provision of health care services.

(iii) Provides health care services primarily through direct care providers who are either employees or partners of the organization, or through arrangements with direct care providers or one or more groups of physicians, organized on a group practice or individual practice basis.

(j) "Large employer" means a person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar year employed at least 50 employees, or, if the employer was not in business during any part of the preceding calendar year, employed at least 50 employees on at least 50 percent of its working days during the preceding calendar quarter.

(k) "Premium commission" means the Washington health insurance premium commission.

(l) "Primary care provider" means a direct care provider that is a family physician, internist, general practitioner, pediatrician, an obstetrician/gynecologist, or a family nurse practitioner or physician assistant practicing under supervision as defined in Washington codes or essential community providers who employ primary care providers.

(m) "Small employer" means a person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service and that, on at least 50 percent of its working days during the preceding calendar year employed at least two but no more than 49 employees, or, if the employer was not in business during any part of the preceding calendar year, employed at least two but no more than 40 eligible employees on

at least 50 percent of its working days during the preceding calendar quarter.

(n) "System" or "health insurance system" means the Washington health insurance system.

NEW SECTION. **Sec. 4.** (1) The commissioner shall be appointed by the governor on or before March 1, 2010, subject to confirmation. The procedures described in subsection (1) of this section shall apply to the confirmation process.

(a) The commissioner may not be a state legislator or a member of the United States congress while holding the position of commissioner.

(b) The commissioner shall not have been employed in any capacity by a for-profit insurance, pharmaceutical, or medical equipment company that sells products to the Washington health insurance system for a period of two years prior to appointment as commissioner.

(c) For two years after completing service in the Washington health insurance system, the commissioner may not receive payments of any kind from, or be employed in any capacity or act as a paid consultant to, a for-profit insurance, pharmaceutical, or medical equipment company that sells products to the Washington health insurance system.

(d) The compensation and benefits of the commissioner shall be determined pursuant to the same process.

(2) The commissioner shall be the chief officer of the Washington health insurance agency and shall administer all aspects of the agency.

(a) The commissioner shall be responsible for the performance of all duties, the exercise of all power and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the agency. The commissioner shall perform all duties imposed upon him or her by this act and other laws related to health care, and shall enforce the execution of those related to the system, and shall enforce the execution of those provisions and laws to promote their underlying aims and purposes. These broad powers shall include, but are not limited to, the power to establish the Washington health

insurance system budget and to set rates, to establish Washington health insurance system goals, standards and priorities, to hire, fire, and fix the compensation of agency personnel, to make allocations and reallocations to the health planning regions, and to promulgate generally binding regulations concerning any and all matters related to the implementation of this act and its purposes.

(b) The commissioner shall appoint the deputy health insurance commissioner, the director of the health insurance fund, the patient advocate, the chief medical officer, the director of the payments board, the director of health planning, the director of the partnerships for health, the regional health planning directors, the chief enforcement counsel, and legal counsel in any action brought by or against the commissioner under or pursuant to any provision of any law under the commissioner's jurisdiction, or in which the commissioner joins or intervenes as to a matter within the commissioner's jurisdiction, as a friend of the court or otherwise, and stenographic reporters to take and transcribe the testimony in any formal hearing or investigation before the commissioner or before a person authorized by the commissioner.

(c) The commissioner may appoint and fix the compensation of clerical, inspection, investigation, evaluation, and auditing personnel as may be necessary to implement this act.

(d) The personnel of the agency shall perform duties as assigned to them by the commissioner. The commissioner shall designate certain employees by the rule or order that are to take and subscribe to the constitutional oath within 15 days after their appointments, and to file that oath with the secretary of state.

(e) The commissioner shall adopt a seal bearing the inscription: "Commissioner, Washington health insurance agency, state of Washington." The seal shall be affixed to or imprinted on all orders and certificate issued by him or her and other instruments as he or she directs. All courts shall take notice of this seal.

(f) The administration of the agency shall be supported from the health insurance fund.

(g) The commissioner, as a general rule, shall publish or make available for public inspection any information filed with or obtained by the agency, unless the commissioner finds that this availability or publication is contrary to law. No provision of this act authorizes the commissioner or any of the commissioner's assistants, clerks, or deputies to disclose any information withheld from public inspection except among themselves or when necessary or appropriate in a proceeding or investigation under this act or to other federal or state regulatory agencies. No provision of this act either creates or derogates from any privilege that exists at common law or otherwise when documentary or other evidence is sought under a subpoena directed to the commissioner or any of his or her assistants, clerks, and deputies.

(h) It is unlawful for the commissioner or any of his or her assistants, clerks, or deputies to use for personal benefit any information that is filed with, or obtained by, the commissioner and that is not then generally available to the public.

(i) The commissioner shall avoid political activity that may create the appearance of political bias or impropriety. Prohibited activities shall include, but not be limited to, leadership of, or employment by, a political party or a political organization; public endorsement of a political candidate.

(j) The commissioner shall not participate in making or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know that he or she or a family or a business partner or colleague has a financial interest.

(k) The commissioner, in pursuit of his or her duties, shall have unlimited access to all nonconfidential and all nonprivileged documents in the custody and control of the agency.

(l) The attorney general shall render to the commissioner opinions upon all questions of law, relating to the construction or interpretation of any law under the commissioner's jurisdiction or arising in the administration thereof, that may be submitted to the attorney general by the commissioner and upon the commissioner's Code Rev/KK:cro

request shall act as the attorney for the commissioner in actions and proceedings brought by or against the commissioner or under or pursuant to any provision of any law under the commissioner's jurisdiction.

(3) The commissioner shall do all of the following:

(a) Oversee the establishment as part of the administration of the agency all of the following:

- (i) The health insurance policy board.
- (ii) The office of patient advocacy.
- (iii) The office of health planning.
- (iv) The office of health care quality.
- (v) The health insurance fund.
- (vi) The payments board.
- (vii) The public advisory committee.
- (viii) Partnerships for health.

(b) Determine Washington health insurance system goals, standards, guidelines, and priorities.

(c) Establish health care regions.

(d) Oversee the establishment of real and virtual locally based integrated service networks that include physicians in fee-for-service, solo and group practice, essential community, and ancillary care providers and facilities in order to pool and align resources and form interdisciplinary teams that share responsibility and accountability for patient care and provide a continuum of coordinated high quality primary to tertiary care to all Washington residents. This shall be accomplished in collaboration with the chief medical officer, the director of health planning, the regional medical officers, the regional planning boards, and the patient advocate.

(e) Establish standards based on clinical efficacy to guide delivery of care and ensure a smooth transition to clinical decision making under statewide standards.

(f) Implement policies to ensure that all Washington residents receive culturally and linguistically sensitive care and develop mechanisms and incentives to achieve this purpose and means to monitor the effectiveness of efforts to achieve this purpose.

(g) Create a systematic approach to the measurement, management, and accountability for care quality that assures the delivery of high quality care to all Washington residents, including a system of performance contracts that contain measurable goals and outcomes.

(h) Develop methods and a framework to measure the performance of health insurance and health delivery system upper level managers, including a system of performance contracts that contain measurable goals and outcomes.

(i) Establish a capital management plan for the Washington health insurance system including, but not limited to, a standardized process and format for the development and submission of regional operating and regional capital budget requests.

(j) Ensure the establishment of policies that support the public health.

(k) Ensure that health insurance system policies and providers support all Washington residents in achieving and maintaining maximum physical and mental functionality.

(l) Establish and maintain appropriate statewide and regional health care databases.

(m) Establish a means to identify areas of medical practice where standards of care do not exist and establish priorities and a timetable for their development.

(n) Establish standards for mandatory reporting by health care providers and penalties for failure to report.

(o) Implement policies to ensure that all residents of this state have access to medically appropriate, coordinated mental health services.

(p) Establish a comprehensive budget that ensures adequate funding to meet the health care needs of the population and the compensation for providers for care provided pursuant to this act.

(q) Establish standards and criteria for allocation of operating and capital funds from the health insurance fund.

(r) Establish standards and criteria for development and submission of provider operating and capital budget requests.

- (s) Determine the level of funding to be allocated to each health care region.
- (t) Annually assess projected revenues and expenditures to assure financial solvency of the system.
- (u) During transition and annually thereafter, determine the appropriate level for a health insurance system reserve fund and implement policies needed to establish the appropriate reserve.
- (v) Institute necessary cost controls to assure financial solvency of the system.
- (w) Develop separate formulae for budget allocations and review the formulae annually to ensure they address disparities in service availability and health care outcomes and for sufficiency of rates, fees, and prices.
- (x) Meet regularly with the chief medical officer, the patient advocate, the public advisory committee, the director of health planning, the director of the payments board, the director of the partnerships for health, the technical advisory committee, regional planning directors, and regional medical officers to review the impact of the agency and its policies on the health of the population and on satisfaction with the Washington health insurance system.
- (y) Negotiate for or set rates, fees, and prices involving any aspect of the Washington health insurance system and establish procedures thereto.
- (z) Establish a capital management framework for the Washington health insurance to ensure that the needs for capital health care infrastructure are met, pursuant to the goals of the system.
- (aa) Ensure a smooth transition to Washington health insurance system oversight of capital health care planning.
- (bb) Establish a formulary based on clinical efficacy for all prescription drugs and durable and nondurable medical equipment for use by the Washington health insurance system.
- (cc) Establish guidelines for prescribing medications, nutritional supplements, and durable medical equipment that are not included in the health system formularies.

(dd) Utilize the purchasing power of the state to negotiate price discounts for prescription drugs and durable and nondurable medical equipment for use by the Washington health insurance system.

(ee) Ensure that use of state purchasing power achieves the lowest possible prices for the Washington health insurance system without adversely affecting needed pharmaceutical research.

(ff) Create incentives and guidelines for research needed to meet the goals of the system and disincentives for research that does not achieve Washington health insurance system goals.

(gg) Implement eligibility standards for the system, including guidelines to prevent an influx of persons to the state for the purpose of obtaining medical care.

(hh) Determine an appropriate level of, and provide support during, the transition for training and job placement for persons who are displaced from employment as a result of the initiation of the new Washington health insurance system.

(ii) Establish an enrollment system that ensures all eligible Washington residents, including those who travel frequently; those who have disabilities that limit their mobility, hearing, or vision; those who cannot read; and those who do not speak or write English are aware of their right to health care and are formally enrolled.

(jj) Oversee the establishment of the system for resolution of disputes.

(kk) Establish an electronic claims and payments system for the Washington health insurance system, to which all claims shall be filed and from which all payments shall be made, and implement, to the extent permitted by federal law, standardized claims and reporting methods.

(ll) Establish a system of secure electronic medical records that comply with state and federal privacy laws and that are compatible across the system.

(mm) Establish an electronic referral system that is accessible to providers and to patients.

(nn) Establish guidelines for mandatory reporting by health care providers.

(oo) Establish a technology advisory committee to evaluate the cost and effectiveness of new medical technology, including electronic medical technology, and to make recommendations about the financial and health impact of their inclusion in the benefit package.

(pp) Investigate the costs and benefits to the health of the population of advances in information technology, including those that support data collection, analysis, and distribution.

(qq) Ensure that consumers of health care have access to information needed to support choice of physician.

(rr) Collaborate with the boards that license health facilities to ensure that facility performance is monitored and that deficient practices are recognized and corrected in a timely fashion and that consumers and providers of health care have access to information needed to support choice of facility.

(ss) Establish a health insurance system internet web site that provides information to the public about the Washington health insurance system that includes, but is not limited to, information that supports choice of provider and facilities and informs the public about state and regional health insurance policy board meetings and activities of the partnerships for health.

(tt) Procure funds, including loans, lease or purchase of insurance for the system, its employees, and agents.

(uu) Collaborate with state and local authorities, including regional health directors, to plan for needed earthquake retrofits in a manner that does not disrupt patient care.

(vv) Establish a process for the system to receive the concerns, opinions, ideas, and recommendation of the public regarding all aspects of the system.

(ww) Annually report to the legislature and the governor, on or before October of each year and at other times pursuant to this act, on the performance of the Washington health insurance system, its fiscal condition and need for rate adjustments, consumer copayments or consumer deductible payments, recommendations for statutory changes, receipt of payments from the federal government and other sources, whether current year goals and priorities are met, future goals, and

priorities, and major new technology or prescription drugs or other circumstances that may affect the cost of health care.

(4) The commissioner shall establish a health insurance policy board and shall serve as the president of the board. The board shall do all of the following:

(a) Establish health insurance system goals and priorities, including research and capital investment priorities.

(b) Establish the scope of services to be provided to the population.

(c) Establish guidelines for evaluating the performance of the health insurance system, health insurance system officers, health care regions, and health care providers.

(d) Establish guidelines for ensuring public input on health insurance system policy, standards, and goals.

(e) The board shall consist of the following members:

(i) The commissioner.

(ii) The deputy commissioner.

(iii) The health insurance fund director.

(iv) The patient advocate.

(v) The chief medical officer.

(vi) The director of health planning.

(vii) The director of the partnerships for health.

(viii) The director of the payments board.

(ix) The state public health officer.

(x) One member of the public advisory committee who shall serve on a rotating basis to be determined by the public advisory committee.

(xi) Two representatives from regional planning boards.

(A) A regional representative shall serve a term of one year and terms shall be rotated in order to allow every region to be represented within a five-year period.

(B) A regional planning director shall appoint the regional representative to serve on the board.

(f) It is unlawful for the board members or any of their assistants, clerks, or deputies to use for personal benefit any

information that is filed with or obtained by the board and that is not then generally available to the public.

(5) The commissioner shall establish a public advisory committee to advise the health insurance policy board on all matters of health insurance system policy.

(a) Members of the public advisory committee shall include all of the following:

(i) Four physicians all of whom shall be board certified in their field and at least one of whom shall be a psychiatrist.

(ii) One registered nurse, to be appointed by the senate committee on rules.

(iii) One licensed vocational nurse, to be appointed by the senate committee on rules.

(iv) One licensed allied health practitioner, to be appointed by the speaker of the house.

(v) One mental health care provider, to be appointed by the senate committee on rules.

(vi) One dentist, to be appointed by the governor.

(vii) One representative of private hospitals, to be appointed by the governor.

(viii) One representative of public hospitals, to be appointed by the governor.

(ix) Four consumers of health care. The governor shall appoint two of these members, one of whom shall be a member of the disability community. The senate committee on rules shall appoint a member who is 65 years of age or older. The speaker of the house shall appoint the fourth member.

(x) One representative of organized labor, to be appointed by the speaker of the house.

(xi) One representative of essential community providers, to be appointed by the senate committee on rules.

(xii) One union member, to be appointed by the senate committee on rules.

(xiii) One representative of small business, to be appointed by the

governor.

(xiv) One representative of large business, to be appointed by the speaker of the house.

(xv) One pharmacist, to be appointed by the speaker of the house.

(b) In making appointments pursuant to this section, the governor, the senate committee on rules, and the speaker of the house shall make good faith efforts to assure that their appointments, as a whole, reflect, to the greatest extent feasible, the social and geographic diversity of the state.

(c) Any member appointed by the governor, the senate committee on rules, or the speaker of the house shall serve for a four-year term. These members may be reappointed for succeeding four-year terms.

(d) Vacancies that occur shall be filled within 30 days after the occurrence of the vacancy, and shall be filled in the same manner in which the vacating member was selected or appointed. The commissioner shall notify the appropriate appointing authority of any expected vacancies on the board.

(e) Members of the advisory committee shall serve without compensation, but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties to the extent that reimbursement for those expenses is not otherwise provided or payable by another public agency or agencies, and shall receive one hundred dollars for each full day of attending meetings of the board. For purposes of this section, "full day of attending a meeting" means presence at, and participation in, not less than 75 percent of the total meeting time of the board during any particular 24-hour period.

(f) The advisory committee shall meet at least six times a year in a place convenient to the public. All meetings of the board shall be open to the public, pursuant to the open public meetings act.

(g) The advisory committee shall elect a chair who shall serve for two years and who may be reelected for an additional two years.

(h) Appointed committee members shall have worked in the field they represent on the committee for a period of at least two years prior to being appointed to the committee.

(i) The advisory committee shall elect a member to serve on the health insurance policy board. The elected member shall serve for one year, and may be recalled by the advisory committee for cause. In that case a new member shall be elected to serve on that board. The advisory committee representative shall represent the views of the advisory committee members to the board.

(j) It is unlawful for the committee members or any of their assistants, clerks, or deputies to use for personal benefit any information that is filed with or obtained by the committee and that is not generally available to the public.

(6) There is within the agency an office of patient advocacy to represent the interests of the consumers of health care. The goal of the office shall be to help residents of the state secure the health care services and benefits to which they are entitled under the laws administered by the agency and to advocate on behalf of and represent the interests of consumers in governance bodies created by this act and in other forums.

(a) The office shall be headed by a patient advocate appointed by the commissioner.

(b) The patient advocate shall establish an office in the city of Olympia and other offices throughout the state that shall provide convenient access to residents.

(c) The patient advocate shall do all the following:

(i) Administer all aspects of the office of patient advocacy.

(ii) Assure that services of the office of patient advocacy are available to all Washington residents.

(iii) Serve on the health insurance policy board and participate in the regional partnerships for health.

(iv) Oversee the establishment and maintenance of the grievance process.

(v) Participate in the grievance process and independent medical review system on behalf of consumers.

(vi) Receive, evaluate, and respond to consumer complaints about the health insurance system.

(vii) Provide a means to receive recommendations from the public about ways to improve the health insurance system and hold public hearings at least once annually to discuss problems and receive recommendations from the public.

(viii) Develop educational and informational guides for consumers describing their rights and responsibilities and informing them about effective ways to exercise their rights to secure health care services and to participate in the health insurance system. The guides shall be easy to read and understand, available in English and other languages, including Braille and formats suitable for those with hearing limitations, and shall be made available to the public by the agency, including access on the agency's internet web site and through public outreach and educational programs and displayed in provider offices and health care facilities.

(ix) Establish a toll-free number to receive complaints regarding the agency and its services. The agency internet web site shall have complaint forms and instructions on their use.

(x) Report annually to the public, the commissioner, and the legislature about the consumer perspective on the performance of the health insurance system, including recommendations for needed improvements.

(d) Nothing in this act shall prohibit a consumer or class of consumers or the patient advocate from seeking relief through the judicial system.

(e) The patient advocate in pursuit of his or her duties shall have unlimited access to all nonconfidential and all nonprivileged documents in the custody and control of the agency.

(f) It is unlawful for the patient advocate or any of his or her assistants, clerks, or deputies to use for personal benefit any information that is filed with, or obtained by, the agency and that is not then generally available to the public.

(7)(a) Nothing contained in this act is intended to repeal any legislation or regulation governing the professional conduct of any person licensed by the state of Washington or any legislation

governing the licensure of any facility licensed by the state of Washington.

(b) All federal legislation and regulations governing referral fees and fee-splitting shall be applicable to all health care providers of services reimbursed under this act, whether or not the health care provider is paid with funds coming from the federal government.

(8) The health insurance system shall be operational no later than two years after the date this act becomes operative.

(a) The transition shall be funded from a loan from the general fund and from other sources, including private sources identified by the commissioner.

(b) The commissioner shall assess health plans and insurers for care provided by the system in those cases in which a person's health care coverage extends into the time period in which the new system is operative.

(c) The commissioner shall implement means to assist persons who are displaced from employment as a result of the initiation of the new health insurance system, including determination of the period of time during which assistance shall be provided and possible sources of funds, including health insurance funds, to support retraining and job placement. That support shall be provided for a period of five years from the date that this act becomes operative.

(9) The commissioner shall appoint a transition advisory group to assist with the transition to the system.

(a) The transition advisory group shall include, but not be limited to, the following members:

(i) The commissioner.

(ii) The patient advocate.

(iii) The chief medical officer.

(iv) The director of health planning.

(v) The director of the health insurance fund.

(vi) The state public health officer.

(vii) Experts in health care financing and health care administration.

(viii) Direct care providers.

(ix) Representatives of retirement boards.

(x) Employer and employee representatives.

(xi) Hospital, essential community provider, and long-term care facility representatives.

(xii) Representatives from state departments and regulatory bodies that shall or may relinquish some or all parts of their delivery of health service to the system.

(xiii) Representatives of counties.

(xiv) Consumers of health care.

(b) The transition advisory group shall advise the commissioner on all aspects of the implementation of this act.

(c) The transition advisory group shall make recommendations to the commissioner, the governor, and the legislature on how to integrate health care delivery services and responsibilities.

(d) The transition advisory group shall make recommendations to the governor, the legislature, and the commissioner regarding research needed to support transition to the new health insurance system.

(10) The transition advisory group shall make recommendations to the commissioner relative to how the health insurance system shall be regionalized for the purposes of local and community-based planning for the delivery of high quality cost-effective care and efficient service delivery.

(a) The commissioner, in consultation with the director of health planning, shall establish health planning regions composed of geographically contiguous counties grouped on the basis of the following considerations:

(i) Patterns of utilization of health care services.

(ii) Health care resources, including workforce resources.

(iii) Health needs of the population, including public health needs.

(iv) Geography.

(v) Population and demographic characteristics.

(vi) Other considerations as determined by the commissioner, director of health planning, or chief medical officer.

(b) The commissioner shall appoint a director for each region. Regional planning directors shall serve at the will of the commissioner and may serve up to two eight-year terms to coincide with the terms of the commissioner.

(c) Each regional planning director shall appoint a regional medical officer.

(d) Compensation for health system officers and appointees who are exempt from the civil service shall be established by the Washington citizens commission shall take into consideration regional differences in the cost of living.

(11) Regional planning directors shall administer the health planning region. The regional planning director shall be responsible for all duties, the exercise of all powers and jurisdiction, and the assumptions and discharge of all responsibilities vested by law in the regional agency. The regional planning director shall perform all duties imposed upon him or her by this act and by other laws related to health care, and shall enforce execution of those provisions and laws to promote their underlying aims and purposes.

(a) The regional planning director shall reside in the region in which he or she serves.

(b) The regional planning director shall do all of the following:

(i) Establish and administer a regional office of the state agency. Each regional office shall include, at minimum, an office of each of the following: Patient advocacy, health care quality, health planning, and partnerships for health.

(ii) Establish regional goals and priorities pursuant to standards, goals, priorities, and guidelines established by the commissioner.

(iii) Assure that regional administrative costs meet standards established by the division.

(iv) Seek innovative means to lower the costs of administration of the regional planning office and those of regional providers.

(v) Plan for the delivery of, and equal access to, high quality and culturally and linguistically sensitive care that meets the needs

of all regional residents pursuant to standards established by the commissioner.

(vi) Seek innovative and systemic means to improve care quality and efficiency of care delivery. Where it is possible, establish treatment facilities at the local schools, with the goal to provide treatment by physician's assistant or nurse practitioner for the citizens of the local community, prior to acquiring additional outpatient care facilities.

(vii) Appoint regional planning board members and serve as president of the board.

(viii) Recommend means to and implement policies established by the commissioner to provide support to persons displaced from employment as a result of the initiation of the new system.

(ix) Make needed revenue-sharing arrangements so that regionalization does not limit a patient's choice of provider.

(x) Implement procedures established by the commissioner for the resolution of disputes.

(xi) Implement processes established by the commissioner and recommend needed changes to permit the public to share concerns and provide ideas, opinions, and recommendations regarding all aspects of the system policy.

(xii) Report regularly to the public and, at intervals determined by the commissioner, and pursuant to this act, to the commissioner, on the status of the regional planning system, including evaluating access to care, quality of care delivered, and provider performance, and other issues related to regional health care needs, and recommending needed improvements.

(xiii) Identify and prioritize regional health care needs and goals, in collaboration with the regional medical officer, regional health care providers, the regional planning board, and regional director of partnerships for health.

(xiv) Identify or establish guidelines for providers to identify, maintain, and provide to the regional director inventories of regional health care assets.

(xv) Establish and maintain regional health care databases.

(xvi) In collaboration with the regional medical officer, enforce reporting requirements established by the Washington health insurance system and make recommendations to the commissioner, the director of health planning, and the chief medical officer for needed changes in reporting requirements.

(xvii) Convene meetings of regional health care providers to facilitate coordinated regional health care planning.

(xviii) Establish and implement a regional capital management plan pursuant to the capital management plan established by the commissioner for the system.

(xix) Implement standards and formats established by the commissioner for the development and submission of operating and capital budget requests and make recommendations to the commissioner and the director of health planning for needed changes.

(xx) Support regional providers in developing operating and capital budget requests.

(xxi) Receive, evaluate, and prioritize provider operating and capital budget requests pursuant to standards and criteria established by the commissioner.

(xxii) Prepare a three-year regional operating and capital budget request that meets the health care needs of the region pursuant to this act, for submission to the commissioner.

(xxiii) Establish a comprehensive three-year regional planning budget using funds allocated to the region by the commissioner.

(xxiv) Regularly assess projected revenues and expenditures to ensure fiscal solvency of the regional planning system and advise the commissioner of potential revenue shortfalls and the possible need for cost controls.

(c) The regional medical officers shall do all of the following:

(i) Administer all aspects of the regional office of health care quality.

(ii) Serve as a member of the regional planning board.

(iii) Support the delivery of high quality care to all residents of the region pursuant to this act.

(iv) Ensure a smooth transition to care delivery by regional providers under standards based on clinical efficacy that guide clinical decision making.

(v) Support the development and distribution of user-friendly software for use by providers in order to support the delivery of high quality care.

(vi) In collaboration with the chief medical officer and regional providers, evaluate standards of care in use at the time the Washington health insurance system becomes operative.

(vii) Ensure the implementation of needed improvements so that a single standard of high quality care is delivered to all residents under standards that guide clinical decision making.

(viii) In collaboration with the commissioner, the chief medical officer, the regional medical officer, regional planning boards, the patient advocate, regional providers, and patients, oversee the establishment of real and virtual integrated service networks of fee-for-service, solo and group practice, essential community, and ancillary care providers and facilities that pool and align resources and form interdisciplinary teams that share responsibility and accountability for patient care and provide a continuum of coordinated high quality primary to tertiary care to all residents of the region.

(ix) Assure the evaluation and measurement of the quality of care delivered in the region, including assessment of the performance of individual providers, pursuant to standards and methods established by the chief medical officer.

(x) Provide feedback to, and support and supervision of, medical providers to ensure the delivery of high quality care pursuant to standards established by the health insurance system.

(xi) Assure the provision of information to assist consumers in evaluating the performance of health care providers and facilities.

(xii) Identify areas of medical practice where standards have not been established and collaborate with the chief medical officer and health care providers, to establish priorities in developing needed standards.

(xiii) Collaborate with regional public health officers to establish regional health policies that support the public health.

(xiv) Establish a regional program to monitor and decrease medical errors and their causes pursuant to standards and methods established by the chief medical officer.

(xv) Support the development and implementation of innovative means to provide high quality care and assist providers in securing funds for innovative demonstration projects that seek to improve care quality.

(xvi) Establish means to assess the impact of health insurance system policies intended to assure the delivery of high quality care.

(xvii) Collaborate with the chief medical officer and the director of health planning and health care providers in the development and maintenance of regional health care databases.

(xviii) Ensure the enforcement of, and recommend needed changes in, health insurance system reporting requirements.

(xix) Support providers in developing regional budget requests.

(xx) Collaborate with the regional director of the partnerships for health to develop patient education on appropriate utilization of health care services.

(xxi) Annually report to the commissioner, the public, the regional planning board, and the chief medical officer on the status of regional health care programs, needed improvements, and plans to implement and evaluate delivery of care improvements.

(12) Each region shall have a regional planning board consisting of thirteen members who shall be appointed by the regional planning director. Members shall serve eight-year terms that coincide with the term of the regional planning director and may be reappointed for a second term.

(a) Regional planning board members shall have resided for a minimum of two years in the region in which they serve prior to appointment to the board.

(b) Regional planning board members shall reside in the region they serve while on the board.

(c) The board shall consist of the following members:

(i) The regional planning director, the regional medical officer and the regional director of the partnerships for health and a public health officer from one of the regional counties.

(ii) When there is more than one county in a region, the public health officer board position shall rotate among the public health county officers on a timetable to be established by each regional planning board.

(iii) A representative from the office of patient advocacy.

(iv) One expert in health care financing.

(v) One expert in health care planning.

(vi) Two members who are direct patient care providers in the region, one of whom shall be a registered nurse.

(vii) One member who represents ancillary health care workers in the region.

(viii) One member representing hospitals in the region.

(ix) One member representing essential community providers in the region.

(x) One member representing the public.

(d) The regional planning director shall serve as chair of the board.

(e) The purpose of the regional planning boards is to advise and make recommendations to the regional planning director on all aspects of regional health policy.

(f) Meetings of the board shall be open to the public pursuant to the open public meetings act.

(13) The following conflict of interest prohibitions shall apply to all appointees of the commissioner or transition commission including, but not limited to, the patient advocate, the health insurance fund director, the purchasing director, the director of health planning, the director of the payments board, the chief medical officer, the director of partnerships for health, regional directors, and the inspector general:

(a) The appointee shall not have been employed in any capacity by a for-profit insurance, pharmaceutical, or medical equipment company

that sells products to the system for a period of two years prior to appointment.

(b) For two years after completing service in the system, the appointee may not receive payments of any kind from, or be employed in any capacity or act as a paid consultant to, a for-profit insurance, pharmaceutical, or medical equipment company that sells products to the system.

(c) The appointee shall avoid political activity that may create the appearance of political bias or impropriety. Prohibited activities shall include, but not be limited to, leadership of, or employment by, a political party or a political organization; public endorsement of a political candidate.

(d) The appointee shall not participate in making or in any way attempt to use his or her official position to influence a governmental decision in which he or she or a family or a business partner or colleague has a financial interest.

NEW SECTION. **Sec. 5.** (1) In order to support the agency effectively in the administration of this act, there is hereby established in the state treasury the health insurance fund. The fund shall be administered by a director appointed by the commissioner.

(a) All moneys collected, received, and transferred pursuant to this act, shall be transmitted to the state treasury to be deposited to the credit of the health insurance fund for the purpose of financing the Washington health insurance system.

(b) Moneys deposited in the health insurance fund shall be used exclusively to support this act.

(c) All claims for health care services rendered shall be made to the health insurance fund through an electronic claims and payment system. The commissioner shall investigate the costs, benefits, and means of supporting providers in obtaining electronic systems for claims and payments transactions; however, alternative provisions shall be made for providers without electronic systems.

(d) All payments made for health care services shall be disbursed from the health insurance fund through an electronic claims and

payments system; however, alternative provisions shall be made for providers without electronic systems.

(e) The director of the fund shall serve on the health insurance policy board.

(2) The director of the health insurance fund shall establish the following accounts within the health insurance fund:

(a) A system account to provide for all annual state expenditures for health care.

(b) A reserve account.

(c) Premiums collected each year shall be roughly sufficient to cover that year's projected costs.

(d) The health insurance system shall at all times hold in reserve an amount estimated in the aggregate to provide for the payment of all losses and claims for which the system may be liable, and to provide for the expense of adjustment or settlement of losses and claims.

(e) During the transition, the commissioner shall work with the department of insurance and other experts to determine an appropriate level of health system reserves for the first year and for future years of health insurance system operation.

(f) Moneys currently held in reserve by state, city, and county health programs and federal moneys for health care held in reserve in federal trust accounts shall be transferred to the state health care reserve account when the state assumes financial responsibility for health care under this division that are currently provided by those programs.

(g) The commissioner may implement arrangements to self-insure the system against unforeseen expenditures or revenue shortfalls not covered by reserves and may borrow funds to cover temporary revenue shortfalls not covered by system reserves, including the issuance of bonds for this purpose, whichever is the more cost-effective.

(h) Funds held in the reserve account and other health insurance fund accounts may be prudently invested to increase their value according to the department of insurance's standards for liquidity and asset management.

(3) The director of the health insurance fund shall immediately notify the commissioner when regional or statewide revenue and expenditure trends indicate that expenditures may exceed revenues.

(a) If the commissioner determines that statewide revenue trends indicate the need for statewide cost control measures, the commissioner shall convene the health insurance policy board to discuss the need for cost control measures and shall immediately report to the legislature and the public regarding the possible need for cost control measures.

(b) Cost control measures include any or all of the following:

(i) Changes in the health insurance system or health facility administration that improve efficiency.

(ii) Changes in the delivery of health care services that improve efficiency and care quality.

(iii) Postponement of introduction of new benefits or benefit improvements.

(iv) Seeking statutory authority for a temporary decrease in benefits.

(v) Postponement of planned capital expenditures.

(vi) Adjustments of health care provider payments to correct for deficiencies in care quality and failure to meet compensation contract performance goals.

(vii) Adjustments on the reimbursement of health insurance system managerial employees and upper level health system managers to correct for deficiencies in management and failure to meet contract performance goals.

(viii) Limitations on the reimbursement budgets of health system providers and upper level managers whose compensation is determined by the health insurance system payments board.

(ix) Limitations on aggregate reimbursements to manufacturers of pharmaceutical and durable and nondurable medical equipment.

(x) Deferred funding of the reserve account.

(xi) Imposition of copayments or deductible payments. Any copayment or deductible payments imposed shall be subject to all of the following requirements:

(A) No copayment or deductible may be established when prohibited by federal law.

(B) All copayments and deductibles shall meet federal guidelines for copayments and deductible payments that may lawfully be imposed on persons with low income.

(C) The commissioner shall establish standards and procedures for waiving copayments or deductible payments and a waiver card which shall be issued to a patient or to a family to indicate the waiver. Procedures for copayment waiver may include a determination by a patient's primary care provider that imposition of a copayment would be a financial hardship. Copayment and deductible waivers shall be reviewed annually by the regional planning director.

(D) Waivers shall not affect the reimbursement of health care providers.

(E) Any copayments or deductible payments established pursuant to this section shall be transmitted to the treasurer to be deposited to the credit of the health insurance fund.

(xii) Imposition of an eligibility waiting period and other means if the commissioner determines that large numbers of people are emigrating to the state for the purpose of obtaining health care through the Washington health insurance system.

(c) Nothing in this act shall be construed to diminish the benefits that an individual has under a collective bargaining agreement.

(d) Nothing in this act shall preclude employees from receiving benefits available to them under a collective bargaining agreement or other employee-employer agreement that are superior to benefits under this act.

(e) Cost control measures implemented by the commissioner and the health insurance policy board shall remain in place in the state until the commissioner and the health insurance policy board determine that the cause of a revenue shortfall has been corrected.

(f) If the health insurance policy board determines that cost control measures will not be sufficient to meet a revenue shortfall, the commissioner shall report to the legislature and to the public on

the causes of the shortfall and the reasons for the failure of cost controls and shall recommend measures to correct the shortfall, including an increase in health insurance system premium payments.

(4) If the commissioner or a regional planning director determines that regional revenue and expenditure trends indicate a need for regional cost control measures, the regional planning director shall convene the regional planning board to discuss the possible need for cost control measures and to make a recommendation about appropriate measures to control costs. These may include any of the following:

(a) Changes in health insurance system or health facility administration that improve efficiency.

(b) Changes in the delivery of health services and health system management that improve efficiency or care quality.

(c) Postponement of planned regional capital expenditures.

(d) Adjustment of payments to health care providers to reflect deficiencies in care quality and failure to meet compensation contract performance goals and payments to upper level managers to reflect deficiencies in management and failure to meet compensation contract performance goals.

(e) Adjustment of payments to health care providers and upper level managers above a specified amount of aggregate billing.

(f) Adjustment of payments to pharmaceutical and medical equipment manufacturers and others selling goods and services to the health insurance system above a specified amount of aggregate billing.

(g) In the event a regional planning board is convened to implement cost control measures, the commissioner shall participate in the regional planning board meeting.

(h) The regional planning director, in consultation with the commissioner, shall determine if cost control measures are warranted and those measures that shall be implemented.

(i) Imposition of copayments or deductibles, postponement of new benefits or benefit improvements, deferred funding of the reserve account, establishment of eligibility waiting periods and increases in health insurance premium payments may occur on a statewide basis only

and with the concurrence of the commissioner and the health insurance policy board.

(j) If a regional planning director and regional planning board are considering imposition of cost control measures, the regional planning director shall immediately report to the residents of the region regarding the possible need for cost control measures.

(k) Cost control measures shall remain in place in a region until the regional planning director and the commissioner determine that the cause of a revenue shortfall has been corrected.

(5) If, on June 30th of any year, the budget act for the fiscal year beginning on July 1st has not been enacted, all moneys in the reserve account of the health insurance fund shall be used to implement this act until funds are available through the budget act.

(a) Notwithstanding any other provision of law and without regard to fiscal year, if the annual budget is not enacted by June 30th of any fiscal year preceding the fiscal year to which the budget would apply and if the commissioner determines that funds in the reserve account are depleted, the following shall occur:

(i) The controller shall annually transfer from the general fund, in the form of one or more loans, an amount to the health insurance fund for the purpose of making payments to health care providers and to persons and businesses under contract with the health insurance system or with health providers to provide services, medical equipment, and pharmaceuticals to the Washington health insurance system.

(ii) Upon enactment of the budget act in any fiscal year, the controller shall transfer all expenditures and unexpected funds loaned to the health insurance fund to the appropriate budget act item.

(b) The amount of any loan made for which moneys were expended from the health insurance fund shall be repaid by debiting the appropriate budget act item in accordance with procedures prescribed by the department of finance.

(6) The commissioner annually shall prepare a health insurance system budget that includes all expenditures, specifies a limit on total annual state expenditures, and establishes allocations for each

health care region that shall cover a three-year period and that shall be disbursed on a quarterly basis.

(a) The commissioner shall limit the growth of spending on a statewide and on a regional basis, by reference to average growth in state domestic product across multiple years; population growth, actuarial demographics, and other demographic indicators; differences in regional costs of living, advances in technology and their anticipated adoption into the benefit plan; improvements in efficiency of administration and care delivery; and improvements in the quality of care and to projected future state domestic product growth rates.

(b) The commissioner shall adjust the health insurance system budget so that aggregate spending in the state on health care outside of the system shall not exceed spending under this act by more than 5 percent.

(c) The commissioner shall project health insurance system revenues and expenditures for 3, 6, 9, and 12 years.

(d) The commissioner shall annually convene a health insurance system revenue and expenditure conference to discuss revenue and expenditure projections and future health insurance system policy directions and initiatives, including means to lower the cost of administration, improve management of and investment in capital assets, and improve the quality of care and health system management. Participants shall include regional health directors and medical officers, directors of the health insurance fund and payments board, the patient advocate, state and regional directors of the partnerships for health, and representatives of the health insurance system facility upper level managers.

(e) The Washington health insurance system budget shall include all of the following:

- (i) Transition budget.
- (ii) Providers and managers budget.
- (iii) Capitated operating budgets.
- (iv) Noncapitated operating budgets.
- (v) Capital investment budget.
- (vi) Purchasing budget.

- (vii) Research and innovation budget.
- (viii) Workforce training and development budget.
- (ix) Reserve account.
- (x) System administration system.
- (xi) Regional budgets.

(f) In establishing budgets, the commissioner shall make adjustments based on all of the following:

- (i) Costs of transition to the new system.
- (ii) Projections regarding the health services anticipated to be used by Washington residents.
- (iii) Differences in cost of living between the regions, including the overhead costs of maintaining medical practices.
- (iv) Health risk of enrollees.
- (v) Scope of services provided.
- (vi) Innovative programs that improve care quality, administrative efficiency, and workplace safety.

(vii) Unrecovered cost of providing care to persons who are not members of the Washington health insurance system. The commissioner shall seek to recover the costs of care provided to nonhealth insurance system members.

- (viii) Costs of workforce training and development.
- (ix) Costs of correcting health outcome disparities and the unmet needs of previously uninsured and underinsured enrollees.
- (x) Relative usage of different health care providers.
- (xi) Needed improvements in access to care.
- (xii) Projected savings in administrative costs.
- (xiii) Projected savings due to provision of primary and preventive care to the population, including savings from decreases in preventable emergency room visits and hospitalizations.
- (xiv) Projected savings from improvements in care quality.
- (xv) Projected savings from decreases in medical errors.
- (xvi) Projected savings from system-wide management of capital expenditures.

(xvii) Cost of incentives and bonuses to support the delivery of high quality care, including incentives and bonuses needed to recruit

and retain an adequate supply of needed providers and managers and to attract providers to medically underserved areas.

(xviii) Costs of treating complex illnesses, including disease management programs.

(xix) Cost of implementing standards of care, care coordination, electronic medical records, and other electronic initiatives.

(xx) Costs of new technology.

(xxi) Technology research and development costs and costs related to health insurance system use of new technologies.

(g) Moneys in the reserve account shall not be considered as available revenues for the purposes of preparing the system budget, except when the state budget has not been enacted by June 30th of any fiscal year.

(7) The commissioner shall annually establish the total funds to be allocated for provider and manager compensation pursuant to this section. In establishing the provider and manager budgets, the commissioner shall allot sufficient funds to assure that Washington can attract and retain those providers and managers needed to meet the health needs of the population. In establishing provider and manager budgets, the commissioner shall allocate funds for both salaries, incentives, bonuses, and benefits to be provided to health insurance system officers and upper level managers who are exempt from state civil service statutes.

(8) The commissioner shall establish the payments board and shall appoint a director and members of the board.

(a) The commissioner shall retain the authority to review, approve, reject, and modify all payment contracts and compensation plans established pursuant to this section.

(b) The payments board shall be composed of experts in health care finance and insurance systems, a designated representative of the commissioner, a designated representative of the health insurance fund, and a representative of the regional planning directors. The position of regional representative shall rotate among the directors of the regional planning boards every two years.

(c) The board shall establish and supervise a uniform payments system for providers and managers and shall maintain a compensation plan for all of the following providers and managers pursuant to the provider and manager budget established by the commissioner:

(i) Upper level managers employed in private health care facilities including, but not limited to, hospitals, integrated health care systems, group and solo medical practices, and essential community facilities.

(ii) Appointed Washington health insurance system managers and officers.

(iii) Health care providers including, but not limited to, physicians, osteopathic physicians, dentists, podiatrists, nurse practitioners, physician assistants, chiropractors, acupuncturists, psychologists, social workers, marriage, family and child counselors, and other professional health care providers who are required by law to be licensed to practice in Washington and who provide services pursuant to this act.

(iv) Health care providers licensed and accredited to provide services in Washington may choose, on a case-by-case or on an aggregate basis, to be compensated for their services either by the Washington health insurance system or by a person to whom they provide services.

(v) Compensation for health system employees that is determined through employer-union negotiations before implementation of this act shall be determined by health insurance system-union negotiations after that implementation.

(vi) Providers electing to be compensated by the Washington health insurance system shall enter into a contract with the health insurance system pursuant to provisions of this section.

(vii) Providers electing to be compensated by persons to whom they provide services, instead of by the Washington health insurance system, may establish charges for their services.

(viii) Health care providers who accept any payment under this act shall not bill a patient for any covered service.

(d) Health care providers licensed or accredited to provide services in Washington, who choose to be compensated by the health insurance system instead of by patients to whom they provide services, may choose how they wish to be compensated under this act, as fee-for-service providers or as salaried providers in health care systems that provide comprehensive, coordinated services.

(e) Notwithstanding provisions of the business and professions code, nurse practitioners, physician assistants, and others who under Washington law must be supervised by a physician, an osteopathic physician, a dentist, or a podiatrist may choose fee-for-service compensation while under lawfully required supervision. However, nothing in this section shall interfere with the right of a supervising provider to enter into a contractual arrangement that provides for salaried compensation for employees who must be supervised under the law by a physician, an osteopathic physician, a dentist, or a podiatrist.

(f) The compensation plan shall include all of the following:

(i) Actuarially sound payments that include a just and fair return for providers in the fee-for-service sector and for providers working in health systems where comprehensive and coordinated services are provided, including the actuarial basis for the payment.

(ii) Payment schedules which shall be in effect for three years.

(iii) Bonus and incentive payments including, but not limited to, all of the following:

(A) Bonus payments for providers and upper level managers who, in providing services and managing facilities, practices, and integrated health systems, pursuant to this act, meet performance standards and outcome goals established by the Washington health insurance system.

(B) Incentive payments for providers and upper level managers who provide services to the Washington health insurance system in areas identified by the office of health planning as medically underserved.

(C) Incentive payments required to achieve the ratio of generalist to specialist providers needed in order to meet the standards of care and health needs of the population.

(D) Incentive payments required to recruit and retain nurse practitioners and physician assistants in order to provide primary and preventive care to the population.

(E) No bonus or incentive payment may be made in excess of the total allocation for provider and manager incentive and bonus reimbursement established by the commissioner in the health insurance system budget.

(F) No incentive may adversely affect the care a patient receives or the care a health provider recommends.

(g) Providers shall be paid for all services provided pursuant to this act, including care provided to persons who are subsequently determined to be ineligible for the Washington health insurance system.

(h) Licensed providers who deliver services not covered under the Washington health insurance system may establish rates for, and charge patients for, those services.

(i) Reimbursement to providers and managers may not exceed the amount allocated by the commissioner to provider and manager annual budgets.

(i) Fee-for-service providers shall choose representatives of their specialties to negotiate reimbursement rates with the payments board on their behalf.

(ii) The payments board shall establish a uniform system of payments for all services provided pursuant to this act.

(iii) Payment schedules shall be available to providers in printed and in electronic documents.

(iv) Payment schedules shall be in effect for three years, at which time payment schedules may be renegotiated. Payment adjustments may be made at the discretion of the payments board to meet the goals of the health insurance system.

(v) In establishing a uniform system of payments, the payments board shall collaborate with regional health directors and providers and shall take into consideration regional differences in the cost of living and the need to recruit and retain skilled providers in the region.

(vi) Fee-for-service providers shall submit claims electronically to the health insurance fund and shall be paid within 30 business days for claims filed in compliance with procedures established by the health insurance fund.

(9) Compensation for providers and upper level managers employed by integrated health care systems, group medical practices, and essential community providers that provide comprehensive, coordinated services shall be determined according to the following guidelines:

(a) Providers and upper level managers employed by systems that provide comprehensive, coordinated health care services shall be represented by their respective employers for the purposes of negotiating reimbursement with the payments board.

(b) In negotiating reimbursement with systems providing comprehensive, coordinated services, the payments board shall take into consideration the need for comprehensive systems to have flexibility in establishing provider and upper level manager reimbursement.

(c) Payment schedules shall be in effect for three years. However, payment adjustments may be made at the discretion of the payments board to meet the goals of the health insurance system.

(d) The payments board shall take into consideration regional differences in the cost of living and the need to recruit and retain skilled providers and upper level managers to the regions.

(e) The payments board shall establish a timetable for reimbursement for fee-for-service providers negotiations. In the event that an agreement on reimbursement is not reached according to the timetable established by the payments board, the payments board shall establish reimbursement rates, which shall be binding.

(f) Reimbursement negotiations shall be conducted consistent with the state action doctrine of the antitrust laws.

(10) The payments board shall annually report to the commissioner on the status of provider and upper level manager reimbursement, including satisfaction with reimbursement levels and the sufficiency of funds allocated by the commissioner for provider and upper level

manager reimbursement. The payments board shall recommend needed adjustments in the allocation for provider payments.

(a) The office of health care quality shall annually report to the commissioner on the impact of the bonus payments in improving quality of care, health outcomes, and management effectiveness. The payments board shall recommend needed adjustments in bonus allocations.

(b) The office of health planning shall annually report to the commissioner on the impact of the incentive payments in recruiting health professionals and upper level managers to underserved areas, in establishing the needed ratio of generalist to specialist providers, and in attracting and retaining nurse practitioners and physician assistants to the state and shall recommend needed adjustments.

(11) The commissioner shall establish an allocation for each region to fund regional operating and capital budgets for a period of three years. Allocations shall be disbursed to the regions on a quarterly basis.

(a) Integrated health care systems, essential community providers, and group medical practices that provide comprehensive, coordinated services may choose to be reimbursed on the basis of a capitated system operating budget or a noncapitated system operating budget that covers all costs of providing health care services.

(b) Providers choosing to function on the basis of a capitated or a noncapitated system operating budget shall submit three-year operating budget requests to the regional planning director, pursuant to standards and guidelines established by the commissioner.

(i) Providers may include in their operating budget requests reimbursement for ancillary health care or social services that were previously funded by money now received and disbursed by the health insurance fund.

(ii) No payment may be made from a capitated or noncapitated budget for a capital expense.

(c) Regional planning directors shall negotiate operating budgets with regional health care entities, which shall cover a period of three years.

(d) Operating and capitated budgets shall include health care workforce labor costs where unions represent employees working in systems functioning under capitated or noncapitated budgets, unions shall represent those employees in negotiations with the regional planning director and the payments board for the purpose of establishing their reimbursement.

(12) Health systems and medical practices functioning under capitated and noncapitated operating budgets shall immediately report any projected operating deficit to the regional planning director. The regional planning director shall determine whether projected deficits reflect appropriate increases in expenditures, in which case the director shall make an adjustment to the operating budget. If the director determines that deficits are not justifiable, no adjustment shall be made. If a regional planning director determines that adjustments to operating budgets will cause a regional revenue shortfall and that cost control measures may be required, the regional planning director shall report the possible revenue shortfall to the commissioner and take actions.

(13) Margins generated by a facility operating under a health system operating budget may be retained and used to meet the health care needs of the population.

(a) No margin may be retained if that margin was generated through inappropriate limitations on access to care or compromises in the quality of care or in any way that adversely affected or is likely to adversely affect the health of the persons receiving services from a facility, integrated health care system, group medical practice, or essential community provider functioning under a health insurance system operating budget.

(i) The chief medical officer shall evaluate the source of margin generation and report violations of this section to the commissioner.

(ii) The commissioner shall establish and enforce penalties for violations of this section.

(iii) Penalty payments collected pursuant to violations of this section shall be remitted to the health insurance fund for use in the Washington health insurance system.

(b) Facilities operating under health insurance system operating budgets may raise and expend funds from sources other than the Washington health insurance system including, but not limited to, private or foundation donors and other nonWashington health insurance system sources for purposes related to the goals of this act and in accordance with provisions of this act.

(14) During the transition the commissioner shall develop a capital management plan that shall include conflict-of-interest standards and that shall govern all capital investments and acquisitions undertaken in the Washington health insurance system.

(a) The plan shall include a framework, standards, and guidelines for all of the following:

(i) Standards whereby the office of health care planning shall oversee, assist in the implementation of, and ensure that the provisions of the capital management plan are enforced.

(ii) Assessment and prioritization of short-term and long-term Washington health insurance system capital needs on a statewide and regional basis.

(iii) Assessment of capital health care assets and capital health care asset shortages on a regional and statewide basis at the time this act is first implemented.

(iv) Development by the commissioner of a multiyear system capital development plan that supports health insurance system goals, priorities, and performance standards and meets the health needs of the population.

(v) Development, as part of the Washington health insurance system capital budget, of regional capital allocations that shall cover a period of three years.

(vi) Evaluation of, and support for, noninvestment means to meet health care needs including, but not limited to, improvements in administrative efficiency, care quality, and innovative service delivery, use, adaptation, or refurbishment of existing land and property and identification of publicly owned land or property that may be available to the Washington health insurance system and that may meet a capital need.

(vii) Development and maintenance of capital inventories on a regional basis, including the condition, utilization capacity, maintenance plan and costs, deferred maintenance of existing capital inventory, and excess capital capacity.

(viii) A process whereby those intending to make capital investments or acquisitions shall prepare a business case for making the investment or acquisition, including the full life-cycle costs of the project or acquisition, an environmental impact report that meets existing state standards, and a demonstration of how the investment or acquisition meets the health needs of the population it is intended to serve. Acquisitions include, but are not limited to, the acquisition of land, operational property, or administrative office space.

(ix) Standards and a process whereby the regional planning directors shall evaluate, accept, reject, or modify a business plan for a capital investment or acquisition. Decisions of a regional planning director may be appealed through a dispute resolution process established by the commissioner.

(x) Standards for binding project contracts between the health insurance system and the party developing a capital project or making a capital acquisition that shall govern all terms and conditions of capital investments and acquisitions, including terms and conditions for health insurance system grants, loans, lines of credit, and lease-purchase arrangements.

(xi) A process and standards whereby the health insurance fund shall negotiate terms and conditions of the Washington health insurance system liens, grants, lines of credit, and lease-purchase arrangements for capital investments and acquisitions. Terms and conditions negotiated by the health insurance fund shall be included in project contracts.

(xii) A plan for the commissioner and for the regional planning directors to issue requests for proposals and to oversee a process of competitive bidding for the development of capital projects that meet the needs of the Washington health insurance system and to fund, partially fund, or participate in seeking funding for those capital projects.

(xiii) Responses to requests for proposals and competitive bids shall include a description of how a project meets the service needs of the region and addresses the environmental impact report and shall include the full life-cycle costs of a capital asset.

(xiv) Requests for proposals shall address how intellectual property will be handled and shall include conflict-of-interest guidelines that meet standards established by the commissioner as part of the capital management plan.

(xv) A process and standards for periodic revisions in the capital management plan, including annual meetings in each region to discuss the plan and make recommendations for improvements in the plan.

(xvi) Standards for determining when a violation of these provisions shall be referred to the attorney general for investigation and possible prosecution of the violation.

(b) No registered lobbyist shall participate in or in any way attempt to influence the request for proposals or competitive bid process.

(c) Development of performance standards and a process to monitor and measure performance of those making capital health care investments and acquisitions, including those making capital investments pursuant to a state competitive bidding process.

(d) A process for earned autonomy from state capital investment oversight for those who demonstrate the ability to manage capital investment and capital assets effectively in accordance with Washington health insurance system standards, and standards for loss of earned autonomy when capital management is ineffective.

(e) Terms and conditions of capital project oversight by the Washington health insurance system shall be based on the performance history of the project developer. Providers may earn autonomy from oversight if they demonstrate effective capital planning and project management, pursuant to the goals and guidelines established by the commissioner. Providers who do not demonstrate such proficiency shall remain subject to oversight by the regional planning director or shall lose autonomy from oversight.

(f) In general, no capital investment may be made from an operating budget. However, guidelines shall be established for the types and levels of small capital investments that may be undertaken from an operating budget without the approval of the regional planning director.

(g) Any capital investments required for compliance with federal, state, or local regulatory requirements or quality assurance standards shall be exempt.

(15) Regional planning directors shall develop a regional capital development plan pursuant to the Washington health insurance system capital management plan established by the commissioner. In developing the regional capital development plan, the regional planning director shall do all of the following:

(a) Implement the standards and requirements of the capital management plan established by the commissioner.

(b) Develop a multiyear regional capital health management plan that supports regional health insurance system goals and the state capital management plan.

(c) Assist regional providers to develop capital budget requests pursuant to the regional capital budget plan and the Washington health insurance system capital management plan established by the commissioner.

(d) Receive and evaluate capital budget requests from regional providers.

(e) Establish ranking criteria to assess competing demands for capital.

(f) Participate in planning for needed earthquake retrofits. However, the cost of mandatory earthquake retrofits of health care facilities shall not be the responsibility of the Washington health insurance system.

(g) Conduct ongoing project evaluation to assure that terms and conditions of project funding are met.

(16) Services provided as a result of capital investments or acquisitions that do not meet the terms of the regional capital development plan and the capital management plan developed by the
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commissioner shall not be reimbursed by the Washington health insurance system.

(17) Assets financed by state grants, loans, lines of credit and lease-purchase arrangements shall be owned, operated, and maintained by the recipient of the grant, loan, line of credit, or lease-purchase arrangements, according to terms established at the time of issuance of the grant, loan, line of credit, or lease-purchase arrangement.

(a) Assets financed under long-term leases with the Washington health insurance system shall be transferred to public ownership at the end of the lease, unless the commissioner determines that an alternative disposition would be of greater benefit to the health insurance system, in which case the commissioner may authorize an alternative disposition.

(b) When an asset, which was in whole or in part financed by the health insurance system, is to be sold or transferred by a party that received health insurance system financing for purchase, lease, or construction of the asset, an impartial estimate of the fair market value of the asset shall be undertaken. The system shall receive a share of the fair market value of the asset at the time of its sale or transfer that is in proportion to the system's original investment. The system may elect to postpone receipt of its share of the value of the asset if the commissioner determines that the postponement meets the needs of the system.

(18) The health regions must make financial information available to the public when the Washington health insurance system contribution to a capital project is greater than twenty-five million dollars. Information shall include the purpose of the project or acquisition, its relation to Washington health insurance system goals, the project budget and the timetable for completion, environmental impact reports, any terms-related conflicts of interest, and performance standards and benchmarks.

(19) The commissioner shall establish a budget for the purchase of prescription drugs and durable and nondurable medical equipment for the health insurance system.

(a) The commissioner shall use the purchasing power of the state to obtain the lowest possible prices for prescription drugs and durable and nondurable medical equipment.

(b) The commissioner shall make discounted prices available to all Washington residents, licensed and accredited providers and facilities under the terms of their licenses and accreditation, health care providers, prescription drug and medical equipment wholesalers, and retailers of products approved for use in and included in the benefit package of the Washington health insurance system.

(20) The commissioner shall establish a budget to support research and innovation that has been recommended by the chief medical officer, the director of planning, the patient advocates, the partnerships for health, the technical advisory committee, and others as required by the commissioner. The research and innovation budget shall support the goals and standards of the Washington health insurance system.

(21) The commissioner shall establish a budget to support the training, development, and continuing education of health care providers and the health care workforce needed to meet the health care needs of the population and the goals and standards of the health insurance system.

(a) During the transition, the commissioner shall determine an appropriate level and duration of spending to support the retraining and job placement of persons who have been displaced from employment as a result of the transition to the new health insurance system.

(b) The commissioner shall establish guidelines for giving special consideration for employment to persons who have been displaced as a result of the transition to the new health insurance system.

(22) The commissioner shall establish a reserve budget pursuant to this section. The reserve budget may be used only for purposes set forth in this act.

(23) The commissioner shall establish a budget that covers all costs of administering the Washington health insurance system.

(a) Administrative costs on a system-wide basis shall be limited to

10 percent of system costs within five years of completing the transition to the Washington health insurance system.

(b) Administrative costs on a system-wide basis shall be limited to 5 percent of system costs within ten years of completing the transition to the Washington health insurance system.

(c) The commissioner shall ensure that the percentage of the budget allocated to support system administration stays within the allowable limits and shall continually seek means to lower system administrative costs.

(d) The commissioner shall report to the public, the regional planning directors, and others attending the annual health insurance system revenue and expenditures conference on the costs of administering the system and the regions and shall make recommendations for lowering administrative costs and receive recommendations for lowering administrative costs.

NEW SECTION. **Sec. 6.** (1) There is hereby created the Washington health insurance premium commission.

(a) The premium commission shall be composed of the following members:

(i) Three health economists with experience relevant to the functions of the premium commission. One shall be appointed by the speaker of the house, one shall be appointed by the senate committee on rules, and one shall be appointed by the governor.

(ii) Two representatives of Washington business community, with one representing small business. One shall be appointed by the governor, and the representative of small business shall be appointed by the senate committee on rules.

(iii) Two representatives from organized labor. One shall be appointed by the senate committee on rules, and one shall be appointed by the speaker of the house.

(iv) Two representatives of nonprofit organizations whose principal purpose includes promoting the establishment of a system of affordable health care in Washington. One shall be appointed by the

senate committee on rules, and one shall be appointed by the speaker of the house.

(v) One representative of a nonprofit advocacy organization with expertise in taxation policy whose principal purpose includes advocating for sustainable funding for the public infrastructure. This person shall be appointed by the speaker of the house.

(vi) Two members of the legislature who shall be members of a policy committee having jurisdiction over health care issues. One shall be appointed by the senate committee on rules, and one shall be appointed by the speaker of the house.

(vii) The executive officer of the franchise tax board.

(viii) The chair of the state board of equalization.

(ix) The director of the employment development department.

(x) The legislative analyst.

(xi) The secretary of the Washington health and human services agency.

(xii) The director of the department of finance.

(xiii) The state controller.

(xiv) The state treasurer.

(xv) The lieutenant governor.

(b) Upon appointment, the premium commission shall meet at least once a month. The premium commission shall elect a chair from its membership during its first meeting. The premium commission shall receive public comments during a portion of each of its meetings, and all of its meetings shall be conducted pursuant to the open public meetings act.

(2) The premium commission shall perform the following functions:

(a) Determine the aggregate costs of providing health insurance coverage pursuant to this act.

(b) Develop an equitable and affordable premium structure that will generate adequate revenue for the health insurance fund established and ensure stable and actuarially sound funding for the health insurance system.

(c) The premium commission shall perform the functions described in this section by considering existing financial simulations and analyses of affordable health care proposals.

(3) The premium structure developed by the premium commission shall satisfy the following criteria:

(a) Be means-based and generate adequate revenue to implement this division.

(b) To the greatest extent possible, ensure that all income earners and all employers contribute a premium amount that is affordable and that is consistent with existing funding sources for health care in Washington.

(c) Maintain the current ratio for aggregate health care contributions among the traditional health care funding sources, including employers, individuals, government, and other sources.

(d) Provide a fair distribution of monetary savings achieved from the establishment of a universal health care system.

(e) Coordinate with existing, ongoing funding sources from federal and state programs.

(f) Be consistent with state and federal requirements governing financial contributions for persons eligible for existing public programs.

(g) Comply with federal requirements.

(4) The premium commission shall seek expert and legal advice regarding the best method to structure premium payments consistent with existing employer-employee health care financing structures.

(5) The premium commission may take all of the following actions:

(a) Obtain grants from, and contract with, individuals and private, local, state, and federal agencies, organizations, and institutions, including institutions of higher education.

(b) Receive charitable contributions or any other source of income that may be lawfully received.

(6)(a) The premium commission may consult with additional persons, advisory entities, governmental agencies, members of the legislature, and legislative staff as it deems necessary to perform its functions. The premium commission shall seek structured input from

representatives of stakeholder organizations, policy institutes, and other persons with expertise in health care, health care financing, or universal health care models in order to ensure that it has the necessary information, expertise, and experience to perform its functions.

(b) The premium commission shall be supported by a reasonable amount of staff time, which shall be provided by the state agencies with membership on the premium commission. The premium commission may request data from, and utilize the technical expertise of, other state agencies.

(7) On or before January 1, 2011, the premium commission shall submit to the governor and the legislature a detailed recommendation for a premium structure in which all employed personnel in the state of Washington contribute this program. The premium commission shall submit a draft recommendation to the governor, the legislature, and the public at least 90 days prior to submission of the final recommendation.

(8) The premium commission shall seek input from the public on the draft recommendation.

NEW SECTION. **Sec. 7.** (1) The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all current federal payments to the state for health care be paid directly to the Washington health insurance system, which shall then assume responsibility for all benefits and services previously paid for by the federal government with those funds.

(a) In obtaining the waivers, exemptions, agreements, or legislation, the commissioner shall seek from the federal government a contribution for health care services in Washington that shall not decrease in relation to the contribution to other states as a result of the waivers, exemptions, agreements, or legislation.

(b)(i) The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all current state payments for health care and industrial insurance, shall be paid directly to the system, which shall then assume responsibility for all

benefits and services previously paid for by state government with those funds.

(ii) In obtaining the waivers, exemptions, agreements, or legislation, the commissioner shall seek from the legislature a contribution for health care services that shall not decrease in relation to state government expenditures for health care services in the year that this act was enacted, except that it may be corrected for change in state gross domestic product, the size and age of population, and the number of residents living below the federal poverty level.

(c) The commissioner shall establish formulas for equitable contributions to the Washington health insurance system from all Washington counties and other local government agencies.

(d) The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all county or other local government agency payments shall be paid directly to the Washington health insurance system.

(2) The system's responsibility for providing care shall be secondary to existing federal, state, or local governmental programs for health care services to the extent that funding for these programs is not transferred to the health insurance fund or that the transfer is delayed beyond the date on which initial benefits are provided under the system.

(3) In order to minimize the administrative burden of maintaining eligibility records for programs transferred to the system, the commissioner shall strive to reach an agreement with federal, state, and local governments in which their contributions to the health insurance fund shall be fixed to the rate of change of the state gross domestic product, the size and age of population, and the number of residents living below the federal poverty level.

(4) If, and to the extent that, federal law and regulations allow the transfer of medicaid, medicare funding to the system, the commissioner shall pay from the health insurance fund all premiums, deductible payments, and coinsurance for qualified medicare beneficiaries who are receiving benefits.

state of Washington. However, until such time as the role of all other payers for health care have been terminated, health care costs shall be collected from collateral sources whenever medical services provided to an individual are, or may be, covered services under a policy of insurance, health care service plan, or other collateral source available to that individual, or for which the individual has a right of action for compensation to the extent permitted by law.

(a) As used in this section, "collateral source" includes all of the following:

(i) Insurance policies written by insurers, including the medical components of automobile, homeowners, and other forms of insurance.

(ii) Health care service plans and pension plans.

(iii) Employers.

(iv) Employee benefit contracts.

(v) Government benefit programs.

(vi) A judgment for damages for personal injury.

(vii) Any third party who is or may be liable to an individual for health care services or costs.

(b) "Collateral source" does not include either of the following:

(i) A contract or plan that is subject to federal preemption.

(ii) Any governmental unit, agency, or service, to the extent that subrogation is prohibited by law. An entity described in this subsection is not excluded from the obligations imposed by this section by virtue of a contract or relationship with a governmental unit, agency, or service.

(c) The commissioner shall attempt to negotiate waivers, seek federal legislation, or make other arrangements to incorporate collateral sources in Washington into the Washington health insurance system.

(2) Whenever an individual receives health care services under the system and he or she is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, he or she shall notify the health care provider and provide information identifying the collateral source, the nature and extent of coverage or entitlement, and other relevant information. The health care

provider shall forward this information to the commissioner. The individual entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source shall provide additional information as requested by the commissioner.

(3) The system shall seek reimbursement from the collateral source for services provided to the individual, and may institute appropriate action, including suit, to recover the reimbursement. Upon demand, the collateral source shall pay to the health insurance fund the sums it would have paid or expended on behalf of the individual for the health care services provided by the system. In addition to any other right to recovery provided in this section, the commissioner shall have the same right to recover the reasonable value of benefits from a collateral source as provided to the director of health services in the manner so provided.

(4) If a collateral source is exempt from subrogation or the obligation to reimburse the system as provided in this section, the commissioner may require that an individual who is entitled to medical services from the source first seek those services from that source before seeking those services from the system. To the extent permitted by federal law, contractual retiree health benefits provided by employers shall be subject to the same subrogation as other contracts, allowing the Washington health insurance system to recover the cost of services provided to individuals covered by the retiree benefits, unless and until arrangements are made to transfer the revenues of the benefits directly to the Washington health insurance system.

(5) Default, underpayment, or late payment of any tax or other obligation imposed by this act shall result in the remedies and penalties provided by law, except as provided in this section. Eligibility for benefits shall not be impaired by any default, underpayment, or late payment of any tax or other obligation.

(6) The agency and the commissioner shall be exempt from the regulatory oversight and review procedures empowered to the office of administrative law. Actions taken by the agency including, but not limited to, the negotiating or setting of rates, fees, or prices, and

the promulgation of any and all regulations, shall be exempt from any review by the office of administrative law, except for sections addressing the publication of regulations.

(7) The Washington health insurance agency shall adopt regulations to implement the provisions of this act. The regulations may initially be adopted as emergency regulations, but those emergency regulations shall be in effect only from the effective date of this act until the conclusion of the transition period.

NEW SECTION. **Sec. 10.** (1) All Washington residents shall be eligible for the Washington health insurance system. Residency shall be based upon physical presence in the state with the intent to reside. The commissioner shall establish standards and a simplified procedure to demonstrate proof of residency.

(2) The commissioner shall establish a procedure to enroll eligible residents and provide each eligible individual with identification that can be used by health care providers to determine eligibility for services.

(3) It is the intent that the Washington health insurance system provide health care coverage to Washington residents who are temporarily out of the state. The commissioner shall determine eligibility standards for residents temporarily out of state for longer than 90 days who intend to return and reside in Washington and for nonresidents temporarily employed in Washington. Coverage for emergency care obtained out of state shall be at prevailing local rates. Coverage for nonemergency care obtained out of state shall be according to rates and conditions established by the commissioner. The commissioner may require that a resident be transported back to Washington when prolonged treatment of an emergency condition is necessary and when that transport will not adversely affect a patient's care or condition.

(4) Visitors to Washington shall be billed for all services received under the system. The commissioner may establish intergovernmental arrangements with other states and countries to provide reciprocal coverage for temporary visitors.

(5) All persons eligible for health benefits from Washington employers but who are working in another jurisdiction shall be eligible for health benefits under this act providing that they make payments equivalent to the payments they would be required to make if they were residing in Washington.

(a) All persons who under an employer-employee contract are eligible for retiree medical benefits, including retirees who elect to reside outside of Washington, shall remain eligible for those benefits providing that the contractually mandated payments for those benefits are made to the Washington health care fund, which shall assume financial responsibility for care provided under the terms of the contract.

(b) The commissioner may establish financial arrangements with states and foreign countries in order to facilitate meeting the terms of care provided by non Washington providers to Washington retirees, who shall be reimbursed at rates established by the commissioner.

(6) Unmarried, unemancipated minors shall be deemed to have the residency of their parent or guardian. If a minor's parents are deceased and a legal guardian has not been appointed, or if a minor has been emancipated by court order, the minor may establish his or her own residency.

(7) An individual shall be presumed to be eligible if he or she arrives at a health facility and is unconscious, comatose, or otherwise unable, because of his or her physical or mental condition, to document eligibility or to act in his or her own behalf, or if the patient is a minor, the patient shall be presumed to be eligible, and the health facility shall provide care as if the patient was eligible.

(a) Any individual shall be presumed to be eligible when brought to a health facility.

(b) Any individual involuntarily committed to an acute psychiatric facility or to a hospital with psychiatric beds providing for involuntary commitment shall be presumed eligible.

(c) All health facilities subject to state and federal provisions governing emergency medical treatment shall continue to comply with those provisions.

(d) In the event of an influx of people into the state for the purposes of receiving medical care, the commissioner shall establish an eligibility waiting period and other criteria needed to ensure the fiscal stability of the health insurance system.

NEW SECTION. **Sec. 11.** (1) Any eligible individual may choose to receive services under the Washington health insurance system from any willing professional health care provider participating in the system. No health care provider may refuse to care for a patient solely on any basis that is specified in the prohibition of employment discrimination.

(2) Covered benefits in this chapter shall include all medical care determined to be medically appropriate by the consumer's health care provider. Covered benefits include, but are not limited to, the following:

(a) Inpatient and outpatient health facility services.

(b) Inpatient and outpatient professional health care provider services by licensed health care professionals.

(c) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services.

(d) Durable medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids and their repair.

(e) Rehabilitative care.

(f) Emergency transportation and necessary transportation for health care services for disabled and indigent persons.

(g) Language interpretation and translation for health care services, including sign language for those unable to speak, or hear, or who are language impaired, and Braille translation or other services for those with no or low vision.

(h) Child and adult immunizations and preventive care.

(i) Health education.

(j) Hospice care.

(k) Home health care.

(l) Prescription drugs that are listed on the system formulary. Nonformulary prescription drugs may be included where standards and criteria established by the commissioner are met.

(m) Mental and behavioral health care.

(n) Dental care.

(o) Podiatric care.

(p) Chiropractic care.

(q) Acupuncture.

(r) Blood and blood products.

(s) Emergency care services.

(t) Vision care.

(u) Adult day care.

(v) Case management and coordination to ensure services necessary to enable a person to remain safely in the least restrictive setting.

(w) Substance abuse treatment.

(x) Care of up to one hundred days in a skilled nursing facility following hospitalization.

(y) Dialysis.

(z) Benefits offered by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means provided by a duly authorized and accredited practitioner or nurse of that bona fide church, sect, denomination, or organization.

(3) The commissioner may expand benefits beyond the minimum benefits described in this chapter when expansion meets the intent of this act and when there are sufficient funds to cover the expansion.

(4) The following health care services shall be excluded from coverage by the system:

(a) Health care services determined to have no medical indication by the commissioner and the chief medical officer.

(b) Surgery, dermatology, orthodontia, prescription drugs, and other procedures primarily for cosmetic purposes, unless required to correct a congenital defect, restore or correct a part of the body that has been altered as a result of injury, disease, or surgery, or

determined to be medically necessary by a qualified, licensed health care provider in the system.

(c) Private rooms in inpatient health facilities where appropriate nonprivate rooms are available, unless determined to be medically necessary by a qualified, licensed health care provider in the system.

(d) Services of a professional health care provider or facility that is not licensed or accredited by the state except for approved services provided to a Washington resident who is temporarily out of the state.

(5) No copayments or deductible payments may be established for preventive care as determined by a patient's primary care provider.

(a) No copayments or deductible payments may be established when prohibited by federal law.

(b) The commissioner shall establish standards and procedures for waiving copayments or deductible payments. Waivers of copayments or deductible payments shall not affect the reimbursement of health care providers.

(c) Any copayments established pursuant to this section and collected by health care providers shall be transmitted to the treasurer to be deposited to the credit of the health insurance fund.

(d) Nothing in this act shall be construed to diminish the benefits that an individual has under a collective bargaining agreement.

(e) Nothing in this act shall preclude employees from receiving benefits available to them under a collective bargaining agreement or other employee-employer agreement that are superior to benefits under this act.

NEW SECTION. Sec. 12. (1) All health care providers licensed or accredited to practice in Washington may participate in the Washington health insurance system.

(a) No health care provider whose license or accreditation is suspended or revoked may be a participating health care provider.

(b) If a health care provider is on probation, the licensing or the accrediting agency shall monitor the health care provider in

question. The licensing or accrediting agency shall report to the chief medical officer at intervals established by the chief medical officer, on the status of providers who are on probation, on measures undertaken to assist providers to return to practice, and to resolve complaints made by patients.

(c) Health care providers may accept eligible persons for care according to the provider's ability to provide services needed by the applicant and according to the number of patients a provider can treat without compromising safety and care quality. A provider may accept patients in the order of time of application.

(d) A health care provider shall not refuse to care for a patient solely on any basis that is specified in the prohibition of employment discrimination contained in the fair employment and housing act.

(e) Choice of provider:

(i) Persons eligible for health care services under this act may choose a primary care provider.

(A) Primary care providers include family practitioners, general practitioners, internists and pediatricians, nurse practitioners and physician assistants practicing under supervision as defined in Washington codes, and doctors of osteopathy licensed to practice as general doctors.

(B) Women may choose an obstetrician-gynecologist, in addition to a primary provider.

(ii) Persons who choose to enroll with integrated health care systems, group medical practices, or essential community providers that offer comprehensive services shall retain membership for at least one year after an initial three-month evaluation period during which time they may withdraw for any reason.

(A) The three-month period shall commence on the date when an enrollee first sees a primary provider.

(B) Persons who want to withdraw after the initial three-month period shall request a withdrawal pursuant to dispute resolution procedures established by the commissioner and may request assistance from the patient advocate in the dispute process. The dispute shall

be resolved in a timely fashion and shall have no adverse effect on the care a patient receives.

(iii) Persons needing to change primary providers because of health care needs that their primary provider cannot meet may change primary providers at any time.

(2) Primary care providers shall coordinate the care a patient receives or shall ensure that a patient's care is coordinated.

(a) Patients shall have a referral from their primary care provider, or from an emergency provider rendering care to them in the emergency room or other accredited emergency setting, or from a provider treating a patient for an emergency condition in any setting, or from their obstetrician/gynecologist, to see a physician or nonphysician specialist whose services are covered by this act, unless the patient agrees to assume the costs of care, in which case a referral is not needed. A referral shall not be required to see a dentist.

(b) Referrals shall be based on the medical needs of the patient and on guidelines, which shall be established by the chief medical officer to support clinical decision making.

(c) Referrals shall not be restricted or provided solely because of financial considerations. The chief medical officer shall monitor referral patterns and intervene as necessary to assure that referrals are neither restricted nor provided solely because of financial considerations.

(d) For the first six months of system operation, no specialist referral shall be required for patients who had been receiving care from a specialist prior to the initiation of the system. Beginning with the seventh month of system operation, all patients shall be required to obtain a referral from a primary or emergency care provider for specialty care if the care is to be paid for by the system. No referral is required if a patient pays the full cost of the specialty care and the specialist accepts that payment arrangement.

(e) Where referral systems are in place prior to the initiation of the system, the chief medical officer shall review the referral

systems to assure that they meet health insurance system standards for care quality and shall assure needed changes are implemented so that all Washington residents receive the same standards of care quality.

(f) A specialist may serve as the primary provider if the patient and the provider agree to this arrangement and if the provider agrees to coordinate the patient's care or to ensure that the care the patient receives is coordinated.

(g) The commissioner shall establish or ensure the establishment of a computerized referral registry to facilitate the referral process and to allow a specialist and a patient to easily determine whether a referral has been made pursuant to this act.

(h) A patient may appeal the denial of a referral through the dispute resolution procedures established by the commissioner and may request the assistance of the patient advocate during the dispute resolution process.

(3)(a) The purpose of the office of health planning is to plan for the short-term and long-term health needs of the population pursuant to the health care and finance standards established by the commissioner and by this act.

(b) The office shall be headed by a director appointed by the commissioner. The director shall do all of the following:

(i) Administer all aspects of the office of health planning.

(ii) Serve on the health insurance policy board.

(iii) Establish performance criteria in measurable terms for health care goals in consultation with the chief medical officer, the regional health officers and directors, and others with experience in health care outcomes measurement and evaluation.

(iv) Evaluate the effectiveness of performance criteria in accurately measuring quality of care, administration, and planning.

(v) Assist the health care regions to develop operating and capital requests pursuant to health care and finance guidelines established by the commissioner and by this act. In assisting regions, the director shall do all of the following:

(A) Identify medically undeserved areas and health service and asset shortages.

(B) Identify disparities in health outcomes.

(C) Establish conventions for the definition, collection, storage, analysis, and transmission of data for use by the health insurance system.

(D) Establish electronic systems that support dissemination of information to providers and patients about integrated health network and integrated care systems community-based health care resources.

(E) Support establishment of comprehensive health care databases using uniform methodology that is compatible between the regions and between the regions and the state health insurance agency.

(F) Provide information to support effective regional planning and innovation.

(G) Provide information to support interregional planning, including planning for access to specialized centers that perform a high volume of procedures for conditions requiring highly specialized treatments, including emergency and trauma and other interregional access to needed care, and planning for coordinated interregional capital investment.

(H) Provide information for, and participate in, earthquake retrofit planning.

(I) Evaluate regional budget requests and make recommendations to the commissioner about regional revenue allocations.

(vi) Estimate the health care workforce required to meet the health needs of the population pursuant to the standards and goals established by the commissioner, the costs of providing the needed workforce, and, in collaboration with regional planners, educational institutions, the governor, and the legislature, develop short-term and long-term plans to meet those needs, including a plan to finance needed training.

(vii) Estimate the number and types of health facilities required to meet the short-term and long-term health needs of the population and the projected costs of needed facilities. In collaboration with the commissioner, regional planning directors and health officers, the chief medical officer, the governor, and the legislature, develop plans to finance and build needed facilities.

(4) The technical advisory group shall explore the feasibility and the value to the health of the population of the following electronic initiatives:

(a) Establish integrated statewide health care databases to support health care planning and determine which databases should be established on a statewide basis and which should be established on a regional basis.

(b) Assure that databases have uniform methodology and formats that are compatible between regions and between the regions and the state insurance agency.

(c) Establish mandatory database reporting requirements and penalties for noncompliance. Monitor the effectiveness of reporting and make needed improvements.

(d) Establish means for anonymous reporting to the chief medical officer and regional medical officers of medical errors and other related problems, and for anonymous reporting to the commissioner and regional planning directors of problems related to ineffective management, and establish guidelines for protection of persons coming forward to report these problems.

(e) In collaboration with the chief medical officer and state and regional patient advocates, investigate the costs and benefits of electronic and online scheduling systems and means of provider-patient communication that allow for electronic visits, and make recommendations to the chief medical officer regarding the use of these concepts in the health insurance system.

(f) In collaboration with the chief medical officer, establish electronic systems and other means that support the use of standards of care based on clinical efficacy to guide clinical decision making by all who provide services in the Washington health insurance system.

(g) In collaboration with the chief medical officer, support the development of disease management programs and their use in the health insurance system.

(h) Establish electronic initiatives that lower administration costs.

(i) Collaborate with the chief medical officer and regional medical officers to assure the development of software systems that link clinical guidelines to individual patient conditions, and guide clinicians through diagnosis and treatment algorithms derived from research based on clinical efficacy and best medical practices.

(j) Collaborate with the chief medical officer and regional medical officers to assure the development of software systems that offer providers access to guidelines that are appropriate for their specialty and that include current information on prevention and treatment of disease.

(k) In collaboration with the partnerships for health and regional health officers, establish web-based patient-centered information systems that assist people to promote and maintain health and provide information on health conditions and recent developments in treatment.

(l) Establish electronic systems and other means to provide patients with easily understandable information about the performance of health care providers. This shall include, but not be limited to, information about the experience that providers have in the field or fields in which they deliver care, the number of years they have practiced in their field, and, in the case of medical and surgical procedures, the number of procedures they have performed in their area or areas of specialization.

(m) Establish electronic systems that facilitate provider continuing medical education that meets licensure requirements.

(n) Recommend to the commissioner the means to link health care research with the goals and priorities of the health insurance system.

(5) The director of health planning shall establish standards for culturally and linguistically competent care.

(a) The director shall annually evaluate the effectiveness of standards for culturally and linguistically competent care and make recommendations to the commissioner, the patient advocate, and the chief medical officer for needed improvements. In evaluating the standards for culturally and linguistically sensitive care, the director shall establish a process to receive concerns and comments from consumers.

(b) The director shall pursue available federal financial participation for the provision of a language services program that supports health insurance system goals.

(6) Within the agency, the commissioner shall establish the office of health care quality.

(a) The office shall be headed by the chief medical officer who shall serve regarding qualifications for appointed health insurance system officers.

(b) The purpose of the office of health care quality is the following:

(i) Support the delivery of high quality, coordinated health care services that enhance health, prevent illness, disease, and disability, slow the progression of chronic diseases, and improve personal health management.

(ii) Promote efficient care delivery.

(iii) Establish processes for measuring, monitoring, and evaluating the quality of care delivered in the health insurance system, including the performance of individual providers.

(iv) Establish means to make changes needed to improve care quality, including innovative programs that improve quality.

(v) Promote patient, provider, and employer satisfaction with the health insurance system.

(vi) Assist regional planning directors and medical officers in the development and evaluation of regional operating and capital budget requests.

(7) In supporting the goals of the office of health care quality, the chief medical officer shall do all of the following:

(a) Administer all aspects of the office.

(b) Serve on the health insurance policy board.

(c) Collaborate with regional medical officers, directors, health care providers, and consumers, the director of planning, the patient advocate, and partnerships for health directors to develop community-based networks of solo providers, small group practices, essential community providers, and providers of patient care support services in

order to offer comprehensive, multidisciplinary, coordinated services to patients.

(d) Establish standards of care based on clinical efficacy for the health insurance system which shall serve as guidelines to support providers in the delivery of high quality care. Standards shall be based on the best evidence available at the time and shall be continually updated. Standards are intended to support the clinical judgment of individual providers, not to replace it and to support clinical decisions based on the needs of individual patients.

(e) In establishing standards, the chief medical officer shall do all of the following:

(i) Draw on existing standards established by Washington health care institutions, on peer-created standards, and on standards developed by other institutions that have had a positive impact on care quality, such as the centers for disease control, the national quality forum, and the agency for health care quality and research.

(ii) Collaborate with regional medical officers in establishing regional goals, priorities, and a timetable for implementation of standards of care.

(iii) Assure a process for patients to provide their views on standards of care to the patient advocate who shall report those views to the chief medical officer.

(iv) Collaborate with the director of health planning and regional medical officers to support the development of computer software systems that link clinical guidelines to individual patient conditions, guide clinicians through diagnosis and treatment algorithms based on research and best medical practices based on clinical efficacy, offer access to guidelines appropriate to each medical specialty, and offer current information on disease prevention and treatment and that support continuing medical education.

(v) Where referral systems for access to specialty care are in place prior to the initiation of the health insurance system, the chief medical officer shall review the referral systems to assure that they meet health insurance system standards for care quality and shall

assure that needed changes are implemented so that all Washington residents receive the same standards of care quality.

(f) In collaboration with the director of health planning and regional medical officer, the chief medical officer shall implement means to measure and monitor the quality of care delivered in the health insurance system. Monitoring systems shall include, but shall not be limited to, peer and patient performance reviews.

(g) The chief medical officer shall establish means to support individual providers and health systems in correcting quality of care problems, including time frames for making needed improvements and means to evaluate the effectiveness of interventions.

(h) In collaboration with regional medical officers and directors and the director of health planning, the chief medical officer shall establish means to identify medical errors and their causes and develop plans to prevent them. Means shall include a system for anonymous reporting of errors, and guidelines to protect those who report the errors against recrimination, including job demotion, promotion discrimination, or job loss.

(i) The chief medical officer shall convene an annual statewide conference to discuss medical errors that occurred during the year, their causes, means to prevent errors, and the effectiveness of efforts to decrease errors.

(j) The chief medical officer shall recommend to the commissioner a benefits package based on clinical efficacy for the health insurance system, including priorities for needed benefit improvements. In making recommendations, the chief medical officer shall do all of the following:

(i) Identify safe and effective treatments.

(ii) Evaluate and draw on existing benefit packages.

(iii) Receive comments and recommendations from health care providers about benefits that meet the needs of their patients.

(iv) Receive comments and recommendations made directly by patients or indirectly through the patient advocate.

(v) Identify and recommend to the commissioner and the health insurance policy board innovative approaches to health promotion,

disease and injury prevention, education, research, and care delivery for possible inclusion in the benefit package.

(vi) Identify complementary and alternative modalities that have been shown by the national institutes of health, division of complementary and alternative medicine to be safe and effective for possible inclusion as covered benefits.

(vii) Recommend to the commissioner and update as appropriate, pharmaceutical and durable and nondurable medical equipment formularies based on clinical efficacy. In establishing the formularies the chief medical officer shall establish a pharmacy and therapeutics committee composed of pharmacy and medical health care providers, representatives of health facilities, and organizations that have system formularies in place at the time the system is implemented and other experts that shall do all of the following:

(A) Identify safe and effective pharmaceutical agents for use in the Washington health insurance system.

(B) Draw on existing standards and formularies.

(C) Identify experimental drugs and drug treatment protocols for possible inclusion in the formulary.

(D) Review formularies in a timely fashion to ensure that safe and effective drugs are available and that unsafe drugs are removed from use.

(E) Assure the timely dissemination of information needed to prescribe safely and effectively to all Washington providers and the development and utilization of electronic dispensing systems that decrease pharmaceutical dispensing errors.

(F) Establish standards and criteria and a process for providers to seek authorization for prescribing pharmaceutical agents and durable and nondurable medical equipment that are not included in the system formulary. No standard or criteria shall impose an undue administrative burden on patients, health care providers, including pharmacies and pharmacists, and none shall delay care a patient needs.

(G) Develop standards and criteria and a process for providers to request authorization for services and treatments, including

experimental treatments that are not included in the system benefit package.

(viii) Where such processes are in place when the health insurance system is initiated, the chief medical officer shall review the systems to assure that they meet health insurance system standards for care quality and shall assure that needed changes are implemented so that all Washington residents receive the same standards of care quality.

(ix) No standard or criteria shall impose an undue administrative burden on a provider or a patient and none shall delay the care a patient needs.

(x) In collaboration with the director of health planning, regional planning directors, and regional medical officers, identify appropriate ratios of general medical providers to specialty medical providers on a regional basis in order to meet the health care needs of the population and the goals of the health insurance system.

(xi) Recommend to the commissioner and to the payment board, financial and nonfinancial incentives and other means to achieve recommended provider ratios.

(xii) Collaborate with the director of health planning and regional medical officers and patient advocates in development of electronic initiatives.

(xiii) Collaborate with the commissioner, the regional health officers, the directors of the payments board, and the health insurance fund to formulate a provider reimbursement model that promotes the delivery of coordinated, high quality health services in all sectors of the health insurance system and creates financial and other incentives for the delivery of high quality care.

(xiv) Establish or assure the establishment of continuing medical education programs about advances in the delivery of high quality of care.

(xv) Convene an annual statewide quality of care conference to discuss problems with care quality and to make recommendations for changes needed to improve care quality. Participants shall include regional medical directors, health care providers, providers,

patients, policy experts, experts in quality of care measurement, and others.

(xvi) Annually report to the commissioner, the health insurance policy board, and the public on the quality of care delivered in the health insurance system, including improvements that have been made and problems that have been identified during the year, goals for care improvement in the coming year and plans to meet these goals.

(xvii) No person working within the agency, or on a pharmacy and therapeutics committee or serving as a consultant to the agency or a pharmacy and therapeutics committee, may receive fees or remuneration of any kind from a pharmaceutical company.

(8) The patient advocate, in collaboration with the chief medical officer, the regional patient advocates, medical officers, and directors, shall establish a program in the state health insurance agency and in each region called the "partnerships for health."

(a) The purpose of the partnerships for health is to improve health through community health initiatives, to support the development of innovative means to improve care quality, to promote efficient, coordinated care delivery, and to educate the public about the following:

- (i) Personal maintenance of health.
- (ii) Prevention of disease.
- (iii) Improvement in communication between patients and providers.
- (iv) Improving quality of care.

(b) The patient advocate shall work with the community and health care providers in proposing partnerships for health projects and in developing project budget requests that shall be included in the regional budget request to the commissioner.

(c) In developing educational programs, the partnerships for health shall collaborate with educators in the region.

(d) Partnerships for health shall support the coordination of the Washington health insurance system and public health system programs.

(9) The chief medical officer shall establish an independent medical review system to act as an independent, external medical review process for the health care system to provide timely

examinations of disputed health care services and coverage decisions regarding experimental and investigational therapies to ensure the system provides efficient, appropriate, high quality health care, and that the health care system is responsive to member disputes.

(a) For the purposes of this section, "disputed health care service" means any health care service eligible for coverage and payment under the benefits package of the health care system that has been denied, modified, or delayed by a decision of the system, or by one of its contracting providers, in whole or in part, due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision. If the system, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the system, the statement of decision shall clearly specify the provisions of the system that exclude coverage.

(b) For the purposes of this section, "coverage decision" means the approval or denial of the health care system, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care system.

(c) Coverage decisions regarding experimental or investigational therapies for individual members who meet all of the following criteria are eligible for review by the independent medical review system:

(i) The member has a life-threatening or seriously debilitating condition.

(ii) For purposes of this section, "life-threatening" means either or both of the following:

(A) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(B) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

(iii) For purposes of this section, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

(iv) The member's physician certifies that the member has a condition, as defined in (e)(i) of this subsection, for which standard therapies have not been effective in improving the condition of the enrollee, for which standard therapies would not be medically appropriate for the member, or for which there is no more beneficial standard therapy covered by the system than the therapy proposed.

(v) Either (A) the member's physician, who is under contract with or employed by the system, has recommended a drug, device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to the member than any available standard therapies, or

(B) The member, or the member's physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's condition, has requested a therapy that, based on two documents from the medical and scientific evidence, is likely to be more beneficial for the member than any available standard therapy. The physician certification pursuant to this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this subsection shall be construed to require the system to pay for the services of a nonparticipating physician provided pursuant to this act, that are not otherwise covered pursuant to the system benefits package.

(vi) The member has been denied coverage by the system for a drug, device, procedure, or other therapy recommended or requested.

(vii) The specific drug, device, procedure, or other therapy recommended pursuant to this subsection would be a covered service, except for the system's determination that the therapy is experimental or investigational.

(viii) All member grievances involving a disputed health care service are eligible for review under the independent medical review system if the requirements of this section are met. If the chief medical officer finds that a patient grievance involving a disputed Code Rev/KK:cro

health care service does not meet the requirements of this section for review under the independent medical review system, the enrollee request for review shall be treated as a request for the chief medical officer to review the grievance. All other enrollee grievances, including grievances involving coverage decisions, remain eligible for review by the chief medical officer.

(ix) In any case in which an enrollee or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical appropriateness, the chief medical officer shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review as provided under this act.

(x) The chief medical officer shall be the final arbiter when there is a question as to whether an enrollee grievance is a disputed health care service or a coverage decision. The chief medical officer shall establish a process to complete an initial screening of an enrollee grievance. If there appears to be any medical appropriateness issue, the grievance shall be resolved pursuant to an independent medical review.

(d) For purposes of this chapter, an enrollee may designate an agent to act on his or her behalf. The provider may join with or otherwise assist the enrollee in seeking an independent medical review, and may advocate on behalf of the enrollee.

(e) The independent medical review process authorized by this section is in addition to any other procedures or remedies that may be available.

(f) The office of the chief medical officer shall prominently display in every relevant informational brochure, on copies of health care system procedures for resolving grievances, on letters of denials issued by either the health care system or its contracting providers, on the grievance forms, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the health care system, or by one of its contracting providers.

(i) An enrollee may apply to the chief medical officer for an independent medical review when all of the following conditions are met:

(A) The enrollee's health care provider has recommended a health care service as medically appropriate.

(B) The enrollee has received urgent care or emergency services that a provider determined was medically appropriate.

(C) The enrollee seeks coverage for experimental or investigational therapies.

(D) The enrollee, in the absence of a provider recommendation under (c)(v)(A) of this subsection or the receipt of urgent care or emergency services by a provider, has been seen by a system provider for the diagnosis or treatment of the medical condition for which the enrollee seeks independent review. The health care system shall expedite access to a system provider upon request of an enrollee. The system provider need not recommend the disputed health care service as a condition for the enrollee to be eligible for an independent review.

(E) The disputed health care service has been denied, modified, or delayed by the health care system, or by one of its contracting providers, based in whole or in part on a decision that the health care service is not medically appropriate.

(F) The enrollee has filed a grievance with the chief medical officer and the disputed decision is upheld or the grievance remains unresolved after 30 days. The enrollee shall not be required to participate in the health care system's grievance process for more than 30 days. In the case of a grievance that requires expedited review, the enrollee shall not be required to participate in the health care system's grievance process for more than three days.

(ii) An enrollee may apply to the chief medical officer for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically appropriate, within six months of any of the qualifying periods or events. The chief medical officer may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

(iii) The enrollee shall pay no application or processing fees of any kind.

(iv) Upon notice from the chief medical officer that the enrollee has applied for an independent medical review, the health care system or its contracting providers shall provide to the independent medical review organization designated by the chief medical officer a copy of all of the following documents within three business days of the health care system's receipt of the chief medical officer's notice of a request by an enrollee for an independent review:

(A) A copy of all of the enrollee's medical records in the possession of the health care system or its contracting providers relevant to each of the following:

(I) The enrollee's medical condition.

(II) The health care services being provided by the health care system and its contracting providers for the condition.

(III) The disputed health care services requested by the enrollee for the condition.

(B) Any newly developed or discovered relevant medical records in the possession of the health care system or its contracting providers after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The system shall concurrently provide a copy of medical records required by this subsection to the enrollee or the enrollee's provider, if authorized by the enrollee, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

(C) A copy of all information provided to the enrollee by the system and any of its contracting providers concerning health care system and provider decisions regarding the enrollee's condition and care, and a copy of any materials the enrollee or the enrollee's provider submitted to the health care system and to the health care system's contracting providers in support of the enrollee's request for disputed health care services. This documentation shall include the written response to the enrollee's grievance. The confidentiality

of any enrollee medical information shall be maintained pursuant to applicable state and federal laws.

(D) A copy of any other relevant documents or information used by the health care system or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the system and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity. The system shall concurrently provide a copy of documents required by this subsection, except for any information found by the chief medical officer to be legally privileged information, to the enrollee and the enrollee's provider. The chief medical officer and the independent review organization shall maintain the confidentiality of any information found by the chief medical officer to be the proprietary information of the health care system.

(11) If there is an imminent and serious threat to the health of the enrollee, all necessary information and documents shall be delivered to an independent medical review organization within 24 hours of approval of the request for review. In reviewing a request for review, the chief medical officer may waive the requirement that the enrollee follow the system's grievance process in extraordinary and compelling cases, where the chief medical officer finds that the enrollee has acted reasonably.

(a) The chief medical officer shall expeditiously review requests and immediately notify the enrollee in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. The health care system shall promptly issue a notification to the enrollee, after submitting all of the required material to the independent medical review organization that includes an annotated list of documents submitted, and offer the enrollee the opportunity to request copies of those documents from the health care system. The chief medical officer shall promptly approve enrollee requests whenever the health care system has agreed that the case is eligible for an independent medical review. To the extent an enrollee request for independent

review is not approved by the chief medical officer, the enrollee request shall be treated as an immediate request for the chief medical officer to review the grievance.

(b) An independent medical review organization shall conduct the review and any regulations or orders of the chief medical officer adopted pursuant thereto. The organization's review shall be limited to an examination of the medical necessity of the disputed health care services and shall not include any consideration of coverage decisions or other contractual issues.

(c) The chief medical officer shall contract with one or more independent medical review organizations in the state to conduct reviews for purposes of this section. The independent medical review organizations shall be independent of the health care system. The chief medical officer may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this section that an organization shall be required to meet in order to qualify for participation in the independent medical review system and to assist the chief medical officer in carrying out its responsibilities.

(d) The independent medical review organizations and the medical professionals retained to conduct reviews shall be deemed to be medical consultants.

(e) The independent medical review organization, any experts it designates to conduct a review, or any officer, chief medical officer, or employee of the independent medical review organization shall not have any material professional, familial, or financial affiliation, as determined by the patient advocate, with any of the following:

(i) The health care system.

(ii) Any officer or employee of the health care system.

(iii) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(iv) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the health care system, would be provided.

(v) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the patient whose treatments under review, or the alternative therapy, if any, recommended by the health care system.

(vi) The enrollee or the enrollee's immediate family.

(12) Upon receipt of information and documents related to a case, the medical professional reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the enrollee, provider reports, as well as any other information submitted to the organization as authorized by the chief medical officer or requested from any of the parties to the dispute by the reviewers. If reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria.

(a) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically appropriate based on the specific medical needs of the patient and any of the following:

(i) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(ii) Nationally recognized professional standards.

(iii) Expert opinion.

(iv) Generally accepted standards of medical practice.

(v) Treatments likely to provide a benefit to an enrollee for conditions for which other treatments are not clinically efficacious.

(b) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the chief medical officer. If the disputed health care service has not been provided and the enrollee's provider or the chief medical officer certifies in writing that an imminent and serious threat to the health of the enrollee may exist including, but not

limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the enrollee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information. Subject to the approval of the chief medical officer, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the chief medical officer for up to three days in extraordinary circumstances or for good cause.

(c) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically appropriate. Each analysis shall cite the enrollee's medical condition, the relevant documents in the record, and the relevant findings. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(d) The independent medical review organization shall provide the chief medical officer, the health care system, the enrollee, and the enrollee's provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization, except in cases where the reviewer is called to testify and in response to court orders. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(e) The chief medical officer shall immediately adopt the determination of the independent medical review organization, and shall promptly issue a written decision to the parties that shall be binding on the health care system.

(f) After removing the names of the parties including, but not limited to, the enrollee and all medical providers, the chief medical officer's decisions adopting a determination of an independent medical review organization shall be made available by the chief medical officer to the public upon request, at the chief medical officer's cost and after considering applicable laws governing disclosure of public records, confidentiality, and personal privacy.

(13) Upon receiving the decision adopted by the chief medical officer that a disputed health care service is medically appropriate, the health care system shall promptly implement the decision. In the case of reimbursement for services already rendered, the health care provider or enrollee, whichever applies, shall be paid within five working days. In the case of services not yet rendered, the health care system shall authorize the services within five working days of receipt of the written decision from the chief medical officer, or sooner if appropriate for the nature of the enrollee's medical condition, and shall inform the enrollee and provider of the authorization.

(a) The health care system shall not engage in any conduct that has the effect of prolonging the independent review process.

(b) The chief medical officer shall require the health care system to promptly reimburse the enrollee for any reasonable costs associated with those services when the chief medical officer finds that the disputed health care services were a covered benefit and the services are found by the independent medical review organization to have been medically appropriate and the enrollee's decision to secure the services outside of the health care system provider network was reasonable under the emergency or urgent medical circumstances.

(14) The chief medical officer shall utilize a competitive bidding process and use any other information on program costs reasonable to establish a per-case reimbursement schedule to pay the costs of independent medical review organization reviews, which may vary depending on the type of medical condition under review and on other relevant factors.

(15) The costs of the independent medical review system for enrollees shall be borne by the health care system.

NEW SECTION. **Sec. 13.** Notwithstanding any other provisions of law, the effective date of this act shall be the date the secretary of health and human services notifies the secretary of the senate and the chief clerk of the house of representatives that he or she has determined that the health insurance fund will have sufficient revenues to fund the costs of implementing this act. No state entity shall incur any transition or planning costs prior to that date. However, this prohibition shall not apply to activities of the Washington health insurance premium commission which shall become operative on January 1, 2010.

NEW SECTION. **Sec. 14.** This act takes effect January 1, 2010.

NEW SECTION. **Sec. 15.** The secretary of the department of health, the secretary of the department of social and health services, and the insurance commissioner are directed to report to the appropriate committees of the legislature on how best to implement the terms of this act, in the event of its passage.

NEW SECTION. **Sec. 16.** Sections 1 through 14 of this act constitute a new chapter in Title 48 RCW.