
ENGROSSED SECOND SUBSTITUTE HOUSE BILL 2572

AS AMENDED BY THE SENATE

Passed Legislature - 2014 Regular Session

State of Washington 63rd Legislature 2014 Regular Session

By House Appropriations (originally sponsored by Representative
Cody; by request of Governor Inslee)

READ FIRST TIME 02/11/14.

1 AN ACT Relating to improving the effectiveness of health care
2 purchasing and transforming the health care delivery system by
3 advancing value-based purchasing, promoting community health, and
4 providing greater integration of chronic illness care and needed social
5 supports; amending RCW 42.56.360 and 70.02.045; adding new sections to
6 chapter 41.05 RCW; adding a new section to chapter 43.70 RCW; adding a
7 new section to chapter 74.09 RCW; adding a new section to chapter 48.02
8 RCW; adding a new chapter to Title 44 RCW; adding a new chapter to
9 Title 43 RCW; creating new sections; and providing an expiration date.

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

11 NEW SECTION. **Sec. 1.** (1) The legislature finds that the state of
12 Washington has an opportunity to transform its health care delivery
13 system.

14 (2) The state health care innovation plan establishes the following
15 primary drivers of health transformation, each with individual key
16 actions that are necessary to achieve the objective:

17 (a) Improve health overall by stressing prevention and early
18 detection of disease and integration of behavioral health;

1 (b) Developing linkages between the health care delivery system and
2 community; and

3 (c) Supporting regional collaboratives for communities and
4 populations, improve health care quality, and lower costs.

5 NEW SECTION. **Sec. 2.** (1) The health care authority is responsible
6 for coordination, implementation, and administration of interagency
7 efforts and local collaborations of public and private organizations to
8 implement the state health care innovation plan.

9 (2) Prior to the authority submitting a grant application for
10 innovation plan funding, the authority must consult a neutral actuarial
11 firm not currently contracted with the agency to review the estimated
12 savings with the innovation plan prior to application submission. The
13 plan and the actuarial information must be presented to the joint
14 select committee on health care oversight, including the scope and
15 details of the grant application and any request for proposal, prior to
16 an application submission. The joint committee must review the
17 application in a timely fashion that enables the grant application, if
18 approved, to be submitted within the required time frame.

19 (3) The grant application cannot commit the state to any financial
20 obligations beyond the actual grant award amount.

21 (4) All required federal reporting related to a grant award must be
22 shared with the joint committee at the same time it is submitted to the
23 federal government.

24 (5) By January 1, 2015, and January 1st of each year through
25 January 1, 2019, the health care authority shall coordinate and submit
26 a status report to the appropriate committees of the legislature
27 regarding implementation of the innovation plan. The report must
28 summarize any actions taken to implement the innovation plan, progress
29 toward achieving the aims of the innovation plan, and anticipated
30 future implementation efforts. In addition, the health care authority
31 shall submit any recommendations for legislation necessary to implement
32 the innovation plan.

33 NEW SECTION. **Sec. 3.** (1) The joint select committee on health
34 care oversight is established in statute, continuing the committee
35 created in Engrossed Substitute Senate Concurrent Resolution No. 8401
36 passed in 2013.

1 (2) The membership of the joint select committee on health care
2 oversight must consist of the following: (a) The chairs of the health
3 care committees of the senate and the house of representatives, who
4 must serve as cochairs; (b) four additional members of the senate, two
5 each appointed by the leadership of the two largest political parties
6 in the senate; and (c) four additional members of the house of
7 representatives, two each appointed by the leadership of the two
8 largest political parties in the house of representatives. The
9 governor must be invited to appoint, as a liaison to the joint select
10 committee, a person who must be a nonvoting member.

11 (3) The joint select committee on health care oversight must
12 provide oversight between the health care authority, health benefit
13 exchange, the office of the insurance commissioner, the department of
14 health, and the department of social and health services. The goal
15 must be to ensure that these entities are not duplicating their efforts
16 and are working toward a goal of increased quality of services which
17 will lead to reduced costs to the health care consumer.

18 (4) The joint select committee on health care oversight must, as
19 necessary, propose legislation to the health care committees and budget
20 recommendations to the ways and means committees of the legislature
21 that aids in their coordination of activities and that leads to better
22 quality and cost savings.

23 (5) The joint select committee on health care oversight expires on
24 December 31, 2022.

25 NEW SECTION. **Sec. 4.** A new section is added to chapter 41.05 RCW
26 to read as follows:

27 (1) The authority shall, subject to the availability of amounts
28 appropriated or grants received for this specific purpose, award grants
29 to support the development of two pilot projects for a community of
30 health. A community of health is a regionally based, voluntary
31 collaborative. The purpose of the collaborative is to align actions to
32 achieve healthy communities and populations, improve health care
33 quality, and lower costs. Grants may only be used for start-up costs.

34 (2) The authority shall develop a process for designating an entity
35 as a community of health. An entity seeking designation is eligible
36 if:

1 (a) It is a nonprofit or public-private partnership, including
2 those led by local public health agencies;

3 (b) Its membership is broad and incorporates key stakeholders, such
4 as the long-term care system, the health care delivery system,
5 behavioral health, social supports and services, primary care and
6 specialty providers, hospitals, consumers, small and large employers,
7 health plans, and public health, with no single entity or
8 organizational cohort serving in a majority capacity; and

9 (c) It demonstrates an ongoing capacity to:

10 (i) Lead health improvement activities within the region with other
11 local systems to improve health outcomes and the overall health of the
12 community, improve health care quality, and lower costs; and

13 (ii) Distribute tools and resources from the health extension
14 program created in section 5 of this act.

15 (3) In awarding grants under this section, the authority shall
16 consider the extent to which the applicant will:

17 (a) Base decisions on public input and an active collaboration
18 among key community partners, which can include, but are not limited
19 to, local governments, housing providers, school districts, early
20 learning regional coalitions, large and small businesses, labor
21 organizations, health and human service organizations, tribal
22 governments, health carriers, providers, hospitals, public health
23 agencies, and consumers;

24 (b) Match the grant funding with funds from other sources; and

25 (c) Demonstrate capability for sustainability without reliance on
26 state general fund appropriations.

27 (4) The authority may prioritize applications that commit to
28 providing at least one dollar in matching funds for each grant dollar
29 awarded.

30 (5) Before grant funds are disbursed, the authority and the
31 applicant must agree on performance requirements.

32 (6) The authority may adopt rules necessary to implement this
33 section, but may not adopt rules, policies, or procedures beyond the
34 scope of the authority granted in this section.

35 NEW SECTION. **Sec. 5.** A new section is added to chapter 43.70 RCW
36 to read as follows:

37 (1) Subject to the availability of amounts appropriated for this

1 specific purpose, the department shall establish a health extension
2 program to provide training, tools, and technical assistance to primary
3 care, behavioral health, and other providers. The program must
4 emphasize high quality preventive, chronic disease, and behavioral
5 health care that is comprehensive and evidence-based.

6 (2) The health extension program must coordinate dissemination of
7 evidence-based tools and resources that promote:

8 (a) Integration of physical and behavioral health;

9 (b) Clinical decision support to promote evidence-based care;

10 (c) Reports of the Robert Bree collaborative created by RCW
11 70.250.050 and findings of health technology assessments under RCW
12 70.14.080 through 70.14.130;

13 (d) Methods of formal assessment;

14 (e) Support for patients managing their own conditions;

15 (f) Identification and use of resources that are available in the
16 community for patients and their families, including community health
17 workers; and

18 (g) Identification of evidence-based models to effectively treat
19 depression and other conditions in primary care settings, such as the
20 program advancing integrated mental health solutions, and others.

21 (3) The department may adopt rules necessary to implement this
22 section, but may not adopt rules, policies, or procedures beyond the
23 scope of authority granted in this section.

24 NEW SECTION. **Sec. 6.** A new section is added to chapter 41.05 RCW
25 to read as follows:

26 (1) There is created a performance measures committee, the purpose
27 of which is to identify and recommend standard statewide measures of
28 health performance to inform public and private health care purchasers
29 and to propose benchmarks to track costs and improvements in health
30 outcomes.

31 (2) Members of the committee must include representation from state
32 agencies, small and large employers, health plans, patient groups,
33 federally recognized tribes, consumers, academic experts on health care
34 measurement, hospitals, physicians, and other providers. The governor
35 shall appoint the members of the committee, except that a statewide
36 association representing hospitals may appoint a member representing
37 hospitals, and a statewide association representing physicians may

1 appoint a member representing physicians. The governor shall ensure
2 that members represent diverse geographic locations and both rural and
3 urban communities. The chief executive officer of the lead
4 organization must also serve on the committee. The committee must be
5 chaired by the director of the authority.

6 (3) The committee shall develop a transparent process for selecting
7 performance measures, and the process must include opportunities for
8 public comment.

9 (4) By January 1, 2015, the committee shall submit the performance
10 measures to the authority. The measures must include dimensions of:

- 11 (a) Prevention and screening;
- 12 (b) Effective management of chronic conditions;
- 13 (c) Key health outcomes;
- 14 (d) Care coordination and patient safety; and
- 15 (e) Use of the lowest cost, highest quality care for preventive
16 care and acute and chronic conditions.

17 (5) The committee shall develop a measure set that:

- 18 (a) Is of manageable size;
- 19 (b) Is based on readily available claims and clinical data;
- 20 (c) Gives preference to nationally reported measures and, where
21 nationally reported measures may not be appropriate, measures used by
22 state agencies that purchase health care or commercial health plans;
- 23 (d) Focuses on the overall performance of the system, including
24 outcomes and total cost;
- 25 (e) Is aligned with the governor's performance management system
26 measures and common measure requirements specific to medicaid delivery
27 systems under RCW 70.320.020 and 43.20A.895;
- 28 (f) Considers the needs of different stakeholders and the
29 populations served; and
- 30 (g) Is usable by multiple payers, providers, hospitals, purchasers,
31 public health, and communities as part of health improvement, care
32 improvement, provider payment systems, benefit design, and
33 administrative simplification for providers and hospitals.

34 (6) State agencies shall use the measure set developed under this
35 section to inform and set benchmarks for purchasing decisions.

36 (7) The committee shall establish a public process to periodically
37 evaluate the measure set and make additions or changes to the measure
38 set as needed.

1 NEW SECTION. **Sec. 7.** A new section is added to chapter 74.09 RCW
2 to read as follows:

3 (1) The authority and the department may restructure medicaid
4 procurement of health care services and agreements with managed care
5 systems on a phased basis to better support integrated physical health,
6 mental health, and chemical dependency treatment, consistent with
7 assumptions in Second Substitute Senate Bill No. 6312, Laws of 2014,
8 and recommendations provided by the behavioral health task force. The
9 authority and the department may develop and utilize innovative
10 mechanisms to promote and sustain integrated clinical models of
11 physical and behavioral health care.

12 (2) The authority and the department may incorporate the following
13 principles into future medicaid procurement efforts aimed at
14 integrating the delivery of physical and behavioral health services:

15 (a) Medicaid purchasing must support delivery of integrated,
16 person-centered care that addresses the spectrum of individuals' health
17 needs in the context of the communities in which they live and with the
18 availability of care continuity as their health needs change;

19 (b) Accountability for the client outcomes established in RCW
20 43.20A.895 and 71.36.025 and performance measures linked to those
21 outcomes;

22 (c) Medicaid benefit design must recognize that adequate preventive
23 care, crisis intervention, and support services promote a recovery-
24 focused approach;

25 (d) Evidence-based care interventions and continuous quality
26 improvement must be enforced through contract specifications and
27 performance measures that provide meaningful integration at the patient
28 care level with broadly distributed accountability for results;

29 (e) Active purchasing and oversight of medicaid managed care
30 contracts is a state responsibility;

31 (f) A deliberate and flexible system change plan with identified
32 benchmarks to promote system stability, provide continuity of treatment
33 for patients, and protect essential existing behavioral health system
34 infrastructure and capacity; and

35 (g) Community and organizational readiness are key determinants of
36 implementation timing; a phased approach is therefore desirable.

37 (3) The principles identified in subsection (2) of this section are
38 not intended to create an individual entitlement to services.

1 (4) The authority shall increase the use of value based
2 contracting, alternative quality contracting, and other payment
3 incentives that promote quality, efficiency, cost savings, and health
4 improvement, for medicaid and public employee purchasing. The
5 authority shall also implement additional chronic disease management
6 techniques that reduce the subsequent need for hospitalization or
7 readmissions. It is the intent of the legislature that the reforms the
8 authority implements under this subsection are anticipated to reduce
9 extraneous medical costs, across all medical programs, when fully
10 phased in by fiscal year 2017 to generate budget savings identified in
11 the omnibus appropriations act.

12 NEW SECTION. **Sec. 8.** The definitions in this section apply
13 throughout this chapter unless the context clearly requires otherwise.

14 (1) "Authority" means the health care authority.

15 (2) "Carrier" and "health carrier" have the same meaning as in RCW
16 48.43.005.

17 (3) "Claims data" means the data required by section 11 of this act
18 to be submitted to the database, as defined by the director in rule.
19 "Claims data" includes: (a) Claims data related to health care
20 coverage and services funded, in whole or in part, in the omnibus
21 appropriations act, including coverage and services funded by
22 appropriated and nonappropriated state and federal moneys, for medicaid
23 programs and the public employees benefits board program; and (b)
24 claims data voluntarily provided by other data suppliers, including
25 carriers and self-funded employers.

26 (4) "Database" means the statewide all-payer health care claims
27 database established in section 10 of this act.

28 (5) "Director" means the director of financial management.

29 (6) "Lead organization" means the organization selected under
30 section 10 of this act.

31 (7) "Office" means the office of financial management.

32 NEW SECTION. **Sec. 9.** The legislature finds that:

33 (1) The activities authorized by this chapter will require
34 collaboration among state agencies and local governments that purchase
35 health care, private health carriers, third-party purchasers, health
36 care providers, and hospitals. These activities will identify

1 strategies to increase the quality and effectiveness of health care
2 delivered in Washington state and are therefore in the best interest of
3 the public.

4 (2) The benefits of collaboration, together with active state
5 supervision, outweigh potential adverse impacts. Therefore, the
6 legislature intends to exempt from state antitrust laws, and provide
7 immunity through the state action doctrine from federal antitrust laws,
8 activities that are undertaken, reviewed, and approved by the office
9 pursuant to this chapter that might otherwise be constrained by such
10 laws. The legislature does not intend and does not authorize any
11 person or entity to engage in activities not provided for by this
12 chapter, and the legislature neither exempts nor provides immunity for
13 such activities including, but not limited to, agreements among
14 competing providers or carriers to set prices or specific levels of
15 reimbursement for health care services.

16 NEW SECTION. **Sec. 10.** (1) The office shall establish a statewide
17 all-payer health care claims database to support transparent public
18 reporting of health care information. The database must improve
19 transparency to: Assist patients, providers, and hospitals to make
20 informed choices about care; enable providers, hospitals, and
21 communities to improve by benchmarking their performance against that
22 of others by focusing on best practices; enable purchasers to identify
23 value, build expectations into their purchasing strategy, and reward
24 improvements over time; and promote competition based on quality and
25 cost.

26 (2) The director shall select a lead organization to coordinate and
27 manage the database. The lead organization is responsible for internal
28 governance, management, funding, and operations of the database. At
29 the direction of the office, the lead organization shall:

30 (a) Collect claims data from data suppliers as provided in section
31 11 of this act;

32 (b) Design data collection mechanisms with consideration for the
33 time and cost involved in collection and the benefits that measurement
34 would achieve;

35 (c) Ensure protection of collected data and store and use any data
36 with patient-specific information in a manner that protects patient
37 privacy;

1 (d) Consistent with the requirements of this chapter, make
2 information from the database available as a resource for public and
3 private entities, including carriers, employers, providers, hospitals,
4 and purchasers of health care;

5 (e) Report performance on cost and quality pursuant to section 14
6 of this act using, but not limited to, the performance measures
7 developed under section 6 of this act;

8 (f) Develop protocols and policies to ensure the quality of data
9 releases;

10 (g) Develop a plan for the financial sustainability of the database
11 and charge fees not to exceed five thousand dollars unless otherwise
12 negotiated for reports and data files as needed to fund the database.
13 Any fees must be approved by the office and must be comparable across
14 data requesters and users; and

15 (h) Convene advisory committees with the approval and participation
16 of the office, including: (i) A committee on data policy development;
17 and (ii) a committee to establish a data release process consistent
18 with the requirements of this chapter and to provide advice regarding
19 formal data release requests. The advisory committees must include
20 representation from key provider, hospital, payer, public health,
21 health maintenance organization, purchaser, and consumer organizations.

22 (3) The lead organization governance structure and advisory
23 committees must include representation of the third-party administrator
24 of the uniform medical plan. A payer, health maintenance organization,
25 or third-party administrator must be a data supplier to the all-payer
26 health care claims database to be represented on the lead organization
27 governance structure or advisory committees.

28 NEW SECTION. **Sec. 11.** (1) Data suppliers must submit claims data
29 to the database within the time frames established by the director in
30 rule and in accordance with procedures established by the lead
31 organization.

32 (2) An entity that is not a data supplier but that chooses to
33 participate in the database shall require any third-party administrator
34 utilized by the entity's plan to release any claims data related to
35 persons receiving health coverage from the plan.

36 (3) Each data supplier shall submit an annual status report to the

1 office regarding its compliance with this section. The report to the
2 legislature required by section 2 of this act must include a summary of
3 these status reports.

4 NEW SECTION. **Sec. 12.** (1) The claims data provided to the
5 database, the database itself, including the data compilation, and any
6 raw data received from the database are not public records and are
7 exempt from public disclosure under chapter 42.56 RCW.

8 (2) Claims data obtained in the course of activities undertaken
9 pursuant to or supported under this chapter are not subject to subpoena
10 or similar compulsory process in any civil or criminal, judicial, or
11 administrative proceeding, nor may any individual or organization with
12 lawful access to data under this chapter be compelled to testify with
13 regard to such data, except that data pertaining to a party in
14 litigation may be subject to subpoena or similar compulsory process in
15 an action brought by or on behalf of such individual to enforce any
16 liability arising under this chapter.

17 NEW SECTION. **Sec. 13.** (1) Except as otherwise required by law,
18 claims or other data from the database shall only be available for
19 retrieval in original or processed form to public and private
20 requesters pursuant to this section and shall be made available within
21 a reasonable time after the request.

22 (2) Except as otherwise required by law, the office shall direct
23 the lead organization to maintain the confidentiality of claims or
24 other data it collects for the database that include direct and
25 indirect patient identifiers. Any agency, researcher, or other person
26 that receives claims or other data under this section containing direct
27 or indirect patient identifiers must also maintain confidentiality and
28 may not release such claims or other data except as consistent with
29 this section. The office shall oversee the lead organization's release
30 of data as follows:

31 (a) Claims or other data that include direct or indirect patient
32 identifiers, as specifically defined in rule, may be released to:

33 (i) Federal, state, and local government agencies upon receipt of
34 a signed data use agreement with the office and the lead organization;
35 and

1 (ii) Researchers with approval of an institutional review board
2 upon receipt of a signed confidentiality agreement with the office and
3 the lead organization.

4 (b) Claims or other data that do not contain direct patient
5 identifiers but that may contain indirect patient identifiers may be
6 released to agencies, researchers, and other persons upon receipt of a
7 signed data use agreement with the lead organization.

8 (c) Claims or other data that do not contain direct or indirect
9 patient identifiers may be released upon request.

10 (3) Recipients of claims or other data under subsection (2)(a) or
11 (b) of this section must agree in a data use agreement or a
12 confidentiality agreement to, at a minimum:

13 (a) Take steps to protect direct and indirect patient identifying
14 information as described in the agreement; and

15 (b) Not redisclose the data except as authorized in the agreement
16 consistent with the purpose of the agreement or as otherwise required
17 by law.

18 (4) Recipients of the claims or other data under subsection (2)(b)
19 of this section must not attempt to determine the identity of persons
20 whose information is included in the data set or use the claims or
21 other data in any manner that identifies the individuals or their
22 families.

23 (5) For purposes of this section, the following definitions apply
24 unless the context clearly requires otherwise.

25 (a) "Direct patient identifier" means information that identifies
26 a patient.

27 (b) "Indirect patient identifier" means information that may
28 identify a patient when combined with other information.

29 NEW SECTION. **Sec. 14.** (1) Under the supervision of the office,
30 the lead organization shall prepare health care data reports using the
31 database and the statewide health performance and quality measure set,
32 including only those measures that can be completed with readily
33 available claims data. Prior to releasing any health care data reports
34 that use claims data, the lead organization must submit the reports to
35 the office for review and approval.

36 (2)(a) Health care data reports prepared by the lead organization

1 that use claims data must assist the legislature and the public with
2 awareness and promotion of transparency in the health care market by
3 reporting on:

4 (i) Whether providers and health systems deliver efficient, high
5 quality care; and

6 (ii) Geographic and other variations in medical care and costs as
7 demonstrated by data available to the lead organization.

8 (b) Measures in the health care data reports should be stratified
9 by demography, income, language, health status, and geography when
10 feasible with available data to identify disparities in care and
11 successful efforts to reduce disparities.

12 (c) Comparisons of costs among providers and health care systems
13 must account for differences in acuity of patients, as appropriate and
14 feasible, and must take into consideration the cost impact of
15 subsidization for uninsured and governmental patients, as well as
16 teaching expenses, when feasible with available data.

17 (3) The lead organization may not publish any data or health care
18 data reports that:

19 (a) Directly or indirectly identify patients;

20 (b) Disclose specific terms of contracts, discounts, or fixed
21 reimbursement arrangements or other specific reimbursement arrangements
22 between an individual provider and a specific payer; or

23 (c) Compares performance in a report generated for the general
24 public that includes any provider in a practice with fewer than five
25 providers.

26 (4) The lead organization may not release a report that compares
27 and identifies providers, hospitals, or data suppliers unless it:

28 (a) Allows the data supplier, the hospital, or the provider to
29 verify the accuracy of the information submitted to the lead
30 organization and submit to the lead organization any corrections of
31 errors with supporting evidence and comments within forty-five days of
32 receipt of the report; and

33 (b) Corrects data found to be in error within a reasonable amount
34 of time.

35 (5) The office and the lead organization may use claims data to
36 identify and make available information on payers, providers, and
37 facilities, but may not use claims data to recommend or incentivize
38 direct contracting between providers and employers.

1 (6) The lead organization shall ensure that no individual data
2 supplier comprises more than twenty-five percent of the claims data
3 used in any report or other analysis generated from the database. For
4 purposes of this subsection, a "data supplier" means a carrier and any
5 self-insured employer that uses the carrier's provider contracts.

6 NEW SECTION. **Sec. 15.** (1) The director shall adopt any rules
7 necessary to implement this chapter, including:

8 (a) Definitions of claim and data files that data suppliers must
9 submit to the database, including: Files for covered medical services,
10 pharmacy claims, and dental claims; member eligibility and enrollment
11 data; and provider data with necessary identifiers;

12 (b) Deadlines for submission of claim files;

13 (c) Penalties for failure to submit claim files as required;

14 (d) Procedures for ensuring that all data received from data
15 suppliers are securely collected and stored in compliance with state
16 and federal law; and

17 (e) Procedures for ensuring compliance with state and federal
18 privacy laws.

19 (2) The director may not adopt rules, policies, or procedures
20 beyond the authority granted in this chapter.

21 NEW SECTION. **Sec. 16.** A new section is added to chapter 48.02 RCW
22 to read as follows:

23 (1) The commissioner may not use data acquired from the statewide
24 all-payer health care claims database created in section 10 of this act
25 for purposes of reviewing rates pursuant to this title.

26 (2) The commissioner's authority to access data from any other
27 source for rate review pursuant to this title is not otherwise
28 curtailed, even if that data may have been separately submitted to the
29 statewide all-payer health care claims database.

30 **Sec. 17.** RCW 42.56.360 and 2013 c 19 s 47 are each amended to read
31 as follows:

32 (1) The following health care information is exempt from disclosure
33 under this chapter:

34 (a) Information obtained by the pharmacy quality assurance
35 commission as provided in RCW 69.45.090;

1 (b) Information obtained by the pharmacy quality assurance
2 commission or the department of health and its representatives as
3 provided in RCW 69.41.044, 69.41.280, and 18.64.420;

4 (c) Information and documents created specifically for, and
5 collected and maintained by a quality improvement committee under RCW
6 43.70.510, 70.230.080, or 70.41.200, or by a peer review committee
7 under RCW 4.24.250, or by a quality assurance committee pursuant to RCW
8 74.42.640 or 18.20.390, or by a hospital, as defined in RCW 43.70.056,
9 for reporting of health care-associated infections under RCW 43.70.056,
10 a notification of an incident under RCW 70.56.040(5), and reports
11 regarding adverse events under RCW 70.56.020(2)(b), regardless of which
12 agency is in possession of the information and documents;

13 (d)(i) Proprietary financial and commercial information that the
14 submitting entity, with review by the department of health,
15 specifically identifies at the time it is submitted and that is
16 provided to or obtained by the department of health in connection with
17 an application for, or the supervision of, an antitrust exemption
18 sought by the submitting entity under RCW 43.72.310;

19 (ii) If a request for such information is received, the submitting
20 entity must be notified of the request. Within ten business days of
21 receipt of the notice, the submitting entity shall provide a written
22 statement of the continuing need for confidentiality, which shall be
23 provided to the requester. Upon receipt of such notice, the department
24 of health shall continue to treat information designated under this
25 subsection (1)(d) as exempt from disclosure;

26 (iii) If the requester initiates an action to compel disclosure
27 under this chapter, the submitting entity must be joined as a party to
28 demonstrate the continuing need for confidentiality;

29 (e) Records of the entity obtained in an action under RCW 18.71.300
30 through 18.71.340;

31 (f) Complaints filed under chapter 18.130 RCW after July 27, 1997,
32 to the extent provided in RCW 18.130.095(1);

33 (g) Information obtained by the department of health under chapter
34 70.225 RCW;

35 (h) Information collected by the department of health under chapter
36 70.245 RCW except as provided in RCW 70.245.150;

37 (i) Cardiac and stroke system performance data submitted to

1 national, state, or local data collection systems under RCW
2 70.168.150(2)(b); (~~and~~)

3 (j) All documents, including completed forms, received pursuant to
4 a wellness program under RCW 41.04.362, but not statistical reports
5 that do not identify an individual; and

6 (k) Data and information exempt from disclosure under section 12 of
7 this act.

8 (2) Chapter 70.02 RCW applies to public inspection and copying of
9 health care information of patients.

10 (3)(a) Documents related to infant mortality reviews conducted
11 pursuant to RCW 70.05.170 are exempt from disclosure as provided for in
12 RCW 70.05.170(3).

13 (b)(i) If an agency provides copies of public records to another
14 agency that are exempt from public disclosure under this subsection
15 (3), those records remain exempt to the same extent the records were
16 exempt in the possession of the originating entity.

17 (ii) For notice purposes only, agencies providing exempt records
18 under this subsection (3) to other agencies may mark any exempt records
19 as "exempt" so that the receiving agency is aware of the exemption,
20 however whether or not a record is marked exempt does not affect
21 whether the record is actually exempt from disclosure.

22 **Sec. 18.** RCW 70.02.045 and 2000 c 5 s 2 are each amended to read
23 as follows:

24 Third-party payors shall not release health care information
25 disclosed under this chapter, except as required by chapter 43.--- RCW
26 (the new chapter created in section 22 of this act) and to the extent
27 that health care providers are authorized to do so under RCW 70.02.050.

28 NEW SECTION. **Sec. 19.** If any provision of this act or its
29 application to any person or circumstance is held invalid, the
30 remainder of the act or the application of the provision to other
31 persons or circumstances is not affected.

32 NEW SECTION. **Sec. 20.** Section 3 of this act constitutes a new
33 chapter in Title 44 RCW.

34 NEW SECTION. **Sec. 21.** Section 4 of this act expires July 1, 2020.

1 NEW_SECTION. **Sec. 22.** Sections 8 through 15 of this act
2 constitute a new chapter in Title 43 RCW.

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