RCW 48.43.530 Requirement for carriers to have comprehensive grievance and appeal processes—Carrier's duties—Procedures—Appeals—Rules. (1) Each carrier and health plan must have fully operational, comprehensive grievance and appeal processes, and for plans that are not grandfathered, fully operational, comprehensive, and effective grievance and review of adverse benefit determination processes that comply with the requirements of this section and any rules adopted by the commissioner to implement this section. For the purposes of this section, the commissioner must consider applicable grievance and appeal or review of adverse benefit determination process standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services, and for health plans that are not grandfathered health plans as approved by the United States department of health and human services or the United States department of labor. In the case of coverage offered in connection with a group health plan, if either the carrier or the health plan complies with the requirements of this section and RCW 48.43.535, then the obligation to comply is satisfied for both the carrier and the plan with respect to the health insurance coverage.

(2) Each carrier and health plan must process as a grievance an enrollee's expression of dissatisfaction about customer service or the quality or availability of a health service. Each carrier must implement procedures for registering and responding to oral and written grievances in a timely and thorough manner.

(3) Each carrier and health plan must provide written notice to an enrollee or the enrollee's designated representative, and the enrollee's provider, of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility. Such notice must be sent directly to a protected individual receiving care when accessing sensitive health care services or when a protected individual has requested confidential communication pursuant to RCW 48.43.505(5).

(4) An enrollee's written or oral request that a carrier reconsider its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility must be processed as follows:

(a) When the request is made under a grandfathered health plan, the plan and the carrier must process it as an appeal;

(b) When the request is made under a health plan that is not grandfathered, the plan and the carrier must process it as a review of an adverse benefit determination; and

(c) Neither a carrier nor a health plan, whether grandfathered or not, may require that an enrollee file a complaint or grievance prior to seeking appeal of a decision or review of an adverse benefit determination under this subsection.

(5) To process an appeal, each plan that is not grandfathered and each carrier offering that plan must:

(a) Provide written notice to the enrollee when the appeal is received;

(b) Assist the enrollee with the appeal process;

(c) Make its decision regarding the appeal within thirty days of the date the appeal is received. An appeal must be expedited if the enrollee's provider or the carrier's medical director reasonably determines that following the appeal process response timelines could

seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours of the date the appeal is received;

(d) Cooperate with a representative authorized in writing by the enrollee;

(e) Consider information submitted by the enrollee;

(f) Investigate and resolve the appeal; and

(g) Provide written notice of its resolution of the appeal to the enrollee and, with the permission of the enrollee, to the enrollee's providers. The written notice must explain the carrier's and health plan's decision and the supporting coverage or clinical reasons and the enrollee's right to request independent review of the carrier's decision under RCW 48.43.535.

(6) Written notice required by subsection (3) of this section must explain:

(a) The carrier's and health plan's decision and the supporting coverage or clinical reasons; and

(b) The carrier's and grandfathered plan's appeal or for plans that are not grandfathered, adverse benefit determination review process, including information, as appropriate, about how to exercise the enrollee's rights to obtain a second opinion, and how to continue receiving services as provided in this section.

(7) When an enrollee requests that the carrier or health plan reconsider its decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving through the health plan and the carrier's or health plan's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier and health plan must continue to provide that health service until the appeal, or for health plans that are not grandfathered, the review of an adverse benefit determination, is resolved. If the resolution of the appeal, review of an adverse benefit determination, or any review sought by the enrollee under RCW 48.43.535 affirms the carrier's or health plan's decision, the enrollee may be responsible for the cost of this continued health service.

(8) Each carrier and health plan must provide a clear explanation of the grievance and appeal, or for plans that are not grandfathered, the process for review of an adverse benefit determination process upon request, upon enrollment to new enrollees, and annually to enrollees and subcontractors.

(9) Each carrier and health plan must ensure that each grievance, appeal, and for plans that are not grandfathered, grievance and review of adverse benefit determinations, process is accessible to enrollees who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance, appeal or review of an adverse benefit determination.

(10)(a) Each plan that is not grandfathered and the carrier that offers it must: Track each appeal until final resolution; maintain, and make accessible to the commissioner for a period of three years, a log of all appeals; and identify and evaluate trends in appeals.

(b) Each grandfathered plan and the carrier that offers it must: Track each review of an adverse benefit determination until final resolution; maintain and make accessible to the commissioner, for a period of six years, a log of all such determinations; and identify and evaluate trends in requests for and resolution of review of adverse benefit determinations.

(11) In complying with this section, plans that are not grandfathered and the carriers offering them must treat a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at that time, and any decision to deny coverage in an initial eligibility determination as an adverse benefit determination. [2019 c 56 s 6; 2012 c 211 s 20; 2011 c 314 s 4; 2000 c 5 s 10.]

Findings—Declarations—Effective date—2019 c 56: See notes following RCW 48.43.5051.

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.