Z-0855.1

HOUSE BILL 1828

State of Washington 54th Legislature 1995 Regular Session

By Representatives Dellwo, Morris and Jacobsen; by request of Health Services Commission

Read first time 02/10/95. Referred to Committee on Health Care.

AN ACT Relating to uniform benefits package and supplemental benefits rate limitations; amending RCW 43.72.100 and 43.72.170; providing an effective date; and declaring an emergency.

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

Sec. 1. RCW 43.72.100 and 1993 c 492 s 428 are each amended to read as follows:

A certified health plan shall:

(1) Provide the benefits included in the uniform benefits package to enrolled Washington residents in a group contract for a prepaid per capita amount that is not more than ten percent above nor more than ten percent below the certified health plan's age-adjusted, community-rated premium, and to enrolled Washington residents in individual contracts for a prepaid per capita age-adjusted, community-rated premium. In all cases the premium for the uniform benefits package shall not ((~~to~~)) exceed the maximum premium established by the commission ((~~and~~)). A certified health plan shall provide such benefits through managed care in accordance with rules adopted by the commission;

(2) Offer supplemental benefits to enrolled Washington residents for a prepaid per capita community-rated premium and provide such

benefits through managed care in accordance with rules adopted by the commission;

(3) Accept for enrollment any state resident within the plan's service area and provide or assure the provision of all services within the uniform benefits package and offer supplemental benefits regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The insurance commissioner may grant a temporary exemption from this subsection, if, upon application by a certified health plan, the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a certified health plan is required to continue enrollment of additional eligible individuals;

(4) If the plan provides benefits through contracts with, ownership of, or management of health care facilities and contracts with or employs health care providers, demonstrate to the satisfaction of the insurance commissioner in consultation with the department of health and the commission that its facilities and personnel are adequate to provide the benefits prescribed in the uniform benefits package and offer supplemental benefits to enrolled Washington residents, and that it is financially capable of providing such residents with, or has made adequate contractual arrangements with health care providers and facilities to provide enrollees with such benefits;

(5) Comply with portability of benefits requirements prescribed by the commission;

(6) Comply with administrative rules prescribed by the commission, the insurance commissioner, and other state agencies governing certified health plans;

(7) Provide all enrollees with instruction and informational materials to increase individual and family awareness of injury and illness prevention; encourage assumption of personal responsibility for protecting personal health; and stimulate discussion about the use and limits of medical care in improving the health of individuals and communities;

(8) Disclose to enrollees the charity care requirements under chapter 70.170 RCW;

(9) Include in all of its contracts with health care providers and health care facilities a provision prohibiting such providers and

facilities from billing enrollees for any amounts in excess of applicable enrollee point of service cost-sharing obligations for services included in the uniform benefits package and supplemental benefits;

(10) Include in all of its contracts issued for uniform benefits package and supplemental benefits coverage a subrogation provision that allows the certified health plan to recover the costs of uniform benefits package and supplemental benefits services incurred to care for an enrollee injured by a negligent third party. The costs recovered shall be limited to:

(a) If the certified health plan has not intervened in the action by an injured enrollee against a negligent third party, then the amount of costs the certified health plan can recover shall be limited to the excess remaining after the enrollee has been fully compensated for his or her loss minus a proportionate share of the enrollee's costs and fees in bringing the action. The proportionate share shall be determined by:

(i) The fees and costs approved by the court in which the action was initiated; or

(ii) The written agreement between the attorney and client that established fees and costs when fees and costs are not addressed by the court.

When fees and costs have been approved by a court, after notice to the certified health plan, the certified health plan shall have the right to be heard on the matter of attorneys' fees and costs or its proportionate share;

(b) If the certified health plan has intervened in the action by an injured enrollee against a negligent third party, then the amount of costs the certified health plan can recover shall be the excess remaining after the enrollee has been fully compensated for his or her loss or the amount of the plan's incurred costs, whichever is less;

(11) Establish and maintain a grievance procedure approved by the commissioner, to provide a reasonable and effective resolution of complaints initiated by enrollees concerning any matter relating to the provision of benefits under the uniform benefits package and supplemental benefits, access to health care services, and quality of services. Each certified health plan shall respond to complaints filed with the insurance commissioner within fifteen working days. The

insurance commissioner in consultation with the commission shall establish standards for resolution of grievances;

(12) Comply with the provisions of chapter 48.30 RCW prohibiting unfair and deceptive acts and practices to the extent such provisions are not specifically modified or superseded by the provisions of chapter 492, Laws of 1993 and be prohibited from offering or supplying incentives that would have the effect of avoiding the requirements of subsection (3) of this section;

(13) Have culturally sensitive health promotion programs that include approaches that are specifically effective for persons of color and accommodating to different cultural value systems, gender, and age;

(14) Permit every category of health care provider to provide health services or care for conditions included in the uniform benefits package to the extent that:

(a) The provision of such health services or care is within the health care providers' permitted scope of practice; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of health services;

(ii) Management and administrative procedures; and

(iii) Provision of cost-effective and clinically efficacious health services;

(15) Establish the geographic boundaries in which they will obligate themselves to deliver the services required under the uniform benefits package and include such information in their application for certification, but the commissioner shall review such boundaries and may disapprove, in conformance with guidelines adopted by the commission, those that have been clearly drawn to be exclusionary within a health care catchment area;

(16) Annually report the names and addresses of all officers, directors, or trustees of the certified health plan during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals;

(17) Annually report the number of residents enrolled and terminated during the previous year. Additional information regarding the enrollment and termination pattern for a certified health plan may be required by the commissioner to determine compliance with the open enrollment and free access requirements of chapter 492, Laws of 1993; and

(18) Disclose any financial interests held by officers and directors in any facilities associated with or operated by the certified health plan.

Sec. 2. RCW 43.72.170 and 1993 c 492 s 453 are each amended to read as follows:

(1) Premium rates for uniform benefits package and supplemental benefits shall not be excessive or inadequate, and shall not discriminate in a manner prohibited by RCW 43.72.100(3). Premium rates, enrollee point of service cost-sharing, or maximum enrollee financial participation amounts for a uniform benefits package may not exceed the limits established by the health services commission in accordance with RCW 43.72.040. Premium rates for uniform benefits package and supplemental benefits shall be developed on a community-rated basis as determined by the health services commission. The premium offered to any group purchaser of the uniform benefits package shall not be more than ten percent above nor more than ten percent below the age-adjusted community rate for the uniform benefits package developed by the certified health plan.

(2) Prior to using, every certified health plan shall file with the commissioner its enrollee point of service, cost-sharing amounts, enrollee financial participation amounts, rates, its rating plan, and any other information used to determine the specific premium to be charged any enrollee and every modification of any of the foregoing.

(3) Every such filing shall indicate the type and extent of the health services contemplated and must be accompanied by sufficient information to permit the commissioner to determine whether it meets the requirements of this chapter. A plan shall offer in support of any filing:

(a) Any historical data and actuarial projections used to establish the rate filed;

(b) An exhibit detailing the major elements of operating expense for the types of health services affected by the filing;

(c) An explanation of how investment income has been taken into account in the proposed rates;

(d) Any other information that the plan deems relevant; and

(e) Any other information that the commissioner requires by rule.

(4) If a plan has insufficient loss experience to support its proposed rates, it may submit loss experience for similar exposures of other plans within the state.

(5) Every filing shall state its proposed effective date.

(6) Actuarial formulas, statistics, and assumptions submitted in support of a rate or form filing by a plan or submitted to the commissioner at the commissioner's request shall be withheld from public inspection in order to preserve trade secrets or prevent unfair competition.

(7) No plan may make or issue a benefits package except in accordance with its filing then in effect.

(8) The commissioner shall review a filing as soon as reasonably possible after made, to determine whether it meets the requirements of this section.

(9)(a) No filing may become effective within thirty days after the date of filing with the commissioner, which period may be extended by the commissioner for an additional period not to exceed fifteen days if the commissioner gives notice within such waiting period to the plan that the commissioner needs additional time to consider the filing.

(b) A filing shall be deemed to meet the requirements of this section unless disapproved by the commissioner within the waiting period or any extension period.

(c) If within the waiting or any extension period, the commissioner finds that a filing does not meet the requirements of this section, the commissioner shall disapprove the filing, shall notify the plan of the grounds for disapproval, and shall prohibit the use of the disapproved filing.

(10) If at any time after the applicable review period provided in this section, the commissioner finds that a filing does not meet the requirements of this section, the commissioner shall, after notice and hearing, issue an order specifying in what respect the commissioner finds that such filing fails to meet the requirements of this section, and stating when, within a reasonable period thereafter, the filings shall be deemed no longer effective.

The order shall not affect any benefits package made or issued prior to the expiration of the period set forth in the order.

NEW SECTION. **Sec. 3.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the

state government and its existing public institutions, and shall take effect July 1, 1995.

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