H-4946.1

SUBSTITUTE HOUSE BILL 2486

State of Washington 54th Legislature 1996 Regular Session

By House Committee on Health Care (originally sponsored by Representatives Backlund, Hymes, Skinner, Cody, Dyer and Murray)

Read first time 02/02/96.

AN ACT Relating to consumer health information; adding new sections to chapter 48.43 RCW; and creating a new section.

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

NEW SECTION. **Sec. 1.** LEGISLATIVE FINDINGS. The legislature finds that:

(1) The pace of health care reforms initiated by both the public and private sectors can result in unforeseen consequences in the delivery system unless safeguards are put in place. These undesired consequences can include negative effects on the quality of patient care, reducing the options open to patients to receive the kind of care they desire, depriving the patients of information that is necessary for an informed choice, regulation that decreases the competition in the delivery system, and concentration in the marketplace, the effect of which is to achieve market power in relation to consumers and to disrupt established and historically useful relationships in the delivery system.

(2) Preserving the best of what already exists in the delivery system, while providing for sufficient flexibility so the system can

evolve into a more cost-effective one, requires careful balancing among competing objectives.

NEW SECTION. **Sec. 2.** CENSORING PROVIDER INFORMATION TO PATIENTS BY INSURERS. (1) No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for any service.

(2) No health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier. A provider must disclose to patients any ownership interests that the provider has in any carrier and whether the provider will personally benefit from the choices made by the patient upon recommendation by the provider.

NEW SECTION. **Sec. 3.** PATIENT AND PROVIDER MANAGED CARE OPT-OUT PROVISION. Notwithstanding any other provision of law, no health carrier subject to the jurisdiction of the state of Washington may prohibit directly or indirectly its enrollees from freely contracting at any time to obtain any health care services outside the health care plan on any terms or conditions the enrollees choose. Nothing in this section shall be construed to bind a carrier for any services delivered outside the health plan.

NEW SECTION. **Sec. 4.** INSURER DISCLOSURE TO PATIENTS REGARDING INSURER POLICIES. (1) Upon request by an enrollee or prospective enrollee, all health carriers subject to the jurisdiction of the state of Washington shall provide the following:

(a) Whether a point-of-service plan is available and how it is structured;

(b) Any documents, instruments, or other information referred to in the enrollee's service agreement;

(c) A full description of the procedures to be followed by an enrollee for consulting a practitioner other than the primary care practitioner, and whether the enrollee's practitioner, the plan's medical director, or someone else must first authorize the referral;

(d) Whether a plan practitioner is restricted to prescribing drugs from a plan list or plan formulary, what drugs are on the plan list or formulary, and the extent to which enrollees will be reimbursed for drugs that are not on that list or formulary.

(2)(a) A public or private entity who exercises due diligence in preparing a document of any kind that compares health carriers of any kind is immune from civil liability from claims based on the document and the contents of the document.

(b)(i) There is absolute immunity to civil liability from claims based on such a comparison document and its contents if the information was provided by the carrier, was substantially accurately presented, and contained the effective date of the information that the carrier supplied, if any.

(ii) Where due diligence efforts to obtain accurate information have been taken, there is immunity from claims based on such a comparison document and its contents if the publisher of the comparison document asked for such information from the carrier, was refused, and relied on any usually reliable source for the information including, but not limited to, carrier enrollees, customers, agents, brokers, or providers. The carrier enrollees, customers, agents, brokers, or providers are likewise immune from civil liability on claims based on information they provided if they believed the information to be accurate and had exercised due diligence in their efforts to confirm the accuracy of the information provided.

(c) The immunity from liability contained in this section applies only if the comparison document contains the following in a conspicuous place and in easy to read typeface:

> This comparison is based on information believed to be reliable by its publisher, but the accuracy of the information cannot be guaranteed. Caution is suggested to all readers who are encouraged to confirm data of importance to the reader before any purchasing or other decisions are made.

NEW SECTION. **Sec. 5.** UTILIZATION REVIEW BY INSURERS. (1) Unless the context clearly requires otherwise, the definitions in this section apply throughout this section.

(a) "Appeal" means a formal request, either orally or in writing, to reconsider a determination not to certify an admission, extension of stay, or other health care service.

(b) "Adverse determination" means a decision by a review organization not to certify an admission, service, procedure, or extension of stay.

(c) "Certification" means a determination by a utilization review organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

(d) "Review organization" means a person or entity performing utilization review that is either employed by, affiliated with, under contract with, or acting on behalf of:

(i) A business entity doing business in this state; or

(ii) A party that provides or administers health care benefits to citizens of this state, including a disability insurer, a health care service contractor, a health maintenance organization authorized to offer health insurance policies or contracts or pay for the delivery of health care services or treatment in this state, or a designee of one of these parties.

(e) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to a patient or group of patients. Utilization review does not mean elective requests for clarification of coverage or medical claims review.

(2) Beginning July 1, 1996, every review organization that proposes to provide coverage of inpatient hospital and medical benefits and outpatient surgical benefits for residents of this state with utilization review of those benefits must meet the following standards:

(a) Review organizations must comply with all applicable state and federal laws to protect confidentiality of enrollee medical records;

(b) Notification of a determination to certify by the review organization must be mailed or otherwise communicated either to the

provider of record or the enrollee, or both the provider of record and the enrollee, or other appropriate individual, within two business days of the determination, which is based on the receipt of all information necessary to complete the review;

(c) Review organizations must maintain a written description of the appeal procedure by which enrollees or the provider of record may seek review of determinations by the review organization. The appeal procedure must provide for the following:

(i) On appeal, all determinations to deny an admission, service, or procedure as being necessary or appropriate must be made by an individual in a licensed physician category who is familiar with the treatment of the medical condition, procedure, or treatment under discussion and is reasonably available as appropriate to review the case, other than the physician or licensed medical professional who made the initial determination;

(ii) Review organizations must complete the adjudication of appeals of determinations not to certify admissions, services, and procedures no later than thirty days from the date the appeal is filed and all information necessary to complete the appeal is received; and

(iii) Review organizations must also provide for an expedited appeals process for emergency or life-threatening situations. Review organizations must complete the adjudication of the expedited appeals within two business days of the date the appeal is filed and the receipt of all information necessary to complete the appeal;

(d) Review organizations must make staff available by toll-free telephone at least forty hours per week during normal business hours;

(e) Review organizations must have a phone system capable of either accepting or recording, or both accepting and recording, incoming phone calls during other than normal business hours and must respond to these calls within two business days; and

(f) Review organizations must allow a minimum of forty-eight hours following an emergency admission, service, or procedure for an enrollee or his or her representative to notify the review organization and request certification or continuing treatment for that condition. A review organization must permit immediate hospitalization of an enrollee for whom the physician of record determines the admission to be of a life-threatening emergency, so long as medical necessity is promptly documented. Nothing in this section requires the review organization or another party to authorize payment for services

provided during that forty-eight hour period, regardless of medical necessity, if those services do not otherwise constitute covered benefits.

(3) A determination by a review organization to deny the necessity or appropriateness of an admission, service, or procedure must be reviewed by a physician or a licensed medical professional making a determination in accordance with standards or guidelines approved by a physician. A final determination not to certify an admission, service, or procedure must be made by a licensed physician.

(4) A notification of a determination not to certify an admission, service, or procedure must include:

(a) The principal reason for the determination; and

(b) The procedure to initiate an appeal of the determination.

(5) Hospitals and physicians must cooperate with the reasonable efforts of review organizations to ensure that all necessary patient information is available in a timely fashion by phone during normal business hours. Procedures must be established by hospitals and physicians to allow on-site review of medical records by review organizations.

NEW SECTION. **Sec. 6.** CAPTIONS. Captions used in this act do not constitute part of the law.

NEW SECTION. **Sec. 7.** CODIFICATION. Sections 1 through 5 of this act are each added to chapter 48.43 RCW.

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