H-3893.1

HOUSE BILL 2618

State of Washington 54th Legislature 1996 Regular Session

By Representatives Cody, Murray, Conway and Dellwo

Read first time 01/15/96. Referred to Committee on Health Care.

AN ACT Relating to managed care providers; and adding a new chapter to Title 48 RCW.

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

NEW SECTION. **Sec. 1.** The purpose of this chapter is to assure the availability, accessibility, and quality of health care services offered under a managed care plan by establishing requirements for written agreements between health carriers offering managed care plans and participating providers regarding standards, terms, and provisions under which the participating provider will provide services or supplies or both to covered persons, and standards for the creation and maintenance of health care networks by health carriers.

NEW SECTION. **Sec. 2.** Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Closed plan" means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan.

(2) "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(3) "Covered person" means any person entitled to receive benefits or services under a health benefit plan.

(4) "Emergency" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention and failure to provide the medical attention would result in serious impairment to bodily function, permanent dysfunction to any bodily organ or part, or would place the person’s health in serious jeopardy.

(5) "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

(6) "Health benefit plan" means any policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(7) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law.

(8) "Health care provider" means a health care professional or a facility.

(9) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(10) "Health carrier" means any entity subject to Title 48 RCW that contracts or offers to contract, or enters into an agreement, to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

(11) "Intermediary" means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers.

(12) "Managed care plan" means any policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange

for, pay for, or reimburse any of the costs of health care services through the covered person's use of health care providers or facilities managed, owned, under contract with, or employed by the carrier because the carrier either requires the use of, or creates incentives, including financial incentives, for the covered person's use of such providers and facilities.

(13) "Network" means those providers contracting with a health carrier under either an open or closed plan.

(14) "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

(15) "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

(16) "Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for speciality care and maintain supervision of health care services rendered to the covered person.

NEW SECTION. **Sec. 3.** (1) A health carrier shall enter into contracts with sufficient numbers and types of providers through which health care services are usually provided to covered persons for covered benefits offered under each of its managed care plans to assure that all covered benefits will be accessible to covered persons on an appropriate basis without delays detrimental to the health of covered persons. In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. Sufficiency may be determined by a number of factors, including but not limited to: Provider-patient ratios by specialty; primary care provider-patient ratios; geographic accessibility; waiting times for appointments with participating providers; and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced and/or specialty care.

(a) Covered persons must be able to obtain all covered benefits offered under a managed care plan from participating providers. In any case where the health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier must ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or make other arrangements acceptable to the commissioner.

(b) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons so as not to result in unreasonable barriers to access. In determining whether a health carrier has complied with this provision, due consideration shall be given to the relative availability of health care providers in the service area under consideration.

(c) If the commissioner determines that there are not enough participating providers to assure that covered persons have accessible health services available in a geographic area, the commissioner may institute a corrective action that shall be followed by the health carrier.

(d) A health carrier shall be responsible for assuring, on an ongoing basis, that the providers and facilities with which it contracts have the ability, capacity, and legal authority to provide all covered benefits to covered persons.

(e) A covered person who chooses to obtain from a nonparticipating provider any health care services that are obtainable from the health carrier’s participating providers may be held personally responsible by the health carrier for paying some or all of the cost of using that nonparticipating provider.

(2) Every health carrier shall establish and maintain its open and closed plans in a manner that does not exclude providers based on their location in geographic areas that include populations or providers presenting a risk of higher than average claims, losses, or health service utilization.

(3) Every health carrier shall establish and maintain its open and closed networks in a manner that does not discriminate against providers serving populations presenting a risk of higher than average claims, losses, or health service utilization.

(4) At the time of initial licensing or certification of the carrier and beginning on the effective date of this act, every carrier shall file with the insurance commissioner, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this chapter for each of the managed care plans the carrier offers in this state. The carrier shall file an updated access plan prior to offering a new managed care plan, or upon any material change to an existing managed care plan. If the commissioner determines that the access plan does not assure reasonable access to covered benefits, the commissioner may institute a corrective action that shall be followed by the health carrier. The access plan shall contain at least the following:

(a) A detailed description of its provider network;

(b) Its procedures for making referrals in and out of its provider network;

(c) A description of the health carrier's proposed plan to monitor on an ongoing basis the sufficiency of the provider network;

(d) A description of the health carrier's strategy for integrating public health goals with health services offered to covered persons under the managed care plans of the health carrier, including a description of the health carrier's good faith efforts to initiate and/or maintain communication with public health agencies;

(e) A description of the health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(f) A description of how the health carrier assesses covered persons' health care needs and satisfaction with services;

(g) A description of how the health carrier informs covered persons of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for obtaining emergency and specialty care;

(h) A description of how the health carrier shall ensure the coordination and continuity of care for covered persons referred to specialty physicians, and for covered persons using ancillary services, including social services and other community resources, and appropriate discharge planning;

(i) A description of the process by which covered persons may change primary care providers;

(j) A description of the health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description will explain how the health carrier will identify covered persons with special medical needs or who are at special risk, and how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner;

(k) A description of the circumstances and process by which a covered person may request a referral to a terminated provider if the termination was not for cause; and

(l) Any other information required by the commissioner to determine compliance with this chapter.

NEW SECTION. **Sec. 4.** Every contract between a health carrier and a provider or its representative concerning the delivery, provision, payment, or offering of care or services covered by a managed care plan shall make provision for all of the requirements in this section.

(1) Each contract shall include a description of the method by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on those services.

(2) Each contract shall include the following hold harmless provision specifying protection for covered persons:

> "Provider agrees that in no event, including but not limited to nonpayment by the health carrier/provider network, insolvency of the health carrier/provider network, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a covered person or a person (other than the network carrier/provider network) acting on behalf of the covered person for services provided pursuant to this agreement. This does not prohibit the provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for

uncovered services delivered on a fee-for-service basis to covered persons nor from any recourse against the network carrier or provider intermediary or their successor or assigns or from [insert name of Guaranty Association.]"

(3) Each contract must include provisions identifying arrangements for continuation of covered services for covered persons including:

(a) Provider agrees that in the event of a health carrier/provider network insolvency or other cessation of operations, covered services to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person; and

(b) Provider agrees to continue any medically necessary procedures commenced but unfinished at the time of network insolvency or other cessation of operations, and to continue all necessary care to persons receiving care in inpatient and other facilities.

(4) Notwithstanding subsections (2) and (3) of this section, no contract between a health care professional and an intermediary or between a health care professional and a health carrier may contain a provision prohibiting a provider and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the covered person has received clear notice that the health carrier will not cover or continue to cover a specific service or services. This subsection does not apply to any health care professional who is employed full time on the staff of a health carrier or who has agreed to provide services exclusively to a health carrier’s covered persons and no others.

(5) The following provisions must be included in the agreement between the health carrier and each provider with whom it contracts for care or services under a managed care plan:

(a) The terms of the contract survive the termination of the contrary regardless of the reason for termination, including insolvency of the health carrier/provider network, and are for the benefit of the covered person;

(b) The terms of the contract supersede any oral or written contrary agreement now existing or hereafter entered into between the provider and covered persons or persons acting upon their behalf insofar as the contrary agreement is inconsistent with the hold harmless and continuation of covered services required under subsections (2) and (3) of this section; and

(c) The terms of the contract contain provisions similar to those in subsections (2) and (3) of this section. To receive credit for health care services being covered for prior liabilities or continuation of benefits or both, contracts with individual physicians and medical group contracts with providers who are not members of the medical group must also contain these provisions.

(6) All contracts shall contain provisions clearly stating the requirements and responsibilities of the health carrier and participating providers with respect to administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs.

(7) No provider contract shall contain a provision offering directly or indirectly under the managed care plan an inducement to a provider to reduce or limit medically necessary services to a covered person.

(8) No provider contract may contain any provision designed to terminate or otherwise penalize a provider who expresses disagreement with a plan's decision to deny or limit benefits to a covered person and who assists the covered person to seek a reconsideration of the plan's decision.

(9) The contracts shall contain provisions regarding the availability and confidentiality of the health records necessary to monitor and evaluate the quality of care, conduct evaluations and audits, and determine, on a concurrent or retrospective basis, the necessity and appropriateness of care provided to covered persons. Contracts shall include provisions requiring the provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to confidentiality of medical or health records.

(10) Provider contracts shall require at least sixty days' written notice from either party that wishes to terminate the contract without cause and without the written permission of the other party. However, in the event of a termination, the health carrier and the participating provider will continue to be bound by the terms of the contract as they

relate to any covered person until the anniversary date of the covered person's health benefit plan.

(11) The provider contract shall state that the rights and responsibilities under the contract cannot be assigned or delegated by the provider without the prior written consent of the health carrier.

(12) The contract shall contain adequate provisions for professional liability and malpractice coverage for both parties.

(13) The provider contract shall require the provider to provide health care services without discrimination against any covered person on the basis of age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed health services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

(14) The provider contract shall contain a provision regarding the participating provider's obligation, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage, and to provide them notice of their personal financial obligations for noncovered services.

(15) The contract shall describe the provider's hours and days of availability to provide the covered health services.

(16) The provider contract shall contain a provision informing the provider that the health carrier will take no action designed to penalize a provider who reports to state or federal authorities any act or practice by the health carrier which jeopardizes patient health or welfare.

(17) The provider contract shall identify the mechanism by which the provider may access the health carrier's current eligibility data system.

(18) The provider contract shall identify or include the procedures for seeking reconsideration of administrative or payment decisions affecting the participating provider.

(19) The provider contract shall contain specific provision for the resolution of disputes arising out of the contract.

(20) A provider contract may not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or this chapter.

NEW SECTION. **Sec. 5.** Each contract between a health carrier and an intermediary shall meet the following requirements:

(1) The contract shall require that each subcontract between the intermediary and participating providers contain all the provisions required by section 4 of this act;

(2) The contract shall clearly specify the health carrier's statutory responsibility to monitor and oversee the offering of covered health care services to covered persons. That responsibility cannot be delegated or assigned to the intermediary;

(3) The health carrier shall have the right to approve or disapprove participation status in the health carrier's network of any subcontracted provider;

(4) The health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or the health carrier shall have access to all subcontracts and provide copies to facilitate regulatory review upon twenty days' prior written notice;

(5) The health carrier shall routinely receive from the intermediary utilization documentation or claims paid documentation, or both, and shall monitor the timeliness and appropriateness of payment and services received by its members;

(6) The commissioner shall have access to the intermediary's books, records, financial information, and any documentation of services provided to covered persons to the extent allowed by law. A health carrier contract with an intermediary shall confirm regulatory access to documents related to services performed under the contract, or as provided by statute; and

(7) The intermediary shall maintain the books, records, financial information, and documentation of services provided to covered persons at its principal place of business in the state and shall preserve them for a period of time determined by the commissioner by rule and in a manner that facilitates regulatory review.

NEW SECTION. **Sec. 6.** (1) At the time of initial licensing or certification of the carrier and beginning on the effective date of this act, every health carrier shall file with the commissioner sample contract forms proposed for use with its participating providers.

(2) Subsequent to obtaining the commissioner's approval, material changes to the provider contract shall be resubmitted to the commissioner for approval prior to use. For the purposes of this subsection, "material" includes a change in the method of payment to a participating provider, a change that significantly alters any risk assumed by the participating provider, any significant delegation of administrative or clinical obligations of the health carrier, and any operational or organizational modification of either the health carrier or the participating provider that would affect a provision required by statute or rule. Changes in provider payment rates, coinsurance, copayments, or deductibles, or other plan benefit modifications are not considered material changes for the purpose of this section.

(3) Unless the commissioner disapproves, at the expiration of thirty days after submission of the provider contract or a material change to a contract, it is approved. However, the commissioner may extend the period for the review for an additional thirty days by giving written notice of the extension to the health carrier before the end of the initial thirty-day period. If the contract form or a material change is not approved or disapproved by the end of the thirty-day extension, the form or change is approved.

(4) The health carrier shall maintain provider contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty days' prior written notice.

NEW SECTION. **Sec. 7.** (1) Health carrier selection standards for participating providers should be developed for primary care professionals and each health care professional specialty. These standards should be used in determining the selection, retention, and disaffiliation of health care professionals by the health carrier, its intermediaries, and any provider networks with which it contracts. The standards shall meet the requirements of the professional credentialing model chosen by the commissioner.

(2)(a) The carrier's selection standards shall be disclosed to current and prospective participating providers and consumers upon request. Amendments to selection standards shall be communicated to participating providers in a timely manner. Disclosure is subject to reasonable limitations to protect proprietary information.

(b) Health carriers, their intermediaries, and any provider networks with whom they contract shall make available to anyone, upon written request, their general criteria for selection, retention, and disaffiliation of providers.

(3) Both the health carrier and the provider shall give written notice to the other of the actual reasons for termination or nonrenewal.

(4) This chapter does not require a health carrier, its intermediaries, or the provider networks with which they contract, to employ specific providers or types of providers who may meet their selection criteria.

(5) The commissioner will not act to arbitrate, mediate, or settle disputes regarding a decision not to include a provider in a managed care plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries, or a provider network arising under or by reason of a provider contract or its termination.

NEW SECTION. **Sec. 8.** The commissioner may adopt reasonable rules as necessary to implement this chapter.

NEW SECTION. **Sec. 9.** Chapter . . ., Laws of 1996 (this act) applies to all provider contracts issued, renewed, amended or extended on or after the effective date of this act.

NEW SECTION. **Sec. 10.** Sections 1 through 9 of this act shall constitute a new chapter in Title 48 RCW.

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