Z-0562.1

SENATE BILL 5453

State of Washington 54th Legislature 1995 Regular Session

By Senators Quigley, Moyer, Wojahn, Franklin and Winsley; by request of Health Services Commission

Read first time 01/24/95. Referred to Committee on Health & Long-Term Care.

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

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

5 **Sec. 1.** RCW 43.72.100 and 1993 c 492 s 428 are each amended to
6 read as follows:
7 A certified health plan shall:
8 (1) Provide the benefits included in the uniform benefits package
9 to enrolled Washington residents in a group contract for a prepaid per
10 capita amount that is not more than ten percent above nor more than ten
11 percent below the certified health plan's age-adjusted, community-rated
12 premium, and to enrolled Washington residents in individual contracts
13 for a prepaid per capita age-adjusted, community-rated premium. In all
14 cases the premium for the uniform benefits package shall not ((to))
15 exceed the maximum premium established by the commission ((and)). A
16 certified health plan shall provide such benefits through managed care
17 in accordance with rules adopted by the commission;
18 (2) Offer supplemental benefits to enrolled Washington residents
19 for a prepaid per capita community-rated premium and provide such

1 benefits through managed care in accordance with rules adopted by the
2 commission;
3 (3) Accept for enrollment any state resident within the plan's
4 service area and provide or assure the provision of all services within
5 the uniform benefits package and offer supplemental benefits regardless
6 of age, sex, family structure, ethnicity, race, health condition,
7 geographic location, employment status, socioeconomic status, other
8 condition or situation, or the provisions of RCW 49.60.174(2). The
9 insurance commissioner may grant a temporary exemption from this
10 subsection, if, upon application by a certified health plan, the
11 commissioner finds that the clinical, financial, or administrative
12 capacity to serve existing enrollees will be impaired if a certified
13 health plan is required to continue enrollment of additional eligible
14 individuals;
15 (4) If the plan provides benefits through contracts with, ownership
16 of, or management of health care facilities and contracts with or
17 employs health care providers, demonstrate to the satisfaction of the
18 insurance commissioner in consultation with the department of health
19 and the commission that its facilities and personnel are adequate to
20 provide the benefits prescribed in the uniform benefits package and
21 offer supplemental benefits to enrolled Washington residents, and that
22 it is financially capable of providing such residents with, or has made
23 adequate contractual arrangements with health care providers and
24 facilities to provide enrollees with such benefits;
25 (5) Comply with portability of benefits requirements prescribed by
26 the commission;
27 (6) Comply with administrative rules prescribed by the commission,
28 the insurance commissioner, and other state agencies governing
29 certified health plans;
30 (7) Provide all enrollees with instruction and informational
31 materials to increase individual and family awareness of injury and
32 illness prevention; encourage assumption of personal responsibility for
33 protecting personal health; and stimulate discussion about the use and
34 limits of medical care in improving the health of individuals and
35 communities;
36 (8) Disclose to enrollees the charity care requirements under
37 chapter 70.170 RCW;
38 (9) Include in all of its contracts with health care providers and
39 health care facilities a provision prohibiting such providers and

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

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

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

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

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

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

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

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

1 insurance commissioner in consultation with the commission shall
2 establish standards for resolution of grievances;
3 (12) Comply with the provisions of chapter 48.30 RCW prohibiting
4 unfair and deceptive acts and practices to the extent such provisions
5 are not specifically modified or superseded by the provisions of
6 chapter 492, Laws of 1993 and be prohibited from offering or supplying
7 incentives that would have the effect of avoiding the requirements of
8 subsection (3) of this section;
9 (13) Have culturally sensitive health promotion programs that
10 include approaches that are specifically effective for persons of color
11 and accommodating to different cultural value systems, gender, and age;
12 (14) Permit every category of health care provider to provide
13 health services or care for conditions included in the uniform benefits
14 package to the extent that:
15 (a) The provision of such health services or care is within the
16 health care providers' permitted scope of practice; and
17 (b) The providers agree to abide by standards related to:
18 (i) Provision, utilization review, and cost containment of health
19 services;
20 (ii) Management and administrative procedures; and
21 (iii) Provision of cost-effective and clinically efficacious health
22 services;
23 (15) Establish the geographic boundaries in which they will
24 obligate themselves to deliver the services required under the uniform
25 benefits package and include such information in their application for
26 certification, but the commissioner shall review such boundaries and
27 may disapprove, in conformance with guidelines adopted by the
28 commission, those that have been clearly drawn to be exclusionary
29 within a health care catchment area;
30 (16) Annually report the names and addresses of all officers,
31 directors, or trustees of the certified health plan during the
32 preceding year, and the amount of wages, expense reimbursements, or
33 other payments to such individuals;
34 (17) Annually report the number of residents enrolled and
35 terminated during the previous year. Additional information regarding
36 the enrollment and termination pattern for a certified health plan may
37 be required by the commissioner to determine compliance with the open
38 enrollment and free access requirements of chapter 492, Laws of 1993;
39 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. <u>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.</u>

(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.

1 (4) If a plan has insufficient loss experience to support its
2 proposed rates, it may submit loss experience for similar exposures of
3 other plans within the state.
4 (5) Every filing shall state its proposed effective date.
5 (6) Actuarial formulas, statistics, and assumptions submitted in
6 support of a rate or form filing by a plan or submitted to the
7 commissioner at the commissioner's request shall be withheld from
8 public inspection in order to preserve trade secrets or prevent unfair
9 competition.
10 (7) No plan may make or issue a benefits package except in
11 accordance with its filing then in effect.
12 (8) The commissioner shall review a filing as soon as reasonably
13 possible after made, to determine whether it meets the requirements of
14 this section.
15 (9)(a) No filing may become effective within thirty days after the
16 date of filing with the commissioner, which period may be extended by
17 the commissioner for an additional period not to exceed fifteen days if
18 the commissioner gives notice within such waiting period to the plan
19 that the commissioner needs additional time to consider the filing.
20 (b) A filing shall be deemed to meet the requirements of this
21 section unless disapproved by the commissioner within the waiting
22 period or any extension period.
23 (c) If within the waiting or any extension period, the commissioner
24 finds that a filing does not meet the requirements of this section, the
25 commissioner shall disapprove the filing, shall notify the plan of the
26 grounds for disapproval, and shall prohibit the use of the disapproved
27 filing.
28 (10) If at any time after the applicable review period provided in
29 this section, the commissioner finds that a filing does not meet the
30 requirements of this section, the commissioner shall, after notice and
31 hearing, issue an order specifying in what respect the commissioner
32 finds that such filing fails to meet the requirements of this section,
33 and stating when, within a reasonable period thereafter, the filings
34 shall be deemed no longer effective.
35 The order shall not affect any benefits package made or issued
36 prior to the expiration of the period set forth in the order.

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

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

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