
ENGROSSED SUBSTITUTE SENATE BILL 6392

State of Washington

54th Legislature

1996 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored by Senators Wood, Quigley, Roach, Cantu, Deccio, Prince and Moyer)

Read first time 02/02/96.

1 AN ACT Relating to disclosure by managed care entities; adding a
2 new section to chapter 48.43 RCW; adding a new section to chapter 48.44
3 RCW; and creating a new section.

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

5 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43 RCW
6 to read as follows:

7 (1) Each health maintenance organization that offers a health care
8 plan to the public after December 31, 1996, shall provide disclosure
9 forms as required by this section. The disclosure forms shall be filed
10 with the insurance commissioner and shall include the following:

11 (a) A separate roster of plan primary care providers who are
12 regulated under chapter 18.130 or 70.127 RCW, including the provider's
13 degree, practice specialty, the year first licensed to practice, and,
14 if different, the year initially licensed to practice in Washington;

15 (b) In concise and specific terms:

16 (i) The full premium cost of the plan;

17 (ii) Any copayment, coinsurance, or deductible requirements that an
18 enrollee or the enrollee's family may incur in obtaining coverage under
19 the plan and any reservation by the plan to change premiums; and

1 (iii) The health care benefits to which an enrollee is entitled.
2 The disclosure shall state where and in what manner an enrollee may
3 obtain services, including the procedures for selecting or changing
4 primary care providers and the locations of hospitals and outpatient
5 treatment centers that are under contract with the health maintenance
6 organization;

7 (c) Any limitations of the services, kinds of service, benefits,
8 and exclusions that apply to the plan. A description of limitations
9 shall include:

10 (i) Procedures for emergency room, nighttime, or weekend visits and
11 referrals to specialists;

12 (ii) Whether services received outside the plan are covered and in
13 what manner they are covered;

14 (iii) Procedures an enrollee must follow, if any, to obtain prior
15 authorization for services;

16 (iv) The circumstances under which prior authorization is required
17 for emergency medical care and a statement as to whether and where the
18 plan provides twenty-four-hour emergency services;

19 (v) The circumstances under which the plan may retroactively deny
20 coverage for emergency medical treatment and nonemergency medical
21 treatment that had prior authorization under the plan's written
22 policies;

23 (vi) A statement whether plan providers must comply with any
24 specified numbers, targeted averages, or maximum durations of patient
25 visits. If any of these are required of plan providers, the disclosure
26 shall state the specific requirements;

27 (vii) The procedures to be followed by an enrollee for consulting
28 a provider other than the primary care provider, and whether the
29 enrollee's provider, the plan's medical director, or a committee must
30 first authorize the referral;

31 (viii) The necessity of repeating prior authorization if the
32 specialist care is continuing; and

33 (ix) Whether a point of service option is available, and if so, how
34 it is structured;

35 (d) Grievance procedures for claim or treatment denials,
36 dissatisfaction with care, and access to care issues;

37 (e) A response to whether a plan provider is restricted to
38 prescribing drugs from a plan list or plan formulary and the extent to

1 which an enrollee will be reimbursed for costs of a drug that is not on
2 a plan list or plan formulary;

3 (f) A response to whether plan provider compensation programs
4 include any incentives or penalties that would in effect encourage plan
5 providers to withhold services or minimize or avoid referrals to
6 specialists. If these types of incentives or penalties are included,
7 the health maintenance organization shall provide a concise description
8 of them. The health maintenance organization may also include, in a
9 separate section, a concise explanation or justification for the use of
10 these incentives or penalties; and

11 (g) A statement that the disclosure form is a summary only and that
12 the plan evidence of coverage should be consulted to determine
13 governing contractual provisions.

14 (2) A health maintenance organization shall not disseminate a
15 completed disclosure form until the form is filed with the insurance
16 commissioner. For purposes of this section, a health maintenance
17 organization is not required to file its separate roster of plan
18 providers or any roster updates.

19 (3) Upon request, a health maintenance organization shall provide
20 the information required under subsection (1) of this section to all
21 employers who are considering participating in a health care plan that
22 is offered by the health maintenance organization or to an employer
23 that is considering renewal of a plan that is provided by the health
24 maintenance organization.

25 (4) An employer shall provide to its eligible employees the
26 disclosures required under subsection (1) of this section no later than
27 the initiation of any open enrollment period or at least ten days
28 before any employee enrollment deadline that is not associated with an
29 open enrollment period.

30 (5) An employer shall not execute a contract with a health
31 maintenance organization until the employer receives the information
32 required under subsection (1) of this section.

33 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.44 RCW
34 to read as follows:

35 (1) Each health care service contractor that offers a health care
36 plan to the public after December 31, 1996, shall provide disclosure
37 forms as required by this section. The disclosure forms shall be filed
38 with the insurance commissioner and shall include the following:

1 (a) A separate roster of plan primary care providers who are
2 regulated under chapter 18.130 or 70.127 RCW, including the provider's
3 degree, practice specialty, the year first licensed to practice, and,
4 if different, the year initially licensed to practice in Washington;

5 (b) In concise and specific terms:

6 (i) The full premium cost of the plan;

7 (ii) Any copayment, coinsurance, or deductible requirements that an
8 enrollee or the enrollee's family may incur in obtaining coverage under
9 the plan and any reservation by the plan to change premiums; and

10 (iii) The health care benefits to which an enrollee is entitled.
11 The disclosure shall state where and in what manner an enrollee may
12 obtain services, including the procedures for selecting or changing
13 primary care providers and the locations of hospitals and outpatient
14 treatment centers that are under contract with the health care service
15 contractor;

16 (c) Any limitations of the services, kinds of service, benefits,
17 and exclusions that apply to the plan. A description of limitations
18 shall include:

19 (i) Procedures for emergency room, nighttime, or weekend visits and
20 referrals to specialists;

21 (ii) Whether services received outside the plan are covered and in
22 what manner they are covered;

23 (iii) Procedures an enrollee must follow, if any, to obtain prior
24 authorization for services;

25 (iv) The circumstances under which prior authorization is required
26 for emergency medical care and a statement as to whether and where the
27 plan provides twenty-four-hour emergency services;

28 (v) The circumstances under which the plan may retroactively deny
29 coverage for emergency medical treatment and nonemergency medical
30 treatment that had prior authorization under the plan's written
31 policies;

32 (vi) A statement whether plan providers must comply with any
33 specified numbers, targeted averages, or maximum durations of patient
34 visits. If any of these are required of plan providers, the disclosure
35 shall state the specific requirements;

36 (vii) The procedures to be followed by an enrollee for consulting
37 a provider other than the primary care provider, and whether the
38 enrollee's provider, the plan's medical director, or a committee must
39 first authorize the referral;

1 (viii) The necessity of repeating prior authorization if the
2 specialist care is continuing; and
3 (ix) Whether a point of service option is available, and if so, how
4 it is structured;
5 (d) Grievance procedures for claim or treatment denials,
6 dissatisfaction with care, and access to care issues;
7 (e) A response to whether a plan provider is restricted to
8 prescribing drugs from a plan list or plan formulary and the extent to
9 which an enrollee will be reimbursed for costs of a drug that is not on
10 a plan list or plan formulary;
11 (f) A response to whether plan provider compensation programs
12 include any incentives or penalties that would in effect encourage plan
13 providers to withhold services or minimize or avoid referrals to
14 specialists. If these types of incentives or penalties are included,
15 the health care service contractor shall provide a concise description
16 of them. The health care service contractor may also include, in a
17 separate section, a concise explanation or justification for the use of
18 these incentives or penalties; and
19 (g) A statement that the disclosure form is a summary only and that
20 the plan evidence of coverage should be consulted to determine
21 governing contractual provisions.
22 (2) A health care service contractor shall not disseminate a
23 completed disclosure form until the form is filed with the insurance
24 commissioner. For purposes of this section, a health care service
25 contractor is not required to file its separate roster of plan
26 providers or any roster updates.
27 (3) Upon request, a health care service contractor shall provide
28 the information required under subsection (1) of this section to all
29 employers who are considering participating in a health care plan that
30 is offered by the health care service contractor or to an employer that
31 is considering renewal of a plan that is provided by the health care
32 service contractor.
33 (4) An employer shall provide to its eligible employees the
34 disclosures required under subsection (1) of this section no later than
35 the initiation of any open enrollment period or at least ten days
36 before any employee enrollment deadline that is not associated with an
37 open enrollment period.

1 (5) An employer shall not execute a contract with a health care
2 service contractor until the employer receives the information required
3 under subsection (1) of this section.

4 NEW SECTION. **Sec. 3.** Nothing in this act provides any private
5 right or cause of action to, or on behalf of, any enrollee, prospective
6 enrollee, employer, or other person, whether a resident or nonresident
7 of this state. This act provides solely an administrative remedy to
8 the insurance commissioner for any violation of Title 48 RCW or any
9 related rule.

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