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**SUBSTITUTE SENATE BILL 6392**

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**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 in a  
10 form prescribed by the insurance commissioner and shall include the  
11 following:

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

16       (b) In concise and specific terms:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (e) A response to whether a plan provider is restricted to  
2 prescribing drugs from a plan list or plan formulary and the extent to  
3 which an enrollee will be reimbursed for costs of a drug that is not on  
4 a plan list or plan formulary;

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

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

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

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

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

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

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

37 (1) Each health care service contractor that offers a health care  
38 plan to the public after December 31, 1996, shall provide disclosure

1 forms as required by this section. The disclosure forms shall be in a  
2 form prescribed by the insurance commissioner and shall include the  
3 following:

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

8 (b) In concise and specific terms:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 (e) A response to whether a plan provider is restricted to  
12 prescribing drugs from a plan list or plan formulary and the extent to  
13 which an enrollee will be reimbursed for costs of a drug that is not on  
14 a plan list or plan formulary;

15 (f) A response to whether plan provider compensation programs  
16 include any incentives or penalties that would in effect encourage plan  
17 providers to withhold services or minimize or avoid referrals to  
18 specialists. If these types of incentives or penalties are included,  
19 the health care service contractor shall provide a concise description  
20 of them. The health care service contractor may also include, in a  
21 separate section, a concise explanation or justification for the use of  
22 these incentives or penalties; and

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

26 (2) A health care service contractor shall not disseminate a  
27 completed disclosure form until the form is submitted to the insurance  
28 commissioner. For purposes of this section, a health care service  
29 contractor is not required to submit to the insurance commissioner its  
30 separate roster of plan providers or any roster updates.

31 (3) Upon request, a health care service contractor shall provide  
32 the information required under subsection (1) of this section to all  
33 employers who are considering participating in a health care plan that  
34 is offered by the health care service contractor or to an employer that  
35 is considering renewal of a plan that is provided by the health care  
36 service contractor.

37 (4) An employer shall provide to its eligible employees the  
38 disclosures required under subsection (1) of this section no later than  
39 the initiation of any open enrollment period or at least ten days

1 before any employee enrollment deadline that is not associated with an  
2 open enrollment period.

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

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

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