S-5112.1

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.

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

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

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

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

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

(b) In concise and specific terms:

(i) The full premium cost of the plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) In concise and specific terms:

(i) The full premium cost of the plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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