S-4737.1

SUBSTITUTE SENATE BILL 5883

State of Washington 55th Legislature 1998 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored by Senators Benton, Stevens, Jacobsen and Roach)

Read first time 02/06/98.

AN ACT Relating to managed care entities; amending RCW 48.43.001, 48.43.075, 48.43.095, and 48.43.105; adding new sections to chapter 48.43 RCW; adding new sections to chapter 48.44 RCW; adding new sections to chapter 48.46 RCW; creating a new section; repealing RCW 48.43.085; providing an effective date; and declaring an emergency.

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

Sec. 1. RCW 48.43.001 and 1996 c 312 s 1 are each amended to read as follows:

The legislature finds that well-informed and actively involved consumers are essential in making the promise of managed care a reality. The users of managed care, the health care consumer, should play a more visible and central role in shaping the direction of managed care in Washington state and in making decisions regarding health care plans. It is the intent of the legislature to prohibit the withholding of information regarding health care benefits, services, treatment options, and plan performance comparisons to enrollees and the general public. It is also the intent of the legislature to improve consumer understanding of their health care coverage and health care services and to ensure that all enrollees in managed care

settings, and potential enrollees in the marketplace shopping for managed care settings, have access to ((~~adequate~~)) specific disclosure information as specified in chapter . . ., Laws of 1998 (this act), regarding health care services covered by health carriers' health plans, and provided by health care providers and health care facilities. It is only through such disclosure that Washington state ((~~citizens~~)) consumers can be fully informed as to the extent of health insurance coverage, availability of health care service options, and necessary treatment. With such information, ((~~citizens~~)) consumers are able to make appropriate and knowledgeable decisions ((~~regarding~~)) about their health care that reflect both cost and quality considerations.

Sec. 2. RCW 48.43.075 and 1996 c 312 s 2 are each amended to read as follows:

WITHHOLDING PROVIDER INFORMATION TO PLAN ENROLLEE BY CARRIERS PROHIBITED. (1) No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing plan enrollees or covered members of the enrollee's family of the following:

(a) The care the patient((~~s of the care they~~)) requires, including various treatment options((~~,~~));; and

(b) Whether in ((~~their view~~)) the provider's opinion and within his or her scope of training and medical qualifications such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the ((~~patient's~~)) enrollee's service agreement with the health carrier.

(2) No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for or cover any service.

((~~(2)~~)) (3) No health carrier may preclude or discourage ((~~patients~~)) plan enrollees or those paying for their coverage from discussing the comparative merits of different health carriers or health plans with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier.

((~~(3) The insurance commissioner is prohibited from adopting rules regarding this section.~~))

Sec. 3. RCW 48.43.095 and 1996 c 312 s 4 are each amended to read as follows:

CARRIER DISCLOSURE TO PLAN ENROLLEES REGARDING CARRIER POLICIES. (1) ((~~Upon the request of an enrollee or a prospective enrollee, a~~)) Each health carrier, as defined in RCW 48.43.005, and the Washington state health care authority, established by chapter 41.05 RCW, shall provide to plan enrolles, in writing that is easily understandable to a layperson, the following information:

(a) A separate roster of plan primary care and specialty providers who are regulated under chapter 18.130 or 70.127 RCW, including:

(i) The provider's degree, board eligibility, and certification;

(ii) Practice specialty;

(iii) The year first licensed to practice, and, if different, the year initially licensed to practice in Washington state;

(iv) Hospital affiliations of the provider;

(v) The date of the provider's next contract renewal with the health carrier;

(vi) The address and telephone number of the plan providers' medical offices; and

(vii) Covered person ratios to primary care providers and covered person ratios by specialty at the time of disclosure;

(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;

(iii) The potential total maximum out-of-pocket costs to the enrollee;

(iv) The health care benefits to which a plan enrollee or a plan enrollee's covered family members are entitled, including preventive care services or wellness activity programs; and

(v) The coordination of benefits;

(c) The procedures for selecting or changing primary care providers and specialty providers;

(d) A roster with the names, locations, and the selection process available to enrollees of inpatient and outpatient health care

facilities that are under contract with the carrier, including whether the enrollee or the enrollee's family members may request treatment at a health care facility outside of the list of contracted facilities. The roster will note whether any of the facilities focus on a specialty of care;

(e) A list of surgical procedures that the carrier requires to be performed in a one-day surgery facility or outpatient health care facility;

(f) A brief description of the discharge planning process from inpatient settings, which shall include a statement describing whether a provider must obtain authorization to delay a patient's discharge from the facility, if that provider deems an extended stay medically warranted;

(g) The availability of a point-of-service plan or an option to a point-of-service plan, and how the plan or option operates within the coverage, and any additional costs associated with selecting such a plan or utilizing such an option;

((~~(b) Any~~)) (h) An appendix of samples of documents, instruments, facility or provider rosters, plan telephone numbers, including toll-free numbers, or other information referred to in the enrollment agreement;

((~~(c)~~)) (i) A full description of the procedures to be followed by ((~~an~~)) a plan enrollee or a covered family member of the plan enrollee for consulting a provider other than the primary care provider and whether the enrollee's primary care provider, the carrier's medical director, or another entity must authorize the referral. The description shall include whether repeat prior authorization to specialist care is necessary if the care is continuing;

((~~(d)~~)) (j) A description of plan prescription coverage, to include:

(i) Copayment schedules and maximum patient out-of-pocket costs associated with prescription coverage;

(ii) The name and address of all retail pharmacies that are under contract with the carrier, and whether an enrollee may obtain prescriptions from retail pharmacies outside of any list of contracted pharmacies;

(iii) Whether a plan provider is restricted to prescribing drugs from a plan list or plan formulary((~~,~~));

(iv) What drugs are on the plan list or formulary((~~, and~~));

(v) The extent to which enrollees will be reimbursed for drugs that are not on the plan's list or formulary;

((~~(e)~~)) (vi) Whether a provider must receive prior authorization to prescribe a drug not listed on the plan list or plan formulary that the provider deems therapeutically superior or medically critical to an enrollee's health, and if so, the party who makes such an authorization;

(vii) Whether provider contracts penalize a provider for prescribing outside of the plan formulary; and

(viii) The criteria the carrier considers before adding a drug to the plan list or formulary;

(k) A full description of procedures enrollees or covered family members must follow to access emergency room health care services or after-hour and weekend services. The description shall also specify how the enrollee is to access health care services when the enrollee is out of the plan area. The description shall include procedures, if any, that an enrollee must first follow for obtaining prior authorization ((~~for~~)) to access such health care services;

((~~(f)~~)) (l) A written description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between a carrier and a provider;

((~~(g)~~)) (m) Circumstances under which the plan may retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies;

((~~(h)~~)) (n) A copy of all grievance procedures for claim or service denial and for dissatisfaction with care((~~; and~~)) or access to care. The carrier shall provide written disclosure to a plan enrollee at the time of enrollment regarding the process for initiating reviews of grievances, including expedited reviews for those cases when the time frame of a standard review could jeopardize the life or health of an enrollee or family member. The carrier shall provide written disclosure to a plan enrollee describing the appeal process that is available when coverage is denied for treatment that a provider deems medically warranted. If a provider renders a professional medical judgment that results in the carrier denying coverage for treatment of a condition that the enrollee believes to be covered, the provider shall notify the enrollee and the carrier in writing in those cases when the provider believes the withholding of treatment could

potentially threaten the life of the patient. The carrier is prohibited from penalizing the provider for such written notification. If a resolution between the plan enrollee, provider, and carrier is not achieved within a reasonable time frame, arbitration by an independent panel of similar specialty providers, not affiliated with the carrier, may be used to review the case; and

(o) The telephone number of the insurance commissioner's office.

((~~(i)~~)) (p) Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists.

(2) ((~~Each health carrier, as defined in RCW 48.43.005, and the Washington state health care authority, established by chapter 41.05 RCW, shall provide to all enrollees and prospective enrollees a list of available disclosure items.~~

~~(3)~~)) Nothing in this section shall be construed to require a carrier to divulge proprietary information to an enrollee.

((~~(4) The insurance commissioner is prohibited from adopting rules regarding this section~~)) Proprietary information shall not be defined to include any of the required information listed in this section or section 4 of this act.

NEW SECTION. **Sec. 4.** CARRIER DISCLOSURE IN MARKETING COMMUNICATIONS. (1) A carrier, as defined in RCW 48.43.005, is prohibited from printing or making statements regarding patient choice of provider in any written or verbal communications, plan documentation, or advertisements without disclosing limitations regarding the access to providers outside of a plan's network of providers or access to specialist providers within the plan.

(2) Upon request, a potential plan enrollee, prior to purchasing coverage, may request information in writing that is required to be disclosed in RCW 48.43.095 for the purposes of comparing carriers and plans.

NEW SECTION. **Sec. 5.** CARRIER DISCLOSURE TO THE WASHINGTON OFFICE OF THE INSURANCE COMMISSIONER. Each carrier, as defined in RCW 48.43.005, that offers a health care plan to the public after July 1, 1998, shall file a standardized disclosure form, available from the office of the insurance commissioner, with the commissioner annually.

The commissioner shall create a standardized form that includes the following:

(1) All disclosure requirements listed in RCW 48.43.095; and

(2) Limitations of services, benefits, or exclusions that apply to the plan, not specifically listed in RCW 48.43.095.

The commissioner shall annually prepare a comparative health plan guide for the general public that contains the consumer disclosure information from the standardized form detailed in this section.

NEW SECTION. **Sec. 6.** WITHHOLDING PROVIDER INFORMATION TO PLAN ENROLLEES BY HEALTH CARE SERVICE CONTRACTORS PROHIBITED. (1) No health care service contractor, as defined in RCW 48.44.010, subject to the jurisdiction of the state may in any way preclude or discourage their providers from informing plan enrollees or covered members of the enrollee's family of the following:

(a) The care the patient requires, including various treatment options; and

(b) Whether in the provider's opinion, and within his or her scope of training and medical qualifications, the care is consistent with medical necessity, medical appropriateness, or is otherwise covered by the plan enrollee's service agreement with the health care service contractor.

(2) No health care service contractor may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health care service contractor. Nothing in this section may be construed to authorize providers to bind health care service contractors to pay for or cover any service.

(3) No health care service contractor may preclude or discourage plan enrollees or those paying for their coverage from discussing the comparative merits of different health care service contractors or health plans with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a health care service contractor.

NEW SECTION. **Sec. 7.** DISCLOSURE TO PLAN ENROLLEES REGARDING HEALTH CARE SERVICE CONTRACTOR POLICIES. (1) Each health care service contractor, as defined in RCW 48.44.010, and the Washington state health care authority, established by chapter 41.05 RCW, shall provide

to plan enrollees, in writing that is easily understandable to a layperson, the following information:

(a) A separate roster of plan primary care and specialty providers who are regulated under chapter 18.130 or 70.127 RCW, including:

(i) The provider's degree, board eligibility, and certification;

(ii) Practice specialty;

(iii) The year first licensed to practice, and, if different, the year initially licensed to practice in Washington state;

(iv) Hospital affiliations of the provider;

(v) The date of the provider's next contract renewal with the health care service contractor;

(vi) The address and telephone number of the plan providers' medical offices; and

(vii) Covered persons ratio to primary care providers and covered persons ratio by specialty at the time of disclosure;

(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;

(iii) The potential total maximum out-of-pocket costs to the enrollee;

(iv) The health care benefits to which a plan enrollee or a plan enrollee's covered family members are entitled, including preventive care services or wellness activity programs; and

(v) The coordination of benefits;

(c) The procedures for selecting or changing primary care providers and specialty providers;

(d) A roster with the names, locations, and the selection process available to enrollees of inpatient and outpatient health care facilities that are under contract with the health care service contractor, including whether the enrollee or the enrollee's covered family members may request treatment at a health care facility outside of the list of contracted facilities. The roster will note whether any of the facilities focus on a specialty of care;

(e) A list of surgical procedures that the health care service contractor requires to be performed in a one-day surgery facility or outpatient health care facility;

(f) A brief description of the discharge planning process from inpatient settings, which shall include a statement describing whether a provider must obtain authorization to delay a patient's discharge from the facility, if that provider deems an extended stay medically warranted;

(g) The availability of a point-of-service plan or an option to a point-of-service plan, how such a plan or option operates within the coverage, and any additional costs associated with selecting such a plan or utilizing such an option;

(h) An appendix of samples of documents, instruments, facility or provider rosters, plan telephone numbers, including toll-free numbers, or other information referred to in the enrollment agreement;

(i) A full description of the procedures to be followed by a plan enrollee or a covered family member of the plan enrollee for consulting a provider other than the primary care provider and whether the enrollee's primary care provider, the health care service contractor's medical director, or another entity must authorize the referral. The description shall include whether repeat prior authorization to specialist care is necessary if the care is continuing;

(j) A description of plan prescription coverage to include:

(i) Copayment schedules and maximum patient out-of-pocket costs associated with prescription coverage;

(ii) The name and address of all retail pharmacies that are under contract with the health care service contractor, and whether an enrollee may obtain prescriptions from retail pharmacies outside of any list of contracted pharmacies;

(iii) Whether a plan provider is restricted to prescribing drugs from a plan list or plan formulary;

(iv) What drugs are on the plan list or formulary;

(v) The extent to which enrollees will be reimbursed for drugs that are not on the plan's list or formulary;

(vi) Whether a provider must receive prior authorization to prescribe a drug not listed on the plan list or plan formulary that the provider deems therapeutically superior or medically critical to an enrollee's health, and if so, the party who makes such an authorization;

(vii) Whether provider contracts penalize a provider for prescribing outside of the plan formulary; and

(viii) The criteria the health care service contractor considers before adding a drug to the plan list or formulary;

(k) A full description of procedures that plan enrollees or covered family members must follow to access emergency room health care services or after-hour and weekend services. The description also shall specify how the enrollee is to access health care services when the enrollee is out of the plan area. The description shall include procedures, if any, that an enrollee must follow to obtain prior authorization to access such health care services;

(l) Circumstances under which the plan may retroactively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies;

(m) A copy of all grievance procedures for claim or service denial and for dissatisfaction with care or access to care. The health care service contractor shall provide written disclosure to a plan enrollee at the time of enrollment regarding the process for initiating reviews of grievances, including expedited reviews in those cases when the time frame of a standard review could jeopardize the life or health of an enrollee or covered family member. The health care service contractor shall also provide written disclosure to a plan enrollee describing the appeal process that is available when payment is denied for care that the enrollee believes is a covered service and for which a provider deems medically warranted. If a provider renders a professional medical judgment that results in the health care service contractor denying coverage for treatment of a condition that the enrollee believes to be covered, the provider shall notify the enrollee and the health care service contractor in writing in those cases when the provider believes the withholding of treatment could potentially threaten the life of the patient. The health care service contractor is prohibited from penalizing the provider for such written notification. If a resolution between the plan enrollee, provider, and health care service contractor is not achieved within a reasonable time frame, arbitration by an independent panel of similar specialty providers, not affiliated with the health care service contractor, may be used to review the case;

(n) The telephone number of the insurance commissioner's office.

(2) Nothing in this section may be construed to require a health care service contractor to divulge proprietary information to an

enrollee. Proprietary information does not include any of the required disclosure items listed in this section or section 6 of this act.

NEW SECTION. **Sec. 8.** HEALTH CARE SERVICE CONTRACTOR DISCLOSURE IN MARKETING COMMUNICATIONS. (1) A health care service contractor, as defined in RCW 48.44.010, is prohibited from printing or making statements regarding patient choice of provider in any written or verbal communications, plan documentation, or advertisements without a written disclosure of limitations regarding the access to providers outside of a plan's network of providers or access to specialist providers within the plan.

(2) Upon request, a potential plan enrollee, prior to purchasing coverage, may request information in writing that is required to be disclosed in section 7 of this act for the purposes of comparing health care service contractors and plans.

NEW SECTION. **Sec. 9.** HEALTH CARE SERVICE CONTRACTOR DISCLOSURE TO THE WASHINGTON OFFICE OF THE INSURANCE COMMISSIONER. Each health care service contractor, as defined in RCW 48.44.010, that offers a health care plan to the public after July 1, 1998, shall file a standardized disclosure form, available from the office of the insurance commissioner, with the commissioner annually. The commissioner shall create a standardized form to include the following:

(1) All disclosure requirements listed in section 7 of this act; and

(2) Limitations of services, benefits, or exclusions that apply to the plan, not specifically listed in section 7 of this act.

The commissioner shall annually prepare a comparative health plan guide for the general public that contains the consumer disclosure information from the standardized form detailed in this section.

NEW SECTION. **Sec. 10.** WITHHOLDING PROVIDER INFORMATION TO PLAN ENROLLEES BY HEALTH MAINTENANCE ORGANIZATIONS PROHIBITED. (1) No health maintenance organization, as defined in RCW 48.46.020, subject to the jurisdiction of the state may in any way preclude or discourage their providers from informing enrollees or covered members of an enrollee's family of the following:

(a) The care the patient requires, including various treatment options; and

(b) Whether in the provider's opinion and within the provider's scope of training and medical qualifications, such care is consistent with medical necessity, medical appropriateness, or is otherwise covered by the enrollee's service agreement with the health maintenance organization.

(2) No health maintenance organization may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with the health maintenance organization. Nothing in this section may be construed to authorize providers to bind health maintenance organizations to cover any service not included in the list of covered benefits.

(3) No health maintenance organization may preclude or discourage plan enrollees or those paying for their coverage from discussing the comparative merits of different health maintenance organizations or health plans with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a health maintenance organization.

NEW SECTION. **Sec. 11.** DISCLOSURE TO PLAN ENROLLEES REGARDING HEALTH MAINTENANCE ORGANIZATION POLICIES. (1) Each health maintenance organization, as defined in RCW 48.46.020, and the Washington state health care authority, established by chapter 41.05 RCW, shall provide in writing to plan enrollees the following information:

(a) A separate roster of plan primary care and specialty providers who are regulated under chapter 18.130 or 70.127 RCW, including:

(i) The provider's degree, board eligibility, and certification;

(ii) Practice specialty;

(iii) The year first licensed to practice, and, if different, the year initially licensed to practice in Washington state;

(iv) Hospital affiliations of the provider and health maintenance organization;

(v) The date of the provider's next contract renewal with the health maintenance organization;

(vi) The address and telephone number of the plan providers' medical offices; and

(vii) Covered persons ratio to primary care providers and covered persons ratio by specialty at the time of disclosure;

(b) In concise and specific terms:

(i) The full premium cost of the plan;

(ii) Any copayment requirements that an enrollee or the enrollee's family may incur in obtaining coverage under the plan;

(iii) The potential total maximum out-of-pocket costs to the enrollee;

(iv) The health care benefits to which a plan enrollee or a plan enrollee's covered family members are entitled, including preventive care services or wellness activity programs; and

(v) The coordination of benefits;

(c) The procedures for selecting or changing primary care providers and specialty providers;

(d) A roster with the names, locations, and the selection process available to enrollees of inpatient and outpatient health care facilities that are under contract with the health maintenance organization, including whether the enrollee or the enrollee's covered family members may request treatment at a health care facility outside of the list of contracted facilities. The roster will note whether any of the facilities focus on a specialty of care;

(e) A list of surgical procedures that the health maintenance organization requires to be performed in a one-day surgery facility or outpatient health care facility;

(f) A brief description of the discharge planning process from inpatient settings, which shall include a statement describing whether a provider must obtain authorization to delay a patient's discharge from the facility, if that provider deems an extended stay medically warranted;

(g) The availability of a point-of-service plan or an option to a point-of-service plan, how such a plan or option operates within the coverage, and any additional costs associated with selecting such a plan or utilizing such an option;

(h) An appendix of samples of documents, instruments, facility or provider rosters, plan telephone numbers, including toll-free numbers, or other information referred to in the enrollment agreement;

(i) A full description of the procedures to be followed by a plan enrollee or a covered family member for consulting a provider other than the primary care provider and whether the enrollee's primary care provider, the health maintenance organization's medical director, or another entity must authorize the referral. The description shall include whether repeat prior authorization to specialist care is necessary if the care is continuing;

(j) A description of plan prescription coverage to include:

(i) Copayment schedules and maximum patient out-of-pocket costs associated with prescription coverage;

(ii) The name and address of all retail pharmacies that are under contract with the health maintenance organization, and whether an enrollee may obtain prescriptions from retail pharmacies outside of any list of contracted pharmacies;

(iii) Whether a plan provider is restricted to prescribing drugs from a plan list or plan formulary;

(iv) What drugs are on the plan list or formulary;

(v) The extent to which enrollees will be reimbursed for drugs that are not on the plan's list or formulary;

(vi) Whether a provider must receive prior authorization to prescribe a drug not listed on the plan list or plan formulary that the provider deems therapeutically superior or medically critical to an enrollee's health, and if so, the party who makes such an authorization;

(vii) Whether provider contracts penalize a provider for prescribing outside of the plan formulary; and

(viii) The criteria the health maintenance organization considers before adding a drug to the plan list or formulary.

(k) A full description of procedures an enrollee or covered family member must follow to access emergency room health care services or after-hour and weekend services. The description shall also specify how the enrollee is to access health care services when the enrollee is out of the plan area. The description shall include procedures, if any, that an enrollee must first follow for obtaining prior authorization to access the health care services;

(l) Circumstances under which the plan may retroactively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies;

(m) A copy of all grievance procedures for coverage or service denial and for dissatisfaction with care or access to care. The health maintenance organization shall provide written disclosure to a plan enrollee at the time of enrollment regarding the process for initiating reviews of grievances, including expedited reviews in those cases when the time frame of a standard review could jeopardize the life or health of an enrollee or covered family member. The health maintenance organization shall also provide written disclosure to a plan enrollee

describing the appeal process that is available when coverage is denied for care that the enrollee believes is a covered service and for which a provider deems medically warranted. If a provider renders a professional medical judgment that results in the health maintenance organization denying coverage for treatment of a condition that the enrollee believes to be covered, the provider shall notify the enrollee and the health maintenance organization in writing in those cases when the provider believes the withholding of treatment could potentially threaten the life of the patient. The health maintenance organization is prohibited from penalizing the provider for such written notification. If a resolution between the plan enrollee, provider, and health maintenance organization is not achieved within a reasonable time frame, arbitration by an independent panel of similar specialty providers not affiliated with the health maintenance organization may be used to review the case;

(n) The telephone number of the insurance commissioner's office.

(2) Nothing in this section may be construed to require a health maintenance organization to divulge proprietary information to an enrollee. Proprietary information does not include any of the required disclosure items listed in this section or section 11 of this act.

NEW SECTION. **Sec. 12.** HEALTH MAINTENANCE ORGANIZATION DISCLOSURE IN MARKETING COMMUNICATIONS. (1) A health maintenance organization, as defined in RCW 48.46.020, is prohibited from printing or making statements regarding patient choice of provider in any written or verbal communications, plan documentation, or advertisements without written disclosure of limitations regarding the access to providers outside of a plan's network of providers or access to specialist providers within the plan.

(2) Upon request, a potential plan enrollee, prior to purchasing coverage, may request information in writing that is required to be disclosed in section 11 of this act for the purposes of comparing health maintenance organizations or other plans.

NEW SECTION. **Sec. 13.** HEALTH MAINTENANCE ORGANIZATION DISCLOSURE TO THE WASHINGTON OFFICE OF THE INSURANCE COMMISSIONER. Each health maintenance organization, as defined in RCW 48.46.020, that offers a health care plan to the public after July 1, 1998, shall file a standardized disclosure form, available from the office of the

insurance commissioner, with the commissioner annually. The commissioner shall create a standardized form to include the following:

(1) All disclosure requirements listed in section 11 of this act.

(2) Any limitations of services, benefits, or exclusions that apply to the plan, not specifically listed in section 11 of this act.

The commissioner shall annually prepare a comparative health plan guide for the general public that contains the consumer disclosure information from the standardized form explained in this section.

Sec. 14. RCW 48.43.105 and 1996 c 312 s 5 are each amended to read as follows:

LIABILITY IMMUNITY FOR PLAN COMPARISON ACTIVITIES. (1) A public or private entity ((~~who~~)) that exercises due diligence in preparing a document of any kind that compares health carriers ((~~of any kind~~)), as defined under RCW 48.43.005, health care service contractors, as defined under RCW 48.44.010, or health maintenance organizations, as defined under RCW 48.46.020, is immune from civil liability from claims based on the document and the contents of the document.

(2)(a) There is absolute immunity to civil liability from claims based on such a comparison document and its contents if the information was provided by the carrier, health care service contractor, or health maintenance organization, and was substantially accurately presented, and contained the effective date of the information that the carrier supplied, if any.

(b) Where due diligence efforts to obtain accurate information have been taken, there is immunity from claims based on such a comparison document and its contents if the publisher of the comparison document asked for such information from the carrier, health care service contractor, or health maintenance organization, but was refused, and relied on any usually reliable source for the information including, but not limited to, carrier enrollees, customers, agents, brokers, or providers. The carrier enrollees, customers, agents, brokers, or providers are likewise immune from civil liability on claims based on information they provided if they believed the information to be accurate and had exercised due diligence in their efforts to confirm the accuracy of the information provided.

(3) The immunity from liability contained in this section applies only if the comparison document contains the following in a conspicuous place and in easy to read typeface:

This comparison is based on information believed to be reliable by its publisher, but the accuracy of the information cannot be guaranteed. Caution is suggested to all readers who are encouraged to confirm data of importance to the reader before any purchasing or other decisions are made.

((~~(4) The insurance commissioner is prohibited from adopting rules regarding this section.~~))

NEW SECTION. **Sec. 15.** Sections 4 and 5 of this act are each added to chapter 48.43 RCW.

NEW SECTION. **Sec. 16.** Sections 6 through 9 of this act are each added to chapter 48.44 RCW.

NEW SECTION. **Sec. 17.** Sections 10 through 13 of this act are each added to chapter 48.46 RCW.

NEW SECTION. **Sec. 18.** RCW 48.43.085 and 1996 c 312 s 3 are each repealed.

NEW SECTION. **Sec. 19.** CAPTIONS NOT LAW. Captions used in this act are not any part of the law.

NEW SECTION. **Sec. 20.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 1998.

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