
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.

1 AN ACT Relating to managed care entities; amending RCW 48.43.001,
2 48.43.075, 48.43.095, and 48.43.105; adding new sections to chapter
3 48.43 RCW; adding new sections to chapter 48.44 RCW; adding new
4 sections to chapter 48.46 RCW; creating a new section; repealing RCW
5 48.43.085; providing an effective date; and declaring an emergency.

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

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

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

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

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

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

20 (a) The care the patient((s of the care they)) requires, including
21 various treatment options((7))i and

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

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

32 ((+2)) (3) No health carrier may preclude or discourage
33 ((patients)) plan enrollees or those paying for their coverage from
34 discussing the comparative merits of different health carriers or
35 health plans with their providers. This prohibition specifically
36 includes prohibiting or limiting providers participating in those
37 discussions even if critical of a carrier.

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

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

5 CARRIER DISCLOSURE TO PLAN ENROLLEES REGARDING CARRIER POLICIES.

6 (1) (~~Upon the request of an enrollee or a prospective enrollee, a~~)
7 Each health carrier, as defined in RCW 48.43.005, and the Washington
8 state health care authority, established by chapter 41.05 RCW, shall
9 provide to plan enrolles, in writing that is easily understandable to
10 a layperson, the following information:

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

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

14 (ii) Practice specialty;

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

17 (iv) Hospital affiliations of the provider;

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

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

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

24 (b) In concise and specific terms:

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

26 (ii) Any copayment, coinsurance, or deductible requirements that an
27 enrollee or the enrollee's family may incur in obtaining coverage under
28 the plan;

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

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

34 (v) The coordination of benefits;

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

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

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

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

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

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

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

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

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

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

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

37 (iii) Whether a plan provider is restricted to prescribing drugs
38 from a plan list or plan formulary(~~(7)~~);

39 (iv) What drugs are on the plan list or formulary(~~(7-and)~~);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33 NEW SECTION. Sec. 5. CARRIER DISCLOSURE TO THE WASHINGTON OFFICE
34 OF THE INSURANCE COMMISSIONER. Each carrier, as defined in RCW
35 48.43.005, that offers a health care plan to the public after July 1,
36 1998, shall file a standardized disclosure form, available from the
37 office of the insurance commissioner, with the commissioner annually.

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

- 3 (1) All disclosure requirements listed in RCW 48.43.095; and
- 4 (2) Limitations of services, benefits, or exclusions that apply to
5 the plan, not specifically listed in RCW 48.43.095.

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

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

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

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

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

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

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

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

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

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

6 (ii) Practice specialty;

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

9 (iv) Hospital affiliations of the provider;

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

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

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

16 (b) In concise and specific terms:

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

18 (ii) Any copayment, coinsurance, or deductible requirements that an
19 enrollee or the enrollee's family may incur in obtaining coverage under
20 the plan;

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

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

26 (v) The coordination of benefits;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (ii) Practice specialty;

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

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

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

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

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

37 (b) In concise and specific terms:

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

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

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

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

8 (v) The coordination of benefits;

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

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

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

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

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

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

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

1 (j) A description of plan prescription coverage to include:
2 (i) Copayment schedules and maximum patient out-of-pocket costs
3 associated with prescription coverage;
4 (ii) The name and address of all retail pharmacies that are under
5 contract with the health maintenance organization, and whether an
6 enrollee may obtain prescriptions from retail pharmacies outside of any
7 list of contracted pharmacies;
8 (iii) Whether a plan provider is restricted to prescribing drugs
9 from a plan list or plan formulary;
10 (iv) What drugs are on the plan list or formulary;
11 (v) The extent to which enrollees will be reimbursed for drugs that
12 are not on the plan's list or formulary;
13 (vi) Whether a provider must receive prior authorization to
14 prescribe a drug not listed on the plan list or plan formulary that the
15 provider deems therapeutically superior or medically critical to an
16 enrollee's health, and if so, the party who makes such an
17 authorization;
18 (vii) Whether provider contracts penalize a provider for
19 prescribing outside of the plan formulary; and
20 (viii) The criteria the health maintenance organization considers
21 before adding a drug to the plan list or formulary.
22 (k) A full description of procedures an enrollee or covered family
23 member must follow to access emergency room health care services or
24 after-hour and weekend services. The description shall also specify
25 how the enrollee is to access health care services when the enrollee is
26 out of the plan area. The description shall include procedures, if
27 any, that an enrollee must first follow for obtaining prior
28 authorization to access the health care services;
29 (l) Circumstances under which the plan may retroactively deny
30 coverage for emergency and nonemergency care that had prior
31 authorization under the plan's written policies;
32 (m) A copy of all grievance procedures for coverage or service
33 denial and for dissatisfaction with care or access to care. The health
34 maintenance organization shall provide written disclosure to a plan
35 enrollee at the time of enrollment regarding the process for initiating
36 reviews of grievances, including expedited reviews in those cases when
37 the time frame of a standard review could jeopardize the life or health
38 of an enrollee or covered family member. The health maintenance
39 organization shall also provide written disclosure to a plan enrollee

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

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

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

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

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

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

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

- 3 (1) All disclosure requirements listed in section 11 of this act.
4 (2) Any limitations of services, benefits, or exclusions that apply
5 to the plan, not specifically listed in section 11 of this act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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