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HOUSE BILL 2167

State of Washington 56th Legislature 1999 Regular Session

By Representatives Murray, Parlette, Campbell, Cody, Pflug, Schual-Berke, Edwards, Keiser, Dickerson, Veloria, Lantz, Edmonds, Haigh, Kenney, Rockefeller, Conway, Kagi, Kessler and Ogden

Read first time 02/17/1999. Referred to Committee on Health Care.

AN ACT Relating to health care; amending RCW 48.43.095, 48.43.055, 48.46.020, 48.46.100, and 48.43.093; adding a new chapter to Title 48 RCW; and creating a new section.

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

NEW SECTION. **Sec. 1.** The legislature finds that individuals receiving coverage for health care services should have access to quality services that appropriately meet the needs of the individuals. The legislature further finds that individuals should have choice among the providers offering services within their coverage plan and should have access to appropriate providers for services in need of specialized care. The legislature also finds that disagreements regarding the course of treatment or coverage of services recommended must be addressed in a consistent and expedient manner to ensure the individual receives access to appropriate, medically necessary care in a timely manner.

Sec. 2. RCW 48.43.095 and 1996 c 312 s 4 are each amended to read as follows:

(1) Each health carrier as defined in RCW 48.43.005, and the Washington state health care authority, shall provide to all enrollees at a minimum the following information:

(a) A list of covered benefits, including prescription drugs, if any;

(b) A list of exclusions, reductions, and limitations to covered benefits, including policies and practices related to any drug formulary, and any definition of medical necessity or other coverage criteria upon which they may be based;

(c) A statement containing the cost of premiums and enrollee point-of-service cost-sharing requirements;

(d) A full description of the procedures to be followed by an 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;

(e) Procedures, if any, that an enrollee must first follow for obtaining prior authorization for health care services;

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

(g) A copy of all grievance procedures for claim or service denial and for dissatisfaction with care.

(2) Upon the request of an enrollee or a prospective enrollee, a health carrier, as defined in RCW 48.43.005, and the Washington state health care authority, established by chapter 41.05 RCW, shall provide the following information:

(a) The availability of a point-of-service plan and how the plan operates within the coverage;

(b) Any documents, instruments, or other information referred to in the enrollment agreement;

(c) ((~~A full description of the procedures to be followed by an 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;~~

~~(d)~~)) Whether a plan provider is restricted to prescribing drugs from a plan list or plan formulary, what drugs are on the plan list or formulary, and the extent to which enrollees will be reimbursed for drugs that are not on the plan's list or formulary;

((~~(e) Procedures, if any, that an enrollee must first follow for obtaining prior authorization for health care services;~~

~~(f)~~)) (d) 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) 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) A copy of all grievance procedures for claim or service denial and for dissatisfaction with care;~~)) and

((~~(i)~~)) (e) 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)~~)) (3) 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)~~)) (4) Nothing in this section shall be construed to require a carrier to divulge proprietary information to an enrollee.

((~~(4)~~)) (5) The insurance commissioner is prohibited from adopting rules regarding this section.

NEW SECTION. **Sec. 3.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, in which failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(2) "Grievance" means an oral or written complaint submitted by or on behalf of an enrollee regarding the availability, delivery, or quality of health care services as described in section 4 of this act.

(3) "Grievance procedure" means a procedure for health carriers to respond to consumer complaints and conduct investigations of consumer complaints according to the standards and rules adopted by the office of the insurance commissioner.

(4) "Health plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(5) "Health care provider" or "provider" includes:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(6) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(7) "Health carrier" means a person or entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a disability insurance company, a health care service contractor, a health maintenance organization, and a fraternal benefit society.

(8) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the necessity and appropriateness of the initial proposed health care service.

NEW SECTION. **Sec. 4.** (1) Each enrollee in a health plan must have adequate choice among qualified health care providers. Each health plan must:

(a) Allow each enrollee to choose a primary care provider who is accepting new enrollees from a list of participating providers;

(b) Provide for appropriate and timely referral of enrollees to a choice of specialists within the plan if the primary care provider refers the enrollee to specialty care;

(c) Provide, upon request of an enrollee, access by the enrollee to a second opinion from a participating provider regarding a medical diagnosis or treatment plan;

(d) Allow, upon termination of a participating provider for good cause, an enrollee undergoing an active course of treatment, on either

an inpatient or outpatient basis for an illness or for a pregnancy, to continue treatment through the provider for covered services. However: (i) Coverage is to be provided for up to sixty days after the termination date for the condition that the enrollee is receiving the active course of treatment; or (ii) coverage through completion of postpartum care for an enrollee receiving coverage for a pregnancy. The provider's relationship with the plan must be continued on the same terms and conditions as those of the terminating contract, except for any provision requiring that the health plan assign new enrollees to the terminated provider; and

(e) Communicate the plan's responsibilities under this subsection to all enrollees and participating providers.

(2) To meet the health care needs of enrollees for covered benefits, each health plan must provide enrollees with appropriate access to primary care providers, acute care hospitals, specialists and subspecialists, and specialty medical services, including physical therapy, occupational therapy, chiropractic services, and rehabilitation services as provided by the plan, that are within a reasonable distance or travel time from the enrollee, including times of inclement weather.

(3) Each health carrier, as defined in RCW 48.43.005, is accountable for and must oversee any activities required by this section that it delegates to any contractor. No carrier may delegate any activity required by this section unless the carrier has a written and fully operational delegation policy that ensures that the contractor fulfills the requirements of this section.

(4) No contract executed by the health carrier may relieve the health carrier of its obligations to any enrollee for the provision of health care services or of its responsibility for compliance with applicable statutes or rules.

NEW SECTION. **Sec. 5.** (1) Each health carrier, in its review of inpatient medical and surgical benefits and outpatient medical and surgical benefits for residents of this state, shall meet the standards set forth in this section.

(2) Any decision to deny an admission, length of stay, extension of stay, or health service or procedure must be made by a participating provider who has reasonable access to board-certified specialty providers in making such determinations. The decision shall be

expeditiously transmitted to the enrollee and the health care provider requesting the course of treatment.

(3) Carriers shall maintain a documented utilization review program description and written utilization review criteria based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. Carriers shall make clinical protocols, medical management standards, and other review criteria available upon request to participating providers.

(4) No health carrier may preclude or discourage its providers from informing patients of the care he or she requires, including various treatment options, whether in the providers' view such care is consistent with the plan's health coverage criteria, or otherwise covered by the patient's service agreement with the health carrier. 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 any service.

NEW SECTION. **Sec. 6.** Each health maintenance organization, as defined in chapter 48.46 RCW, must provide adequate telephone access by enrollees to facilities and providers for sufficient time during the business and evening hours to ensure enrollee access to health services for covered health conditions and emergent health care needs.

NEW SECTION. **Sec. 7.** The legislature finds that health carrier grievance procedures should be standardized in order to provide enrollees with a clear, consistent, and efficient means of resolving complaints about the provision of health care. Health carrier grievance procedures should offer consumers the opportunity to have their complaint fairly reviewed first by the health carrier and, if appealed, by an impartial hearing officer. Consumers should also be notified of their right to file a complaint with the office of the insurance commissioner throughout the grievance process. The legislature further recognizes the authority of the office of the insurance commissioner to adopt rules that govern health carrier managed care procedures.

NEW SECTION. **Sec. 8.** (1) The insurance commissioner shall adopt by rule a standardized grievance procedure for enrollees of all health carriers. The standard grievance procedure must be available for all enrollees to file complaints about any health carrier practices that impact enrollee access to, satisfaction with, or quality of health care services, treatments, or providers. Enrollees' rights to appeal health carrier decisions may not be limited in scope and must include, but not be limited to:

(a) Distance or time needed to travel to an appointment;

(b) Access to specialists;

(c) Cleanliness and safety of the providers' facilities;

(d) Qualification and experience of providers;

(e) Choice of provider;

(f) Manner in which the patient is treated;

(g) Access to appropriate services and treatment; and

(h) Timeliness with which referrals, treatments, and services are approved and provided.

(2) The office of the insurance commissioner shall adopt rules to ensure that the standardized grievance procedure:

(a) Fully informs consumers about their rights, including their right to file additional complaints with the appropriate state government agencies, and identify the appropriate agencies for filing complaints;

(b) Allows grievances to be filed orally or in writing;

(c) Provides for action upon nonemergency grievances within twenty days, and responds to emergency grievances within twenty-four hours;

(d) Ensures grievances are reviewed by qualified personnel;

(e) Provides consumers with rights to receive a second opinion about the course of treatment;

(f) Allows consumers to be represented by their provider, family member, attorney, or other designated person, except as otherwise prohibited by law;

(g) Gives both oral and written notification of the decision and the reasons for the decision made;

(h) Maintains recordkeeping on all grievances;

(i) Provides the enrollee with access to all records concerning the enrollee's grievance, excluding any records made confidential by any other section of law;

(j) Involves no more than three levels of review, including the enrollee's initial request for plan assistance or review whether orally or in writing; and

(k) Informs the enrollee at each stage of the grievance procedure of the enrollee's right to file additional complaints with the appropriate state government agencies, and identifies the appropriate agencies for filing complaints.

(3) Each health carrier shall designate qualified personnel to review grievances who meet the standards adopted by rule by the office of the insurance commissioner.

(4) The health carrier shall assure that the grievance process is accessible to enrollees who do not speak English, who have literacy problems, and who have physical or mental disabilities that impede their access to file a grievance. The office of the insurance commissioner shall adopt rules to ensure health carriers make the grievance process accessible to all enrollees.

(5) All health carriers shall file evidence of their implementation of the standardized grievance procedure in writing to the office of the insurance commissioner by January 1st annually. Health carriers may be excused from resubmitting grievance procedures if there have been no changes since the health carrier's previous submission. The filing must be available to the general public by request to the office of the insurance commissioner. Grievance procedures must be given in a separate brochure to each enrollee at the time of enrollment and sent annually to all health carrier enrollees.

NEW SECTION. **Sec. 9.** (1) An enrollee's provider is not subject to liability for the negligent denial of benefits by the health carrier, if the provider reasonably informs the enrollee of the benefits, costs, risks, and alternatives pertaining to such treatment; appeals the decision of the health carrier denying such benefits, in writing, stating the reasons why such care or treatment is reasonable and necessary for the enrollee; and cooperates and assists the enrollee with appeals of the decision denying such treatment to the extent the provider can assist under law. Such written appeal by the provider must be considered in grievance or complaint investigation and any mediation proceeding.

(2) A health carrier is liable in tort as would be a health care provider in a medical negligence case if and when the health carrier is

negligent in its decision to refuse to pay for care to which the enrollee is entitled under the enrollee's policy and that refusal causes personal injury or damages to the enrollee.

Sec. 10. RCW 48.43.055 and 1995 c 265 s 20 are each amended to read as follows:

Each health carrier as defined under RCW 48.43.005 shall file with the commissioner its grievance procedures ((~~for review and adjudication of complaints initiated by covered persons or health care providers. Procedures filed under this section shall provide a fair review for consideration of complaints. Every health carrier shall provide reasonable means whereby any person aggrieved by actions of the health carrier may be heard in person or by their authorized representative on their written request for review. If the health carrier fails to grant or reject such request within thirty days after it is made, the complaining person may proceed as if the complaint had been rejected~~)) as described in sections 3 and 7 through 9 of this act. A complaint that has been rejected by the health carrier may be submitted to nonbinding mediation. Mediation shall be conducted pursuant to mediation rules similar to those of the American arbitration association, the center for public resources, the judicial arbitration and mediation service, RCW 7.70.100, or any other rules of mediation agreed to by the parties.

Sec. 11. RCW 48.46.020 and 1990 c 119 s 1 are each amended to read as follows:

As used in this chapter, the terms defined in this section shall have the meanings indicated unless the context indicates otherwise.

(1) "Health maintenance organization" means any organization receiving a certificate of registration by the commissioner under this chapter which provides comprehensive health care services to enrolled participants of such organization on a group practice per capita prepayment basis or on a prepaid individual practice plan, except for an enrolled participant's responsibility for copayments and/or deductibles, either directly or through contractual or other arrangements with other institutions, entities, or persons, and which qualifies as a health maintenance organization pursuant to RCW 48.46.030 and 48.46.040.

(2) "Comprehensive health care services" means basic consultative, diagnostic, and therapeutic services rendered by licensed health professionals together with emergency and preventive care, inpatient hospital, outpatient and physician care, at a minimum, and any additional health care services offered by the health maintenance organization.

(3) "Enrolled participant" means a person who or group of persons which has entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health maintenance organization to receive health care services.

(4) "Health professionals" means health care practitioners who are regulated by the state of Washington.

(5) "Health maintenance agreement" means an agreement for services between a health maintenance organization which is registered pursuant to the provisions of this chapter and enrolled participants of such organization which provides enrolled participants with comprehensive health services rendered to enrolled participants by health professionals, groups, facilities, and other personnel associated with the health maintenance organization.

(6) "Consumer" means any member, subscriber, enrollee, beneficiary, or other person entitled to health care services under terms of a health maintenance agreement, but not including health professionals, employees of health maintenance organizations, partners, or shareholders of stock corporations licensed as health maintenance organizations.

(7) "Meaningful role in policy making" means a procedure approved by the commissioner which provides consumers or elected representatives of consumers a means of submitting the views and recommendations of such consumers to the governing board of such organization coupled with reasonable assurance that the board will give regard to such views and recommendations.

(8) "Meaningful grievance procedure" means a procedure for investigation of consumer grievances ((~~in a timely manner aimed at mutual agreement for settlement~~)) according to procedures ((~~approved by the commissioner~~)), ((~~and~~)) which may include ((~~arbitration~~)) nonbinding mediation procedures as described in sections 3 and 7 through 9 of this act.

(9) "Provider" means any health professional, hospital, or other institution, organization, or person that furnishes any health care

services and is licensed or otherwise authorized to furnish such services.

(10) "Department" means the state department of social and health services.

(11) "Commissioner" means the insurance commissioner.

(12) "Group practice" means a partnership, association, corporation, or other group of health professionals:

(a) The members of which may be individual health professionals, clinics, or both individuals and clinics who engage in the coordinated practice of their profession; and

(b) The members of which are compensated by a prearranged salary, or by capitation payment or drawing account that is based on the number of enrolled participants.

(13) "Individual practice health care plan" means an association of health professionals in private practice who associate for the purpose of providing prepaid comprehensive health care services on a fee-for-service or capitation basis.

(14) "Uncovered expenditures" means the costs to the health maintenance organization of health care services that are the obligation of the health maintenance organization for which an enrolled participant would also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made as provided herein. The term does not include expenditures for covered services when a provider has agreed not to bill the enrolled participant even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured, or assumed by a person or organization other than the health maintenance organization.

(15) "Copayment" means an amount specified in a subscriber agreement which is an obligation of an enrolled participant for a specific service which is not fully prepaid.

(16) "Deductible" means the amount an enrolled participant is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.

(17) "Fully subordinated debt" means those debts that meet the requirements of RCW 48.46.235(3) and are recorded as equity.

(18) "Net worth" means the excess of total admitted assets as defined in RCW 48.12.010 over total liabilities but the liabilities shall not include fully subordinated debt.

(19) "Participating provider" means a provider as defined in subsection (9) of this section who contracts with the health maintenance organization or with its contractor or subcontractor and has agreed to provide health care services to enrolled participants with an expectation of receiving payment, other than copayment or deductible, directly or indirectly, from the health maintenance organization.

(20) "Carrier" means a health maintenance organization, an insurer, a health care services contractor, or other entity responsible for the payment of benefits or provision of services under a group or individual agreement.

(21) "Replacement coverage" means the benefits provided by a succeeding carrier.

(22) "Insolvent" or "insolvency" means that the organization has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

Sec. 12. RCW 48.46.100 and 1975 1st ex.s. c 290 s 11 are each amended to read as follows:

A health maintenance organization shall establish and maintain a grievance procedure, approved by the commissioner, ((~~to provide reasonable and effective resolution of complaints initiated by enrolled participants concerning any matter relating to the interpretation of any provision of such enrolled participants' health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, cancellations, or nonrenewals of enrolled participants' coverage; and the quality of the health care services rendered, and~~)) which may include procedures for ((~~arbitration~~)) nonbinding mediation as described in sections 3 and 7 through 9 of this act.

Sec. 13. RCW 48.43.093 and 1997 c 231 s 301 are each amended to read as follows:

(1) When conducting a review of the necessity and appropriateness of emergency services or making a benefit determination for emergency services:

(a) A health carrier shall cover emergency services necessary to screen and stabilize a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition

existed. In addition, a health carrier shall not require prior authorization of such services provided prior to the point of stabilization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from a nonparticipating hospital emergency department, a health carrier shall cover emergency services necessary to screen and stabilize a covered person if a prudent layperson would have reasonably believed that use of a participating hospital emergency department would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider or facility. In addition, a health carrier shall not require prior authorization of such services provided prior to the point of stabilization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed and that use of a participating hospital emergency department would result in a delay that would worsen the emergency.

(b) If an authorized representative of a health carrier authorizes coverage of emergency services, the health carrier shall not subsequently retract its authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on a material misrepresentation about the covered person's health condition made by the provider of emergency services.

(c) Coverage of emergency services may be subject to applicable copayments, coinsurance, and deductibles, and a health carrier may impose reasonable differential cost-sharing arrangements for emergency services rendered by nonparticipating providers, if such differential between cost-sharing amounts applied to emergency services rendered by participating provider versus nonparticipating provider does not exceed fifty dollars. Differential cost sharing for emergency services may not be applied when a covered person <u>is outside of the health carrier's service area, or when the covered person</u> presents to a nonparticipating hospital emergency department rather than a participating hospital emergency department when the health carrier requires preauthorization for postevaluation or poststabilization emergency services if:

(i) Due to circumstances beyond the covered person's control, the covered person was unable to go to a participating hospital emergency department in a timely fashion without serious impairment to the covered person's health; or

(ii) A prudent layperson possessing an average knowledge of health and medicine would have reasonably believed that he or she would be unable to go to a participating hospital emergency department in a timely fashion without serious impairment to the covered person's health.

(d) If a health carrier requires preauthorization for postevaluation or poststabilization services, the health carrier shall provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review. In order for postevaluation or poststabilization services to be covered by the health carrier, the provider or facility must make a documented good faith effort to contact the covered person's health carrier within thirty minutes of stabilization, if the covered person needs to be stabilized. The health carrier's authorized representative is required to respond to a telephone request for preauthorization from a provider or facility within thirty minutes. Failure of the health carrier to respond within thirty minutes constitutes authorization for the provision of immediately required medically necessary postevaluation and poststabilization services, unless the health carrier documents that it made a good faith effort but was unable to reach the provider or facility within thirty minutes after receiving the request.

(e) A health carrier shall immediately arrange for an alternative plan of treatment for the covered person if a nonparticipating emergency provider and health plan cannot reach an agreement on which services are necessary beyond those immediately necessary to stabilize the covered person consistent with state and federal laws.

(2) Nothing in this section is to be construed as prohibiting the health carrier from requiring notification within the time frame specified in the contract for inpatient admission or as soon thereafter as medically possible but no less than twenty-four hours. Nothing in this section is to be construed as preventing the health carrier from reserving the right to require transfer of a hospitalized covered person upon stabilization. Follow-up care that is a direct result of the emergency must be obtained in accordance with the health plan's usual terms and conditions of coverage. All other terms and conditions of coverage may be applied to emergency services.

NEW SECTION. **Sec. 14.** (1) Each health carrier shall develop and implement policies and procedures governing the collection, use, and

disclosure of enrollee health information. These policies and procedures shall include methods for enrollees to access information and amend incorrect information, for enrollees to restrict the disclosure of sensitive information, and for enrollees to obtain information about the carrier's health information policies. In addition, these policies and procedures shall include methods for carrier oversight and enforcement of information policies, for carrier storage and disposal of health information, and for carrier conformance to state and federal laws governing the collection, use, and disclosure of personally identifiable health information. Each carrier shall provide a summary notice of its health information policies to enrollees, including the enrollee's right to restrict the collection, use, and disclosure of health information.

(2) Except as otherwise required by statute or rule, a health carrier is, and all persons acting at the direction of or on behalf of a carrier or in receipt of an enrollee's personally identifiable health information are, prohibited from collecting, using, or disclosing personally identifiable health information unless authorized in writing by the person who is the subject of the information. At a minimum, such authorization shall be valid for a limited time and purpose, shall be specific as to purpose and type of information to be collected, used, or disclosed, and shall identify the persons who will be receiving the information.

(3) Health carriers, contractors, and subcontractors are prohibited from selling or otherwise providing health care information regarding enrollees to any private organization for marketing purposes without the consent of the enrollment. The enrollee must confirm their consent in writing after written disclosure from the carrier about the purposes for which the information will be used, who will have access to the information, and how long the information will be stored or used for the specified purpose.

(4) Any person who is the subject of an unauthorized collection, use, or disclosure of personally identifiable health information is entitled to the remedies provided under RCW 9.73.060 governing violations of the right to privacy.

NEW SECTION. **Sec. 15.** Sections 3 through 9 and 14 of this act constitute a new chapter in Title 48 RCW.

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