S-1114.1

SENATE BILL 5780

State of Washington 66th Legislature 2019 Regular Session

By Senators Becker, Short, Brown, Bailey, Warnick, and Wilson, L.

Read first time 01/31/19. Referred to Committee on Health & Long Term Care.

1 AN ACT Relating to health carrier provider networks and enrollee
2 protections; amending RCW 48.43.093 and 48.43.510; and adding new
3 sections to chapter 48.43 RCW.

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

5 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43
6 RCW to read as follows:
7 (1) In reviewing and approving a health plan, the commissioner
8 must affirmatively approve the adequacy of the plan's proposed
9 provider network. In determining the adequacy of the proposed
10 provider network, the commissioner must consider whether the proposed
11 network includes a sufficient number of contracted providers
12 practicing at contracted facilities to reasonably ensure that
13 enrollees have in-network access to covered health care services
14 delivered at those facilities.
15 (2) A health plan must permit an enrollee to petition the plan to
16 cover health care services delivered by an out-of-network provider
17 if: (a) The health plan has an absence of or an insufficient number
18 or type of in-network providers or facilities to provide a particular
19 covered health care service; and (b) the health care services would
20 be covered if provided by an in-network provider. If the enrollee has

already received such services, the plan must provide retroactive coverage of the services.

(3) A health plan must ensure that any enrollee cost-sharing obligation is included in the enrollee's in-network deductible and maximum out-of-pocket expenses if the enrollee receives health care services provided by an out-of-network provider at an in-network facility and the services would have been covered if provided by an in-network provider.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW to read as follows:

Health plans issued or renewed on or after January 1, 2021, must cover treatment for an enrollee resulting from provision of a noncovered treatment to the enrollee, if the resulting treatment is:

(1) Medically necessary;

(2) An otherwise covered benefit; and

(3) Provided by a contracted provider under the plan.

Sec. 3. 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

1 that use of a participating hospital emergency department would
2 result in a delay that would worsen the emergency.

3 (b) If an authorized representative of a health carrier
4 authorizes coverage of emergency services, the health carrier shall
5 not subsequently retract its authorization after the emergency
6 services have been provided, or reduce payment for an item or service
7 furnished in reliance on approval, unless the approval was based on a
8 material misrepresentation about the covered person's health
9 condition made by the provider of emergency services. <u>A violation of</u>
10 <u>this subsection (1)(b) of this section is an unfair or deceptive</u>
11 <u>practice in the conduct of trade or commerce and is a violation of</u>
12 <u>the consumer protection act, chapter 19.86 RCW.</u>

13 (c) Coverage of emergency services may be subject to applicable
14 copayments, coinsurance, and deductibles, and a health carrier may
15 impose reasonable differential cost-sharing arrangements for
16 emergency services rendered by nonparticipating providers, if such
17 differential between cost-sharing amounts applied to emergency
18 services rendered by participating provider versus nonparticipating
19 provider does not exceed fifty dollars. Differential cost sharing for
20 emergency services may not be applied when a covered person presents
21 to a nonparticipating hospital emergency department rather than a
22 participating hospital emergency department when the health carrier
23 requires preauthorization for postevaluation or poststabilization
24 emergency services if:

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

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

34 (d) If a health carrier requires preauthorization for
35 postevaluation or poststabilization services, the health carrier
36 shall provide access to an authorized representative twenty-four
37 hours a day, seven days a week, to facilitate review. In order for
38 postevaluation or poststabilization services to be covered by the
39 health carrier, the provider or facility must make a documented good
40 faith effort to contact the covered person's health carrier within

1 thirty minutes of stabilization, if the covered person needs to be
2 stabilized. The health carrier's authorized representative is
3 required to respond to a telephone request for preauthorization from
4 a provider or facility within thirty minutes. Failure of the health
5 carrier to respond within thirty minutes constitutes authorization
6 for the provision of immediately required medically necessary
7 postevaluation and poststabilization services, unless the health
8 carrier documents that it made a good faith effort but was unable to
9 reach the provider or facility within thirty minutes after receiving
10 the request.

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

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

27 **Sec. 4.** RCW 48.43.510 and 2012 c 211 s 26 are each amended to
28 read as follows:

29 (1) A carrier that offers a health plan may not offer to sell a
30 health plan to an enrollee or to any group representative, agent,
31 employer, or enrollee representative without first offering to
32 provide, and providing upon request, the following information before
33 purchase or selection:

34 (a) A listing of covered benefits, including prescription drug
35 benefits, if any, a copy of the current formulary, if any is used,
36 definitions of terms such as generic versus brand name, and policies
37 regarding coverage of drugs, such as how they become approved or
38 taken off the formulary, and how consumers may be involved in
39 decisions about benefits;

(b) A listing of exclusions, reductions, and limitations to covered benefits, and any definition of medical necessity or other coverage criteria upon which they may be based;

(c) A statement of the carrier's policies for protecting the confidentiality of health information;

(d) A statement of the cost of premiums and any enrollee cost-sharing requirements;

(e) A summary explanation of the carrier's review of adverse benefit determinations and grievance processes;

(f) A statement regarding the availability of a point-of-service option, if any, and how the option operates; and

(g) ((~~A convenient means of obtaining lists of participating primary care and specialty care providers, including disclosure of network arrangements that restrict access to providers within any plan network. The offer to provide the information referenced in this subsection (1)~~)) <u>Information on how to access the health plan's provider directory or directories maintained on the health plan's web site, as required by subsection (3) of this section. This information</u> must be clearly and prominently displayed on any information provided to any prospective enrollee or to any prospective group representative, agent, employer, or enrollee representative.

(2) Upon the request of any person, including a current enrollee, prospective enrollee, or the insurance commissioner, a carrier must provide written information regarding any health care plan it offers, that includes the following written information:

(a) Any documents, instruments, or other information referred to in the medical coverage agreement;

(b) 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;

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

(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 or network;

(e) Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to

1 encourage providers to withhold services or minimize or avoid
2 referrals to specialists;

3 (f) An annual accounting of all payments made by the carrier
4 which have been counted against any payment limitations, visit
5 limitations, or other overall limitations on a person's coverage
6 under a plan;

7 (g) A copy of the carrier's review of adverse benefit
8 determinations grievance process for claim or service denial and its
9 grievance process for dissatisfaction with care; and

10 (h) Accreditation status with one or more national managed care
11 accreditation organizations, and whether the carrier tracks its
12 health care effectiveness performance using the health employer data
13 information set (HEDIS), whether it publicly reports its HEDIS data,
14 and how interested persons can access its HEDIS data.

15 (3) A health plan issued or renewed after December 31, 2019, must
16 publish and maintain a provider directory or directories with
17 information on contracting providers that deliver health care
18 services to the health plan's enrollees.

19 (a) A health plan's provider directory:

20 (i) Must be published on the health plan's web site and be
21 available to enrollees, potential enrollees, providers, and the
22 public without restriction or limitation;

23 (ii) Must indicate which providers are accepting new patients;
24 and

25 (iii) May not include information on a provider that is not
26 currently under contract with the health plan.

27 (b) A health plan must establish and maintain a process for
28 enrollees, potential enrollees, providers, and the public to identify
29 and report potentially inaccurate, incomplete, or misleading
30 information provided in a provider directory. These processes must,
31 at a minimum, include a telephone number and dedicated email address
32 at which the plan will accept these reports, as well as a form on the
33 plan's provider directory web site that allows the information to be
34 reported to the plan directly through the web site.

35 (c)(i) Except as provided in (c)(ii) of this subsection, a health
36 plan must update its provider directory or directories at least once
37 a month.

38 (ii) A health plan must update a provider directory within seven
39 calendar days of confirming that information in the directory is
40 inaccurate if the plan is informed of or otherwise learns of an

inaccuracy related to: Whether a provider is under contract with the plan; whether a contracted provider, or an individual provider in a contracted provider group, is accepting new patients; or a contracted provider's practice location or other contact information.

(d) Upon receipt of a complaint, the commissioner shall determine whether an enrollee obtained health care services from an out-of-network provider that would have been covered if provided by an in-network provider because the enrollee reasonably relied on materially inaccurate, incomplete, or misleading information in a health plan's provider directory. If the commissioner finds that these requirements are met, the commissioner shall require the health plan to: (i) Provide coverage for any health care services provided to the enrollee that would have been covered if provided by an in-network provider; and (ii) reimburse the enrollee for any amount in excess of what the enrollee would have paid had the services been delivered by an in-network provider.

(4) Each carrier shall provide to all enrollees and prospective enrollees a list of available disclosure items.

((~~(4)~~)) (5) Nothing in this section requires a carrier or a health care provider to divulge proprietary information to an enrollee, including the specific contractual terms and conditions between a carrier and a provider.

((~~(5)~~)) (6) No carrier may advertise or market any health plan to the public as a plan that covers services that help prevent illness or promote the health of enrollees unless it:

(a) Provides all clinical preventive health services provided by the basic health plan, authorized by chapter 70.47 RCW;

(b) Monitors and reports annually to enrollees on standardized measures of health care and satisfaction of all enrollees in the health plan. The state department of health shall recommend appropriate standardized measures for this purpose, after consideration of national standardized measurement systems adopted by national managed care accreditation organizations and state agencies that purchase managed health care services; and

(c) Makes available upon request to enrollees its integrated plan to identify and manage the most prevalent diseases within its enrolled population, including cancer, heart disease, and stroke.

((~~(6)~~)) (7) No carrier may preclude or discourage its providers from informing an enrollee of the care he or she requires, including various treatment options, and whether in the providers' view such

care is consistent with the plan's health coverage criteria, or otherwise covered by the enrollee's medical coverage agreement with the carrier. No carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of an enrollee with a carrier. Nothing in this section shall be construed to authorize a provider to bind a carrier to pay for any service.

((~~(7)~~)) (8) No carrier may preclude or discourage enrollees or those paying for their coverage from discussing the comparative merits of different carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier.

((~~(8)~~)) (9) Each carrier must communicate enrollee information required in chapter 5, Laws of 2000 by means that ensure that a substantial portion of the enrollee population can make use of the information. Carriers may implement alternative, efficient methods of communication to ensure enrollees have access to information including, but not limited to, web site alerts, postcard mailings, and electronic communication in lieu of printed materials.

((~~(9)~~)) (10) The commissioner may adopt rules to implement this section. In developing rules to implement this section, the commissioner shall consider relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services, as well as opportunities to reduce administrative costs included in health plans.

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