S-1002.1

SENATE BILL 5587

State of Washington 56th Legislature 1999 Regular Session

By Senators Wojahn, Snyder, Thibaudeau, Fairley, Costa, Winsley, Prentice, McAuliffe, Kohl-Welles, Brown, Shin, Rasmussen and Franklin

Read first time . Referred to Committee on .

AN ACT Relating to health care patient protection; reenacting and amending RCW 48.43.005; adding new sections to chapter 48.43 RCW; creating new sections; and repealing RCW 48.43.075, 48.43.095, and 48.43.105.

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

NEW SECTION. **Sec. 1.** PATIENT RIGHTS. It is the intent of the legislature that patients covered by health plans receive quality health care designed to maintain and improve their health. The purpose of this act is to ensure that health plan patients:

(1) Have sufficient and timely access to clinically and culturally appropriate health care services designed to maintain and improve health;

(2) Have adequate choice among qualified health care professionals;

(3) Are assured that health care decisions are made by appropriate medical personnel based upon sound medical standards;

(4) Have improved access to information regarding their health plans;

(5) Have access to a quick and impartial process for appealing plan denials of health care coverage;

(6) Are protected from unnecessary invasions of health care privacy;

(7) Are assured that personal health care information will be used only as necessary to obtain and pay for health care or to improve the quality of care; and

(8) Are protected from unfair and deceptive practices.

Sec. 2. RCW 48.43.005 and 1997 c 231 s 202 and 1997 c 55 s 1 are each reenacted and amended to read as follows:

Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Adjusted community rate" means the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities.

(2) "Appropriate and medically necessary or medical necessity" means a coverage criterion a carrier may establish for determining a covered benefit which requires that a service:

(a) Is a clinically appropriate choice in the opinion of the enrollee's participating provider, based upon a preponderance of medical evidence;

(b) Has a reasonable probability of achieving the intended clinical outcome, particularly in consideration of expected enrollee compliance with treatment requirements; and

(c) Is based on recognized standards within a relevant health profession.

(3) "Basic health plan" means the plan described under chapter 70.47 RCW, as revised from time to time.

((~~(3)~~)) (4) "Basic health plan model plan" means a health plan as required in RCW 70.47.060(2)(d).

((~~(4)~~)) (5) "Basic health plan services" means that schedule of covered health services, including the description of how those benefits are to be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

((~~(5) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity,~~

~~appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.~~

~~(6) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.~~

~~(7)~~)) (6) "Coverage criterion" means an element that may be used to define a covered benefit and whose application may result in exceptions, reductions, or limitations. "Coverage criteria" include, but are not limited to, definitions of:

(a) Evidence-based determinations of cost-effectiveness or medical efficacy;

(b) Circumstances in which potential health benefits will exceed potential harm of particular treatments;

(c) An explicit exception, reduction, or limitation in a covered benefit, regardless of its medical necessity, except as may be prohibited by state or federal law or rule;

(d) An explicit exception, reduction, or limitation in any covered benefit provided only for the convenience of an enrollee or provider, when such convenience is unrelated to medical necessity; or

(e) Medical necessity.

(7) "Covered benefits" means:

(a) A health care service to treat a covered health condition according to the terms of any health plan; or

(b) Those health care services, such as preventive health care and wellness programs, to which a covered person is entitled under the terms of a health plan. Unless otherwise required by state or federal rule or law, a covered benefit to treat a covered health condition must be stated as treatment for a covered health condition. A carrier may establish coverage criteria whose application may result in exclusions, reductions, or limitations in covered benefits.

(8) "Covered health condition" means any disease, illness, injury, or condition of health risk covered according to the terms of any health plan.

(9) "Covered person" or "enrollee" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

((~~(8)~~)) (10) "Dependent" means, at a minimum, the enrollee's legal spouse and unmarried dependent children who qualify for coverage under the enrollee's health benefit plan.

((~~(9)~~)) (11) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty or more hours. The term includes a self-employed individual, including a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not work less than thirty hours per week and derives at least seventy-five percent of his or her income from a trade or business through which he or she has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form. Persons covered under a health benefit plan pursuant to the consolidated omnibus budget reconciliation act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements of chapter 265, Laws of 1995.

((~~(10)~~)) (12) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if 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.

((~~(11)~~)) (13) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

((~~(12)~~)) (14) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

((~~(13)~~)) (15) "Exception" or "exclusion" means any provision in a health plan whereby coverage for a specified peril is entirely eliminated or any statement of a risk not assumed under the health plan. If a coverage criterion results in the exclusion of a benefit, the coverage criterion must be stated when describing the exception.

(16) "Grievance" means a ((~~written~~)) documented complaint submitted by or on behalf of a covered person regarding: (a) Denial of payment for ((~~medical~~)) health care services or nonprovision of ((~~medical~~)) health care services ((~~included in the covered person's health benefit plan~~)), or (b) service delivery issues other than denial of payment for

((~~medical~~)) health care services or nonprovision of ((~~medical~~)) health care services, including dissatisfaction with ((~~medical~~)) health care, waiting time for ((~~medical~~)) health care services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

((~~(14)~~)) (17) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

((~~(15)~~)) (18) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 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.

((~~(16)~~)) (19) "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.

((~~(17)~~)) (20) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020.

((~~(18)~~)) (21) "Health information" means any information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(a) The past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(b) The provision of health care to an individual; or

(c) Payment for the provision of health care to an individual.

(22) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered or issued by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care services offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

((~~(19) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.~~

~~(20) "Open enrollment" means the annual sixty-two day period during the months of July and August during which every health carrier offering individual health plan coverage must accept onto individual coverage any state resident within the carrier's service area regardless of health condition who submits an application in accordance with RCW 48.43.035(1).~~))

(23) "Institutional advertisement" means an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of health coverage, or the promotion of a particular health carrier.

(24) "Invitation to contract" means an advertisement that is neither an invitation to inquire nor an institutional advertisement.

(25) "Invitation to inquire" means an advertisement the objective of which is the creation of the reader's or viewer's desire to inquire further about a health plan or health plans, which is limited to a brief description of the loss for which a benefit is payable, and which may contain:

(a) The dollar amount of the benefit payable; and/or

(b) The period during which the benefit is payable, if the advertisement does not refer to cost. An advertisement that specifies either the dollar amount of the benefit payable or the period during which the benefit is payable shall contain a provision stating as follows:

FOR COSTS AND FURTHER DETAILS OF THE COVERAGE, INCLUDING EXCLUSIONS, ANY REDUCTIONS OR LIMITATIONS, AND THE TERMS UNDER WHICH THE PLAN MAY BE CONTINUED IN FORCE, SEE YOUR AGENT OR WRITE TO THE COMPANY.

(26) "Limitation" means any provision that restricts coverage under the health plan, other than an exception or a reduction. If a coverage criterion results in a limitation, that coverage criterion must be stated when describing the limitation.

(27) "Medical management practices" means the policies and procedures used by a carrier to ensure the medical necessity or medical efficacy of a covered benefit, and includes, but is not limited to, policies and procedures governing:

(a) Treatment approvals and denials;

(b) Treatment protocols;

(c) Quality assurance activities; and

(d) Utilization management practices.

(28) "Network" means any group of participating providers and facilities providing health care services to an enrollee in a health plan. A health plan network for carriers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

((~~(21)~~)) (29) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(22)~~)) (30) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

((~~(23) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.~~

~~(24)~~)) (31) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

(32) "Reduction" means any provision that reduces the amount of the benefit. A risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used. If a coverage criterion results in a reduction, that coverage criterion must be stated when describing the reduction.

(33) "Small employer" means any person, firm, corporation, partnership, association, political subdivision except school districts, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until

the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term "small employer" includes a self-employed individual or sole proprietor. The term "small employer" also includes a self-employed individual or sole proprietor who derives at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year.

((~~(25)~~)) (34) "Subcontractor" means any person or entity with which a health carrier contracts to provide any service relating to any health plan issued by the carrier.

(35) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

((~~(26)~~)) (36) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

NEW SECTION. **Sec. 3.** ADEQUATE HEALTH CARE NETWORKS. (1) Each health plan must include a sufficient number and type of health care providers and facilities throughout the plan’s service area to meet the health care needs of enrollees for covered benefits while providing enrollees an adequate choice of providers. For the purposes of this section, the commissioner shall consider relevant standards adopted by national managed care accreditation organizations, the health care authority for public employees and for basic health plan enrollees, and the department of social and health services for the medical assistance program when determining what is adequate or reasonable. To the extent that a health plan offers a covered benefit involving health facilities or health services enumerated in this section, that plan must offer:

(a) An adequate number of accessible acute care hospital services within a reasonable distance or travel time;

(b) An adequate number of accessible primary care providers within a reasonable distance or travel time;

(c) An adequate number of accessible specialists and subspecialists within a reasonable distance or travel time. If the type of medical specialist needed for a specific condition is not represented on the specialty panel, enrollees must have access to nonparticipating health care professionals;

(d) Available specialty medical services, including physical therapy, occupational therapy, and rehabilitation services; and

(e) Available nonnetwork specialists, when a patient's unique medical circumstances warrant it.

(2) Each health plan must, at the carrier's expense, allow enrollees to continue receiving services from a provider whose contract with the plan is being terminated by the plan without cause under the terms of that contract for the longer of sixty days following notice of termination to the enrollees or, in group coverage arrangements involving periods of open enrollment, until the end of the next open enrollment period. The provider's contract with the health plan must be continued on the same terms and conditions as those of the contract the plan is terminating.

(3) Each health carrier must provide telephone access to health plan enrollees for sufficient time during business and evening hours to ensure enrollee access for routine care, and twenty-four hour telephone access to either the carrier's health care providers or a participating provider, for medical advice, emergency care, or authorization for care.

(4) Each health carrier must have reasonable standards for waiting times for health plan enrollees to obtain appointments with participating providers. The standards must include appointment scheduling guidelines based upon the type of health care service, including: Preventive, nonsymptomatic care; routine, nonurgent symptomatic care; urgent care; and emergency care.

(5) Carrier utilization reviewers shall have a telephone system capable of accepting or recording, or both, incoming telephone calls during other than normal business hours and shall respond to those calls within two business days.

(6) Each carrier is accountable for and must oversee any activities required by this section that it delegates to any subcontractor. No carrier may delegate any activity required by this section unless:

(a) Before any delegation, the carrier evaluates the prospective subcontractor's ability to perform the activities to be delegated;

(b) There is a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractors and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's performance is inadequate;

(c) The carrier monitors the subcontractor's performance on an ongoing basis and subjects that performance to formal review at least once a year; and

(d) If the carrier identifies deficiencies or areas for improvement, the carrier and the subcontractor take corrective action.

(7) No contract with a subcontractor 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 statutes or regulations.

(8) Each carrier must develop a plan to meet the needs of vulnerable and underserved populations among its health plan enrollees.

(a) The plan must provide culturally appropriate services to the greatest extent possible.

(b) When a significant number of enrollees in the plan speak a first language other than English, the plan must provide access to personnel fluent in languages other than English, to the greatest extent possible.

(c) The carrier must develop standards for continuity of care following enrollment, including sufficient information on how to access care within the plan.

(9) Each health plan must hold enrollees harmless against claims from participating providers for payment of cost of covered health services other than enrollees' cost-sharing obligations.

NEW SECTION. **Sec. 4.** CHOICE OF HEALTH CARE PROVIDER. (1) Each enrollee in a health plan must have adequate choice among qualified health care providers.

(2) Each health plan must allow an enrollee to choose a primary care provider from a list of primary care participating providers. Each carrier must update this list as participating providers are added or removed, and include:

(a) An adequate number of primary care providers who are accepting new enrollees; and

(b) A mix of primary care providers adequate to meet the needs of the enrolled population's varied characteristics, including age, sex, race, cultural background, and health status.

(3) Each health carrier must have a process whereby an enrollee in a health plan whose medical condition so warrants may be authorized to use a medical specialist as a primary care provider. This may include enrollees suffering from chronic diseases and those with other special needs.

(4) Each health plan must provide for continuity of care by:

(a) Assuring that primary care providers are responsible for at least:

(i) Supervision, coordination, and provision of health services to meet the needs of each enrollee; and

(ii) Initiation and coordination of referrals for specialty care; and

(b) Allowing enrollees, already undergoing an active course of treatment that began while enrolled in the plan, to continue receiving services for a reasonable period from a participating provider who is not affiliated with the enrollee's primary care provider's network.

(5)(a) Each health plan must provide for appropriate referral of enrollees to specialists within the plan, when specialty care is warranted.

(b) Enrollees must have access to medical specialists on a timely basis.

(c) Enrollees must be provided with a choice of specialists when a referral is made.

(6) Each health plan offered by a carrier must provide a point-of-service option that allows an enrollee to choose to receive service from a nonparticipating health care provider or facility. The point-of-service option may require that an enrollee pay a reasonable portion of the costs of the out-of-network care.

(7) Each health plan must provide, upon the request of an enrollee, access by the enrollee to a second opinion from a participating provider regarding any medical diagnosis or treatment plan.

NEW SECTION. **Sec. 5.** QUALITY HEALTH CARE. (1) A carrier must have a fully operational, comprehensive, written, quality improvement program that addresses access, continuity, and quality of care for all health plan enrollees. The quality improvement program must:

(a) Clearly outline the program's structure and content;

(b) Require contractual cooperation by practitioners and subcontractors with the carrier's quality activities;

(c) Assign responsibility to persons with appropriate clinical knowledge and skills; and

(d) Have adequate resources to meet the quality improvement program's goals.

(2) The carrier must have a written annual quality improvement work plan or schedule of quality improvement activities that includes at least:

(a) The clinical and nonclinical activities and studies planned for the year;

(b) The scope and expected outcomes of those activities and studies;

(c) A methodology for monitoring and tracking those activities and studies over time;

(d) Follow-up on previously identified quality issues, activities, and studies; and

(e) A planned written evaluation of the overall effectiveness of the quality improvement program.

(3) The scope and content of the carrier's quality improvement program must reflect the carrier's delivery system and include:

(a) Identification, monitoring, and assessment of meaningful clinical issues that affect the carrier's membership, including the health status of members with chronic conditions;

(b) Mechanisms to detect underutilization and overutilization;

(c) Continuity and coordination of members' care; and

(d) Data collection, measurement, and analysis to track clinical issues identified.

(4) The carrier must take action to improve quality, assess the effectiveness of interventions through systematic follow-up, and demonstrate improvements in clinical care and service to its members.

(5) The carrier must identify members with chronic/high-risk illnesses and implement appropriate programmatic responses to manage their care.

(6) The carrier must have a program for credentialing and recredentialing its participating providers. The program must include:

(a) The scope of providers covered by the credentialing program;

(b) The criteria and verification of information used to meet these criteria, including licensure, sanctions or limitations on licensure, and history of professional liability claims;

(c) The process used to make these decisions; and

(d) A recredentialing program that includes reevaluation of information from prior credentialing in addition to information from member complaints, satisfaction utilization management, medical records, and site visits.

NEW SECTION. **Sec. 6.** HEALTH INFORMATION PRIVACY. (1) Each health carrier must have written policies and procedures governing health information and enrollee communications to protect the privacy of health plan enrollees and ensure the confidentiality of enrollee health information.

(2) A health carrier is prohibited from releasing personally identifiable health information unless such a release is authorized in writing by the enrollee or disclosure is authorized pursuant to chapter 70.02 RCW and RCW 70.24.105. A health carrier is prohibited from releasing an enrollee's authorization to release health information without specific enrollee authorization. A health carrier must contractually require any person to whom it discloses an enrollee's health information, except when privileged communication is required by law, to comply with the requirements of this section.

(3) The commissioner shall adopt rules to implement this section and in doing so shall consider model health information privacy provisions recommended by the national association of insurance commissioners and other related professional organizations.

NEW SECTION. **Sec. 7.** INFORMATION DISCLOSURE. (1) It is a false and deceptive act for a health carrier to offer to sell a health plan to an enrollee or to any group representative, agent, employer, or enrollee representative if that person is not given an invitation to contract that contains at least:

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

(b) A listing 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 of the carrier's policies for protecting the confidentiality of health information;

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

(e) A summary explanation of grievance and appeal procedures;

(f) A statement affirming the availability of a point-of-service option and how the option operates; and

(g) A convenient means of obtaining a list of participating providers, including disclosure of network arrangements that restrict access to providers within any plan network.

(2) Upon the request of any person, including a current enrollee, prospective enrollee, or the insurance commissioner, a health carrier and the Washington state health care authority in relation to the uniform medical plan must provide written information regarding any health care plan it offers, including, but not limited to, information on plan structure, decision-making processes, procedures, health care benefits and exclusions, cost and cost-sharing, a list of participating providers, and grievance and appeal procedure, including the following written information:

(a) Any documents, instruments, or other information referred to in the enrollment 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) Circumstances under which the plan may retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies;

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

(g) 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.

(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.

(4) Nothing in this section requires a carrier to divulge proprietary information to an enrollee.

(5) No carrier may advertise, market, or present 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;

(b) Monitors and reports annually to enrollees on standardized measures of health care and satisfaction of all enrollees in the plan as recommended by the state department of health, after consideration of national standardized measurement systems adopted by national managed care accreditation organizations, the health care authority for public employees and for basic health plan enrollees, and the department of social and health services for the medical assistance program when determining what is adequate or reasonable;

(c) Has a certificate of approved partnership with the state department of health or a local health jurisdiction, attesting to the plan's active participation in community-wide efforts to maintain and improve the health status of its enrollees through public health education programs; and

(d) 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) No health carrier may preclude or discourage its providers from informing patients of the care it requires, including various treatment options, and whether in the providers' view such care is consistent with medical necessity, medical appropriateness, the plan's 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.

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

NEW SECTION. **Sec. 8.** MEDICAL DIRECTORS. No health carrier may appoint a medical director who is not a licensed physician in the state of Washington. The medical director is responsible for all medical necessity determinations and any medical management practices including treatment policies, protocols, quality assurance activities, and utilization management decisions for any health plan offered by the carrier. The medical quality assurance commission shall develop a definition of unprofessional conduct as it applies to the conduct of a physician practicing as a health carrier medical director.

NEW SECTION. **Sec. 9.** GRIEVANCE PROCESS. (1) Each health carrier must implement a written grievance process, approved by the commissioner in accordance with rules, that:

(a) Complies with:

(i) The requirements of this section; and

(ii) The notification, complaint-response, grievance process, and expedited grievance process timelines determined by the commissioner. For the purposes of this section, the commissioner shall consider the relevant timelines adopted by national managed care accreditation organizations, the health care authority for public employees and for basic health plan enrollees, and the department of social and health services for the medical assistance program; and

(b) Provides a clear explanation of the grievance process:

(i) Upon request to enrollees, prospective enrollees, and participating providers; and

(ii) Upon enrollment to new enrollees.

(2) Each health carrier must process as a grievance:

(a) An enrollee’s request for reconsideration of:

(i) The health carrier’s decision to modify, discontinue, or deny a health service;

(ii) The health carrier’s resolution of a complaint; or

(iii) The first resolution of any grievance;

(b) An enrollee’s complaint about:

(i) The quality of a health service; or

(ii) The availability of a health service; and

(c) An enrollee's complaint about an issue other than the quality or availability of a health service that the health carrier does not resolve within the required complaint-response timeline.

(3) Each carrier must expedite a grievance if the enrollee's provider indicates, or the health plan medical director determines, after considering the evidence, that following the grievance resolution timeline could seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

(4) Each carrier must process an enrollee's verbal or written grievance in accordance with the carrier's written grievance process and must:

(a) Provide written notice to the enrollee when:

(i) A grievance is received; or

(ii) A grievance is initiated as required by subsection (2)(c) of this section;

(b) Assist the enrollee with the grievance process;

(c) Document the substance of a verbal grievance;

(d) Evaluate the need for an expedited grievance is required and notify the enrollee and attending provider of the decision to expedite as soon as possible;

(e) Cooperate with the representative the enrollee may have chosen;

(f) Make a reasonable effort to discuss the grievance with the enrollee prior to resolving it;

(g) Consider additional information that the enrollee or the enrollee's provider may submit;

(h) Investigate and resolve the grievance; and

(i) Provide written notice as required by subsection (5) of this section.

(5) Each carrier must provide written notice to an enrollee when the carrier:

(a) Decides to modify, discontinue, or deny a health service the enrollee receives or requests; and

(b) Resolves the enrollee's grievance.

(6) Written notice required by subsection (5) of this section must explain:

(a) The carrier's decision about the provision of a health service or the grievance resolution;

(b) The coverage criterion for the decision;

(c) Any alternative health service that may be appropriate;

(d) The carrier's grievance process;

(e) With respect to the carrier's decision about the provision of a health service, how to exercise an enrollee's right to obtain a second opinion from a participating provider;

(f) With respect to the carrier's decision to modify or discontinue a health service currently provided through the plan, how to exercise an enrollee's right to continue that service;

(g) With respect to the carrier's grievance resolution:

(i) The enrollee's right to have that resolution reconsidered by one or more carrier representatives who were not involved in the original decision to provide health care or the grievance resolution, and who have authority to resolve the grievance differently; and

(ii) How to exercise the enrollee's right to discuss the grievance resolution, in person, with such representatives.

(7) Upon filing a grievance, and at the enrollee's request, each carrier must continue providing a health service that an enrollee is currently receiving through the plan and that the carrier has decided to modify or discontinue until the enrollee's grievance is resolved. If the resolution affirms the carrier's decision, the enrollee may be responsible for the cost of this continued health service.

(8) Any written communication required by this section must be:

(a) Readable; and

(b) Translated into the enrollee's primary language.

(9)(a) Each carrier must maintain a log of all grievances.

(b) Each grievance must be tracked until final resolution of the grievance process.

(c) The carrier must retain grievance records for three years and make them accessible to the commissioner.

(10)(a) Each carrier must annually send the commissioner a summary of the carrier's analysis of its grievance log.

(b) The summary must include:

(i) The number and nature of all grievances;

(ii) Time frames within which grievances were resolved and the decisions;

(iii) A listing of all grievances that were not resolved to the satisfaction of the enrollee;

(iv) The number and nature of grievances that the carrier resolved expeditiously; and

(v) Trends related to a particular provider, grievance type, or health service.

(c) If the summary reveals trends indicating problems with quality or access to health services, the carrier must:

(i) With respect to health plans not issued to the department of social and health services or the health care authority:

(A) Conduct a review;

(B) Report the results to the commissioner; and

(C) Take corrective action approved by the commissioner; and

(ii) With respect to health plans issued to the department of social and health services or the health care authority:

(A) Conduct a review;

(B) Report the results to the commissioner and the agency purchasing the health plan; and

(C) Take corrective action approved by the agency purchasing the health plan.

(11) Each carrier is responsible for and must monitor any delegated activities required by this section. Any person or entity to which the health carrier delegates any of the activities and functions described in this section must perform that delegation in compliance with this section.

(12) The commissioner shall adopt rules implementing this section.

NEW SECTION. **Sec. 10.** EXTERNAL REVIEW OF HEALTH CARE DISPUTES. (1) A health carrier must develop and implement a process for the fair consideration of consumer complaints relating to decisions by the health plan to deny or limit coverage of or payment for health care in accordance with rules adopted by the commissioner. Those rules shall:

(a) Permit a person, whose appeal of an adverse decision is denied by the carrier, to seek review of that determination by an independent review organization assigned to the appeal in accordance with rules adopted by the commissioner;

(b) Require carriers to provide to the appropriate independent review organization not later than the third business day after the date the carrier receives a request for review a copy of:

(i) Any medical records of the enrollee that are relevant to the review;

(ii) Any documents used by the plan in making the determination to be reviewed by the organization;

(iii) Any documentation and written information submitted to the carrier in support of the appeal; and

(iv) A list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal; and

(c) Require carriers to comply with the independent review organization's determination regarding the medical necessity or appropriateness of, or the application of other health plan coverage criterion to, health care items and services for an enrollee, and to pay for the independent review.

(2) Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to rules adopted by the commissioner.

NEW SECTION. **Sec. 11.** INDEPENDENT REVIEW OF MEDICAL DECISIONS. (1) The commissioner shall:

(a) Adopt rules for:

(i) The certification, selection, and operation of independent review organizations to perform independent review described by section 13 of this act; and

(ii) The suspension and revocation of the certification;

(b) Designate annually each organization that meets the standards as an independent review organization;

(c) Charge health carriers fees as necessary to fund the operations of independent review organizations; and

(d) Provide ongoing oversight of the independent review organizations to ensure continued compliance with this chapter and the rules adopted under this chapter.

(2) The rules adopted under subsection (1)(a) of this section must ensure:

(a) The timely response of an independent review organization selected under this chapter;

(b) The confidentiality of medical records transmitted to an independent review organization for use in independent reviews;

(c) The qualifications and independence of each health care provider or physician making review determinations for an independent review organization;

(d) The fairness of the procedures used by an independent review organization in making the determinations; and

(e) Timely notice to enrollees of the results of the independent review, including the clinical basis for the determination.

(3) The rules adopted under subsection (1)(a) of this section must include rules that require each independent review organization to make its determination:

(a) Not later than the earlier of:

(i) The fifteenth day after the date the independent review organization receives the information necessary to make the determination; or

(ii) The twentieth day after the date the independent review organization receives the request that the determination be made; and

(b) In the case of a life-threatening condition, not later than the earlier of:

(i) The fifth day after the date the independent review organization receives the information necessary to make the determination; or

(ii) The eighth day after the date the independent review organization receives the request that the determination be made.

(4) To be certified as an independent review organization under this chapter, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

(a) For an applicant that is publicly held, the name of each stockholder or owner of more than five percent of any stock or options;

(b) The name of any holder of bonds or notes of the applicant that exceed one hundred thousand dollars;

(c) The name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the affiliation or control;

(d) The name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed under (c) of this subsection and a description of any relationship the named individual has with:

(i) A health benefit plan;

(ii) A health carrier;

(iii) A utilization review agent;

(iv) A nonprofit health corporation;

(v) A health care provider; or

(vi) A group representing any of the entities described by (d)(i) through (v) of this subsection;

(e) The percentage of the applicant's revenues that are anticipated to be derived from reviews conducted under section 13 of this act;

(f) A description of the areas of expertise of the health care professionals making review determinations for the applicant; and

(g) The procedures to be used by the independent review organization in making review determinations regarding reviews conducted under section 13 of this act.

(5) The independent review organization shall annually submit the information required by subsection (4) of this section. If at any time there is a material change in the information included in the application under subsection (4) of this section, the independent review organization shall submit updated information to the commissioner.

(6) An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a health carrier or a trade or professional association of health carriers.

(7) An independent review organization conducting a review under section 13 of this act is not liable for damages arising from the determination made by the organization. This subsection does not apply to an act or omission of the independent review organization that is made in bad faith or that involves gross negligence.

NEW SECTION. **Sec. 12.** UNFAIR AND DECEPTIVE ACTS. (1) A health carrier shall not engage in unfair or deceptive acts or practices as such acts and practices are prohibited under chapter 48.30 RCW. Such acts and practices include but are not limited to the placement of any advertisement before the public that is false, inaccurate, or misleading. Such advertising is a matter affecting the public interest for the purposes of applying chapter 19.86 RCW, and is not reasonable in relation to the development and preservation of business. A violation of this section constitutes an unfair or deceptive act or practice in trade or commerce for the purpose of applying chapter 19.86 RCW.

(2) The commissioner may by rule define and prohibit other acts and practices by health carriers found by the commissioner to be unfair and deceptive and harmful to consumers.

NEW SECTION. **Sec. 13.** HEALTH CARE DECISIONS. (1) Beginning on July 1, 2000, every health carrier or other organization that performs utilization 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 and any rules adopted by the commissioner to implement this section.

(2) Any medical management practice decision made by a health carrier or its designee must be made in accordance with medical standards or guidelines developed and updated regularly by the health plan's quality improvement program in consultation with participating providers and used exclusively throughout the health plan.

(3) Any decision to deny an admission, length of stay, extension of stay, or service or procedure on the basis of medical necessity or appropriateness must be made by a participating provider who has reasonable access to board-certified specialty providers in making such determinations.

(4) Carriers and other organizations performing utilization review shall make staff available to perform utilization review activities by toll-free or collect telephone, at least forty hours per week during normal business hours.

(5) Reviewers shall have a phone system capable of accepting or recording, or both, incoming phone calls during other than normal business hours and shall respond to these calls within two business days.

(6) Reviewers 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. Review organizations shall make clinical protocols, medical management standards, and other review criteria available upon request to participating providers.

(7) The commissioner shall periodically examine the utilization review standards of the utilization review accreditation commission, the national committee for quality assurance, and other national accreditation organizations and, if appropriate, adopt rules establishing additional standards for utilization review, medical

necessity, and other health care service decision-making processes used by health carriers.

NEW SECTION. **Sec. 14.** This act may be known and cited as the health care patient bill of rights.

NEW SECTION. **Sec. 15.** Captions used in this act are not any part of the law.

NEW SECTION. **Sec. 16.** Sections 1, 3 through 13, and 17 of this act are each added to chapter 48.43 RCW.

NEW SECTION. **Sec. 17.** If any provision of this chapter conflicts with state or federal law, such provision must be construed in a manner most favorable to the enrollee.

NEW SECTION. **Sec. 18.** The following acts or parts of acts are each repealed:

(1) RCW 48.43.075 (Informing patients about their care--Health carriers may not preclude or discourage) and 1996 c 312 s 2;

(2) RCW 48.43.095 (Information provided to an enrollee or a prospective enrollee) and 1996 c 312 s 4; and

(3) RCW 48.43.105 (Preparation of documents that compare health carriers--Immunity--Due diligence) and 1996 c 312 s 5.

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