

CERTIFICATION OF ENROLLMENT
SECOND SUBSTITUTE SENATE BILL 6199

56th Legislature
2000 Regular Session

Passed by the Senate March 6, 2000
YEAS 45 NAYS 1

President of the Senate

Passed by the House March 3, 2000
YEAS 98 NAYS 0

**Speaker of the
House of Representatives**

**Speaker of the
House of Representatives**

Approved

Governor of the State of Washington

CERTIFICATE

I, Tony M. Cook, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SECOND SUBSTITUTE SENATE BILL 6199** as passed by the Senate and the House of Representatives on the dates hereon set forth.

Secretary

FILED

**Secretary of State
State of Washington**

SECOND SUBSTITUTE SENATE BILL 6199

AS AMENDED BY THE HOUSE

Passed Legislature - 2000 Regular Session

State of Washington

56th Legislature

2000 Regular Session

By Senate Committee on Ways & Means (originally sponsored by Senators Wojahn, Winsley, Thibaudeau, Snyder, Goings, Kohl-Welles, Jacobsen, Fraser, Prentice, Costa, Rasmussen, Bauer, Spanel, McAuliffe, Gardner, Franklin and Kline)

Read first time 01/26/00.

1 AN ACT Relating to health care patient protection; amending RCW
2 70.02.110, 70.02.900, 51.04.020, 74.09.050, and 70.47.130; adding new
3 sections to chapter 48.43 RCW; adding a new section to chapter 70.02
4 RCW; adding a new section to chapter 43.70 RCW; adding new sections to
5 chapter 41.05 RCW; creating new sections; repealing RCW 48.43.075 and
6 48.43.095; and providing effective dates.

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

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

12 (1) Have improved access to information regarding their health
13 plans;

14 (2) Have sufficient and timely access to appropriate health care
15 services, and choice among health care providers;

16 (3) Are assured that health care decisions are made by appropriate
17 medical personnel;

18 (4) Have access to a quick and impartial process for appealing plan
19 decisions;

1 (5) Are protected from unnecessary invasions of health care
2 privacy; and

3 (6) Are assured that personal health care information will be used
4 only as necessary to obtain and pay for health care or to improve the
5 quality of care.

6 NEW SECTION. **Sec. 2.** A new section is added to chapter 70.02 RCW
7 to read as follows:

8 HEALTH INFORMATION PRIVACY. Third-party payors shall not release
9 health care information disclosed under this chapter, except to the
10 extent that health care providers are authorized to do so under RCW
11 70.02.050.

12 **Sec. 3.** RCW 70.02.110 and 1991 c 335 s 402 are each amended to
13 read as follows:

14 HEALTH INFORMATION PRIVACY. (1) In making a correction or
15 amendment, the health care provider shall:

16 (a) Add the amending information as a part of the health record;
17 and

18 (b) Mark the challenged entries as corrected or amended entries and
19 indicate the place in the record where the corrected or amended
20 information is located, in a manner practicable under the
21 circumstances.

22 (2) If the health care provider maintaining the record of the
23 patient's health care information refuses to make the patient's
24 proposed correction or amendment, the provider shall:

25 (a) Permit the patient to file as a part of the record of the
26 patient's health care information a concise statement of the correction
27 or amendment requested and the reasons therefor; and

28 (b) Mark the challenged entry to indicate that the patient claims
29 the entry is inaccurate or incomplete and indicate the place in the
30 record where the statement of disagreement is located, in a manner
31 practicable under the circumstances.

32 (3) A health care provider who receives a request from a patient to
33 amend or correct the patient's health care information, as provided in
34 RCW 70.02.100, shall forward any changes made in the patient's health
35 care information or health record, including any statement of
36 disagreement, to any third-party payor or insurer to which the health

1 care provider has disclosed the health care information that is the
2 subject of the request.

3 **Sec. 4.** RCW 70.02.900 and 1991 c 335 s 901 are each amended to
4 read as follows:

5 HEALTH INFORMATION PRIVACY. (1) This chapter does not restrict a
6 health care provider, a third-party payor, or an insurer regulated
7 under Title 48 RCW from complying with obligations imposed by federal
8 or state health care payment programs or federal or state law.

9 (2) This chapter does not modify the terms and conditions of
10 disclosure under Title 51 RCW and chapters 13.50, 26.09, 70.24, 70.39,
11 70.96A, 71.05, and 71.34 RCW and rules adopted under these provisions.

12 NEW SECTION. **Sec. 5.** HEALTH INFORMATION PRIVACY. (1) Health
13 carriers and insurers shall adopt policies and procedures that conform
14 administrative, business, and operational practices to protect an
15 enrollee's right to privacy or right to confidential health care
16 services granted under state or federal laws.

17 (2) The commissioner may adopt rules to implement this section
18 after considering relevant standards adopted by national managed care
19 accreditation organizations and the national association of insurance
20 commissioners, and after considering the effect of those standards on
21 the ability of carriers to undertake enrollee care management and
22 disease management programs.

23 NEW SECTION. **Sec. 6.** INFORMATION DISCLOSURE. (1) A carrier that
24 offers a health plan may not offer to sell a health plan to an enrollee
25 or to any group representative, agent, employer, or enrollee
26 representative without first offering to provide, and providing upon
27 request, the following information before purchase or selection:

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

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

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

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

5 (e) A summary explanation of the carrier's grievance process;

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

8 (g) A convenient means of obtaining lists of participating primary
9 care and specialty care providers, including disclosure of network
10 arrangements that restrict access to providers within any plan network.
11 The offer to provide the information referenced in this subsection (1)
12 must be clearly and prominently displayed on any information provided
13 to any prospective enrollee or to any prospective group representative,
14 agent, employer, or enrollee representative.

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

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

21 (b) A full description of the procedures to be followed by an
22 enrollee for consulting a provider other than the primary care provider
23 and whether the enrollee's primary care provider, the carrier's medical
24 director, or another entity must authorize the referral;

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

27 (d) A written description of any reimbursement or payment
28 arrangements, including, but not limited to, capitation provisions,
29 fee-for-service provisions, and health care delivery efficiency
30 provisions, between a carrier and a provider or network;

31 (e) Descriptions and justifications for provider compensation
32 programs, including any incentives or penalties that are intended to
33 encourage providers to withhold services or minimize or avoid referrals
34 to specialists;

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

38 (g) A copy of the carrier's grievance process for claim or service
39 denial and for dissatisfaction with care; and

1 (h) Accreditation status with one or more national managed care
2 accreditation organizations, and whether the carrier tracks its health
3 care effectiveness performance using the health employer data
4 information set (HEDIS), whether it publicly reports its HEDIS data,
5 and how interested persons can access its HEDIS data.

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

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

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

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

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

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

27 (6) No carrier may preclude or discourage its providers from
28 informing an enrollee of the care he or she requires, including various
29 treatment options, and whether in the providers' view such care is
30 consistent with the plan's health coverage criteria, or otherwise
31 covered by the enrollee's medical coverage agreement with the carrier.
32 No carrier may prohibit, discourage, or penalize a provider otherwise
33 practicing in compliance with the law from advocating on behalf of an
34 enrollee with a carrier. Nothing in this section shall be construed to
35 authorize a provider to bind a carrier to pay for any service.

36 (7) No carrier may preclude or discourage enrollees or those paying
37 for their coverage from discussing the comparative merits of different
38 carriers with their providers. This prohibition specifically includes

1 prohibiting or limiting providers participating in those discussions
2 even if critical of a carrier.

3 (8) Each carrier must communicate enrollee information required in
4 this act by means that ensure that a substantial portion of the
5 enrollee population can make use of the information.

6 (9) The commissioner may adopt rules to implement this section. In
7 developing rules to implement this section, the commissioner shall
8 consider relevant standards adopted by national managed care
9 accreditation organizations and state agencies that purchase managed
10 health care services.

11 NEW SECTION. **Sec. 7. ACCESS TO APPROPRIATE HEALTH SERVICES.** (1)
12 Each enrollee in a health plan must have adequate choice among health
13 care providers.

14 (2) Each carrier must allow an enrollee to choose a primary care
15 provider who is accepting new enrollees from a list of participating
16 providers. Enrollees also must be permitted to change primary care
17 providers at any time with the change becoming effective no later than
18 the beginning of the month following the enrollee's request for the
19 change.

20 (3) Each carrier must have a process whereby an enrollee with a
21 complex or serious medical or psychiatric condition may receive a
22 standing referral to a participating specialist for an extended period
23 of time.

24 (4) Each carrier must provide for appropriate and timely referral
25 of enrollees to a choice of specialists within the plan if specialty
26 care is warranted. If the type of medical specialist needed for a
27 specific condition is not represented on the specialty panel, enrollees
28 must have access to nonparticipating specialty health care providers.

29 (5) Each carrier shall provide enrollees with direct access to the
30 participating chiropractor of the enrollee's choice for covered
31 chiropractic health care without the necessity of prior referral.
32 Nothing in this subsection shall prevent carriers from restricting
33 enrollees to seeing only providers who have signed participating
34 provider agreements or from utilizing other managed care and cost
35 containment techniques and processes. For purposes of this subsection,
36 "covered chiropractic health care" means covered benefits and
37 limitations related to chiropractic health services as stated in the

1 plan's medical coverage agreement, with the exception of any provisions
2 related to prior referral for services.

3 (6) Each carrier must provide, upon the request of an enrollee,
4 access by the enrollee to a second opinion regarding any medical
5 diagnosis or treatment plan from a qualified participating provider of
6 the enrollee's choice.

7 (7) Each carrier must cover services of a primary care provider
8 whose contract with the plan or whose contract with a subcontractor is
9 being terminated by the plan or subcontractor without cause under the
10 terms of that contract for at least sixty days following notice of
11 termination to the enrollees or, in group coverage arrangements
12 involving periods of open enrollment, only until the end of the next
13 open enrollment period. The provider's relationship with the carrier
14 or subcontractor must be continued on the same terms and conditions as
15 those of the contract the plan or subcontractor is terminating, except
16 for any provision requiring that the carrier assign new enrollees to
17 the terminated provider.

18 (8) Every carrier shall meet the standards set forth in this
19 section and any rules adopted by the commissioner to implement this
20 section. In developing rules to implement this section, the
21 commissioner shall consider relevant standards adopted by national
22 managed care accreditation organizations and state agencies that
23 purchase managed health care services.

24 NEW SECTION. **Sec. 8.** HEALTH CARE DECISIONS. (1) Carriers that
25 offer a health plan shall maintain a documented utilization review
26 program description and written utilization review criteria based on
27 reasonable medical evidence. The program must include a method for
28 reviewing and updating criteria. Carriers shall make clinical
29 protocols, medical management standards, and other review criteria
30 available upon request to participating providers.

31 (2) The commissioner shall adopt, in rule, standards for this
32 section after considering relevant standards adopted by national
33 managed care accreditation organizations and state agencies that
34 purchase managed health care services.

35 (3) A carrier shall not be required to use medical evidence or
36 standards in its utilization review of religious nonmedical treatment
37 or religious nonmedical nursing care.

1 NEW SECTION. **Sec. 9.** RETROSPECTIVE DENIAL OF SERVICES. (1) A
2 health carrier that offers a health plan shall not retrospectively deny
3 coverage for emergency and nonemergency care that had prior
4 authorization under the plan's written policies at the time the care
5 was rendered.

6 (2) The commissioner shall adopt, in rule, standards for this
7 section after considering relevant standards adopted by national
8 managed care accreditation organizations and state agencies that
9 purchase managed health care services.

10 NEW SECTION. **Sec. 10.** GRIEVANCE PROCESS. (1) Each carrier that
11 offers a health plan must have a fully operational, comprehensive
12 grievance process that complies with the requirements of this section
13 and any rules adopted by the commissioner to implement this section.
14 For the purposes of this section, the commissioner shall consider
15 grievance process standards adopted by national managed care
16 accreditation organizations and state agencies that purchase managed
17 health care services.

18 (2) Each carrier must process as a complaint an enrollee's
19 expression of dissatisfaction about customer service or the quality or
20 availability of a health service. Each carrier must implement
21 procedures for registering and responding to oral and written
22 complaints in a timely and thorough manner.

23 (3) Each carrier must provide written notice to an enrollee or the
24 enrollee's designated representative, and the enrollee's provider, of
25 its decision to deny, modify, reduce, or terminate payment, coverage,
26 authorization, or provision of health care services or benefits,
27 including the admission to or continued stay in a health care facility.

28 (4) Each carrier must process as an appeal an enrollee's written or
29 oral request that the carrier reconsider: (a) Its resolution of a
30 complaint made by an enrollee; or (b) its decision to deny, modify,
31 reduce, or terminate payment, coverage, authorization, or provision of
32 health care services or benefits, including the admission to, or
33 continued stay in, a health care facility. A carrier must not require
34 that an enrollee file a complaint prior to seeking appeal of a decision
35 under (b) of this subsection.

36 (5) To process an appeal, each carrier must:

37 (a) Provide written notice to the enrollee when the appeal is
38 received;

1 (b) Assist the enrollee with the appeal process;

2 (c) Make its decision regarding the appeal within thirty days of
3 the date the appeal is received. An appeal must be expedited if the
4 enrollee's provider or the carrier's medical director reasonably
5 determines that following the appeal process response timelines could
6 seriously jeopardize the enrollee's life, health, or ability to regain
7 maximum function. The decision regarding an expedited appeal must be
8 made within seventy-two hours of the date the appeal is received;

9 (d) Cooperate with a representative authorized in writing by the
10 enrollee;

11 (e) Consider information submitted by the enrollee;

12 (f) Investigate and resolve the appeal; and

13 (g) Provide written notice of its resolution of the appeal to the
14 enrollee and, with the permission of the enrollee, to the enrollee's
15 providers. The written notice must explain the carrier's decision and
16 the supporting coverage or clinical reasons and the enrollee's right to
17 request independent review of the carrier's decision under section 11
18 of this act.

19 (6) Written notice required by subsection (3) of this section must
20 explain:

21 (a) The carrier's decision and the supporting coverage or clinical
22 reasons; and

23 (b) The carrier's appeal process, including information, as
24 appropriate, about how to exercise the enrollee's rights to obtain a
25 second opinion, and how to continue receiving services as provided in
26 this section.

27 (7) When an enrollee requests that the carrier reconsider its
28 decision to modify, reduce, or terminate an otherwise covered health
29 service that an enrollee is receiving through the health plan and the
30 carrier's decision is based upon a finding that the health service, or
31 level of health service, is no longer medically necessary or
32 appropriate, the carrier must continue to provide that health service
33 until the appeal is resolved. If the resolution of the appeal or any
34 review sought by the enrollee under section 11 of this act affirms the
35 carrier's decision, the enrollee may be responsible for the cost of
36 this continued health service.

37 (8) Each carrier must provide a clear explanation of the grievance
38 process upon request, upon enrollment to new enrollees, and annually to
39 enrollees and subcontractors.

1 (9) Each carrier must ensure that the grievance process is
2 accessible to enrollees who are limited English speakers, who have
3 literacy problems, or who have physical or mental disabilities that
4 impede their ability to file a grievance.

5 (10) Each carrier must: Track each appeal until final resolution;
6 maintain, and make accessible to the commissioner for a period of three
7 years, a log of all appeals; and identify and evaluate trends in
8 appeals.

9 NEW SECTION. **Sec. 11.** INDEPENDENT REVIEW OF HEALTH CARE DISPUTES.

10 (1) There is a need for a process for the fair consideration of
11 disputes relating to decisions by carriers that offer a health plan to
12 deny, modify, reduce, or terminate coverage of or payment for health
13 care services for an enrollee.

14 (2) An enrollee may seek review by a certified independent review
15 organization of a carrier's decision to deny, modify, reduce, or
16 terminate coverage of or payment for a health care service, after
17 exhausting the carrier's grievance process and receiving a decision
18 that is unfavorable to the enrollee, or after the carrier has exceeded
19 the timelines for grievances provided in section 10 of this act,
20 without good cause and without reaching a decision.

21 (3) The commissioner must establish and use a rotational registry
22 system for the assignment of a certified independent review
23 organization to each dispute. The system should be flexible enough to
24 ensure that an independent review organization has the expertise
25 necessary to review the particular medical condition or service at
26 issue in the dispute.

27 (4) Carriers must provide to the appropriate certified independent
28 review organization, not later than the third business day after the
29 date the carrier receives a request for review, a copy of:

30 (a) Any medical records of the enrollee that are relevant to the
31 review;

32 (b) Any documents used by the carrier in making the determination
33 to be reviewed by the certified independent review organization;

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

36 (d) A list of each physician or health care provider who has
37 provided care to the enrollee and who may have medical records relevant
38 to the appeal. Health information or other confidential or proprietary

1 information in the custody of a carrier may be provided to an
2 independent review organization, subject to rules adopted by the
3 commissioner.

4 (5) The medical reviewers from a certified independent review
5 organization will make determinations regarding the medical necessity
6 or appropriateness of, and the application of health plan coverage
7 provisions to, health care services for an enrollee. The medical
8 reviewers' determinations must be based upon their expert medical
9 judgment, after consideration of relevant medical, scientific, and
10 cost-effectiveness evidence, and medical standards of practice in the
11 state of Washington. Except as provided in this subsection, the
12 certified independent review organization must ensure that
13 determinations are consistent with the scope of covered benefits as
14 outlined in the medical coverage agreement. Medical reviewers may
15 override the health plan's medical necessity or appropriateness
16 standards if the standards are determined upon review to be
17 unreasonable or inconsistent with sound, evidence-based medical
18 practice.

19 (6) Once a request for an independent review determination has been
20 made, the independent review organization must proceed to a final
21 determination, unless requested otherwise by both the carrier and the
22 enrollee or the enrollee's representative.

23 (7) Carriers must timely implement the certified independent review
24 organization's determination, and must pay the certified independent
25 review organization's charges.

26 (8) When an enrollee requests independent review of a dispute under
27 this section, and the dispute involves a carrier's decision to modify,
28 reduce, or terminate an otherwise covered health service that an
29 enrollee is receiving at the time the request for review is submitted
30 and the carrier's decision is based upon a finding that the health
31 service, or level of health service, is no longer medically necessary
32 or appropriate, the carrier must continue to provide the health service
33 if requested by the enrollee until a determination is made under this
34 section. If the determination affirms the carrier's decision, the
35 enrollee may be responsible for the cost of the continued health
36 service.

37 (9) A certified independent review organization may notify the
38 office of the insurance commissioner if, based upon its review of

1 disputes under this section, it finds a pattern of substandard or
2 egregious conduct by a carrier.

3 (10)(a) The commissioner shall adopt rules to implement this
4 section after considering relevant standards adopted by national
5 managed care accreditation organizations.

6 (b) This section is not intended to supplant any existing authority
7 of the office of the insurance commissioner under this title to oversee
8 and enforce carrier compliance with applicable statutes and rules.

9 NEW SECTION. **Sec. 12.** A new section is added to chapter 43.70 RCW
10 to read as follows:

11 INDEPENDENT REVIEW ORGANIZATIONS. (1) The department shall adopt
12 rules providing a procedure and criteria for certifying one or more
13 organizations to perform independent review of health care disputes
14 described in section 11 of this act.

15 (2) The rules must require that the organization ensure:

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

18 (b) That each health care provider, physician, or contract
19 specialist making review determinations for an independent review
20 organization is qualified. Physicians, other health care providers,
21 and, if applicable, contract specialists must be appropriately
22 licensed, certified, or registered as required in Washington state or
23 in at least one state with standards substantially comparable to
24 Washington state. Reviewers may be drawn from nationally recognized
25 centers of excellence, academic institutions, and recognized leading
26 practice sites. Expert medical reviewers should have substantial,
27 recent clinical experience dealing with the same or similar health
28 conditions. The organization must have demonstrated expertise and a
29 history of reviewing health care in terms of medical necessity,
30 appropriateness, and the application of other health plan coverage
31 provisions;

32 (c) That any physician, health care provider, or contract
33 specialist making a review determination in a specific review is free
34 of any actual or potential conflict of interest or bias. Neither the
35 expert reviewer, nor the independent review organization, nor any
36 officer, director, or management employee of the independent review
37 organization may have any material professional, familial, or financial
38 affiliation with any of the following: The health carrier;

1 professional associations of carriers and providers; the provider; the
2 provider's medical or practice group; the health facility at which the
3 service would be provided; the developer or manufacturer of a drug or
4 device under review; or the enrollee;

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

7 (e) That each independent review organization make its
8 determination:

9 (i) Not later than the earlier of:

10 (A) The fifteenth day after the date the independent review
11 organization receives the information necessary to make the
12 determination; or

13 (B) The twentieth day after the date the independent review
14 organization receives the request that the determination be made. In
15 exceptional circumstances, when the independent review organization has
16 not obtained information necessary to make a determination, a
17 determination may be made by the twenty-fifth day after the date the
18 organization received the request for the determination; and

19 (ii) In cases of a condition that could seriously jeopardize the
20 enrollee's health or ability to regain maximum function, not later than
21 the earlier of:

22 (A) Seventy-two hours after the date the independent review
23 organization receives the information necessary to make the
24 determination; or

25 (B) The eighth day after the date the independent review
26 organization receives the request that the determination be made;

27 (f) That timely notice is provided to enrollees of the results of
28 the independent review, including the clinical basis for the
29 determination;

30 (g) That the independent review organization has a quality
31 assurance mechanism in place that ensures the timeliness and quality of
32 review and communication of determinations to enrollees and carriers,
33 and the qualifications, impartiality, and freedom from conflict of
34 interest of the organization, its staff, and expert reviewers; and

35 (h) That the independent review organization meets any other
36 reasonable requirements of the department directly related to the
37 functions the organization is to perform under this section and section
38 11 of this act.

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

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

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

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

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

16 (i) A carrier;

17 (ii) A utilization review agent;

18 (iii) A nonprofit or for-profit health corporation;

19 (iv) A health care provider;

20 (v) A drug or device manufacturer; or

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

23 (e) The percentage of the applicant's revenues that are anticipated
24 to be derived from reviews conducted under section 11 of this act;

25 (f) A description of the areas of expertise of the health care
26 professionals and contract specialists making review determinations for
27 the applicant; and

28 (g) The procedures to be used by the independent review
29 organization in making review determinations regarding reviews
30 conducted under section 11 of this act.

31 (4) If at any time there is a material change in the information
32 included in the application under subsection (3) of this section, the
33 independent review organization shall submit updated information to the
34 department.

35 (5) An independent review organization may not be a subsidiary of,
36 or in any way owned or controlled by, a carrier or a trade or
37 professional association of health care providers or carriers.

38 (6) An independent review organization, and individuals acting on
39 its behalf, are immune from suit in a civil action when performing

1 functions under this act. However, this immunity does not apply to an
2 act or omission made in bad faith or that involves gross negligence.

3 (7) Independent review organizations must be free from interference
4 by state government in its functioning except as provided in subsection
5 (8) of this section.

6 (8) The rules adopted under this section shall include provisions
7 for terminating the certification of an independent review organization
8 for failure to comply with the requirements for certification. The
9 department may review the operation and performance of an independent
10 review organization in response to complaints or other concerns about
11 compliance.

12 (9) In adopting rules for this section, the department shall take
13 into consideration standards for independent review organizations
14 adopted by national accreditation organizations. The department may
15 accept national accreditation or certification by another state as
16 evidence that an organization satisfies some or all of the requirements
17 for certification by the department as an independent review
18 organization.

19 NEW SECTION. **Sec. 13.** CARRIER MEDICAL DIRECTOR. Any carrier that
20 offers a health plan and any self-insured health plan subject to the
21 jurisdiction of Washington state shall designate a medical director who
22 is licensed under chapter 18.57 or 18.71 RCW. However, a naturopathic
23 or complementary alternative health plan, which provides solely
24 complementary alternative health care to individuals, groups, or health
25 plans, may have a medical director licensed under chapter 18.36A RCW.
26 A health plan or self-insured health plan that offers only religious
27 nonmedical treatment or religious nonmedical nursing care shall not be
28 required to have a medical director.

29 **Sec. 14.** RCW 51.04.020 and 1994 c 164 s 24 are each amended to
30 read as follows:

31 The director shall:

32 (1) Establish and adopt rules governing the administration of this
33 title;

34 (2) Ascertain and establish the amounts to be paid into and out of
35 the accident fund;

36 (3) Regulate the proof of accident and extent thereof, the proof of
37 death and the proof of relationship and the extent of dependency;

1 (4) Supervise the medical, surgical, and hospital treatment to the
2 intent that it may be in all cases efficient and up to the recognized
3 standard of modern surgery;

4 (5) Issue proper receipts for moneys received and certificates for
5 benefits accrued or accruing;

6 (6) Investigate the cause of all serious injuries and report to the
7 governor from time to time any violations or laxity in performance of
8 protective statutes or regulations coming under the observation of the
9 department;

10 (7) Compile statistics which will afford reliable information upon
11 which to base operations of all divisions under the department;

12 (8) Make an annual report to the governor of the workings of the
13 department;

14 (9) Be empowered to enter into agreements with the appropriate
15 agencies of other states relating to conflicts of jurisdiction where
16 the contract of employment is in one state and injuries are received in
17 the other state, and insofar as permitted by the Constitution and laws
18 of the United States, to enter into similar agreements with the
19 provinces of Canada; and

20 (10) Designate a medical director who is licensed under chapter
21 18.57 or 18.71 RCW.

22 **Sec. 15.** RCW 74.09.050 and 1979 c 141 s 335 are each amended to
23 read as follows:

24 The secretary shall appoint such professional personnel and other
25 assistants and employees, including professional medical screeners, as
26 may be reasonably necessary to carry out the provisions of this
27 chapter. The medical screeners shall be supervised by one or more
28 physicians who shall be appointed by the secretary or his or her
29 designee. The secretary shall appoint a medical director who is
30 licensed under chapter 18.57 or 18.71 RCW.

31 NEW SECTION. **Sec. 16.** A new section is added to chapter 41.05 RCW
32 to read as follows:

33 HEALTH CARE AUTHORITY MEDICAL DIRECTOR. The administrator shall
34 designate a medical director who is licensed under chapter 18.57 or
35 18.71 RCW.

1 NEW SECTION. **Sec. 17.** CARRIER LIABILITY. (1)(a) A health carrier
2 shall adhere to the accepted standard of care for health care providers
3 under chapter 7.70 RCW when arranging for the provision of medically
4 necessary health care services to its enrollees. A health carrier
5 shall be liable for any and all harm proximately caused by its failure
6 to follow that standard of care when the failure resulted in the
7 denial, delay, or modification of the health care service recommended
8 for, or furnished to, an enrollee.

9 (b) A health carrier is also liable for damages under (a) of this
10 subsection for harm to an enrollee proximately caused by health care
11 treatment decisions that result from a failure to follow the accepted
12 standard of care made by its:

13 (i) Employees;

14 (ii) Agents; or

15 (iii) Ostensible agents who are acting on its behalf and over whom
16 it has the right to exercise influence or control or has actually
17 exercised influence or control.

18 (2) The provisions of this section may not be waived, shifted, or
19 modified by contract or agreement and responsibility for the provisions
20 shall be a duty that cannot be delegated. Any effort to waive, modify,
21 delegate, or shift liability for a breach of the duty established by
22 this section, through a contract for indemnification or otherwise, is
23 invalid.

24 (3) This section does not create any new cause of action, or
25 eliminate any presently existing cause of action, with respect to
26 health care providers and health care facilities that are included in
27 and subject to the provisions of chapter 7.70 RCW.

28 (4) It is a defense to any action or liability asserted under this
29 section against a health carrier that:

30 (a) The health care service in question is not a benefit provided
31 under the plan or the service is subject to limitations under the plan
32 that have been exhausted;

33 (b) Neither the health carrier, nor any employee, agent, or
34 ostensible agent for whose conduct the health carrier is liable under
35 subsection (1)(b) of this section, controlled, influenced, or
36 participated in the health care decision; or

37 (c) The health carrier did not deny or unreasonably delay payment
38 for treatment prescribed or recommended by a participating health care
39 provider for the enrollee.

1 (5) This section does not create any liability on the part of an
2 employer, an employer group purchasing organization that purchases
3 coverage or assumes risk on behalf of its employers, or a governmental
4 agency that purchases coverage on behalf of individuals and families.
5 The governmental entity established to offer and provide health
6 insurance to public employees, public retirees, and their covered
7 dependents under RCW 41.05.140 is subject to liability under this
8 section.

9 (6) Nothing in any law of this state prohibiting a health carrier
10 from practicing medicine or being licensed to practice medicine may be
11 asserted as a defense by the health carrier in an action brought
12 against it under this section.

13 (7)(a) A person may not maintain a cause of action under this
14 section against a health carrier unless:

15 (i) The affected enrollee has suffered substantial harm. As used
16 in this subsection, "substantial harm" means loss of life, loss or
17 significant impairment of limb, bodily or cognitive function,
18 significant disfigurement, or severe or chronic physical pain; and

19 (ii) The affected enrollee or the enrollee's representative has
20 exercised the opportunity established in section 11 of this act to seek
21 independent review of the health care treatment decision.

22 (b) This subsection (7) does not prohibit an enrollee from pursuing
23 other appropriate remedies, including injunctive relief, a declaratory
24 judgment, or other relief available under law, if its requirements
25 place the enrollee's health in serious jeopardy.

26 (8) In an action against a health carrier, a finding that a health
27 care provider is an employee, agent, or ostensible agent of such a
28 health carrier shall not be based solely on proof that the person's
29 name appears in a listing of approved physicians or health care
30 providers made available to enrollees under a health plan.

31 (9) Any action under this section shall be commenced within three
32 years of the completion of the independent review process.

33 (10) This section does not apply to workers' compensation insurance
34 under Title 51 RCW.

35 NEW SECTION. **Sec. 18.** DELEGATION OF DUTIES. Each carrier is
36 accountable for and must oversee any activities required by this act
37 that it delegates to any subcontractor. No contract with a
38 subcontractor executed by the health carrier or the subcontractor may

1 relieve the health carrier of its obligations to any enrollee for the
2 provision of health care services or of its responsibility for
3 compliance with statutes or rules.

4 NEW SECTION. **Sec. 19.** APPLICATION. This act applies to: Health
5 plans as defined in RCW 48.43.005 offered, renewed, or issued by a
6 carrier; medical assistance provided under RCW 74.09.522; the basic
7 health plan offered under chapter 70.47 RCW; and health benefits
8 provided under chapter 41.05 RCW.

9 NEW SECTION. **Sec. 20.** A new section is added to chapter 41.05 RCW
10 to read as follows:

11 Each health plan that provides medical insurance offered under this
12 chapter, including plans created by insuring entities, plans not
13 subject to the provisions of Title 48 RCW, and plans created under RCW
14 41.05.140, are subject to the provisions of sections 1, 2, 5 through
15 12, 17, 18, and RCW 70.02.110 and 70.02.900.

16 **Sec. 21.** RCW 70.47.130 and 1997 c 337 s 8 are each amended to read
17 as follows:

18 (1) The activities and operations of the Washington basic health
19 plan under this chapter, including those of managed health care systems
20 to the extent of their participation in the plan, are exempt from the
21 provisions and requirements of Title 48 RCW except:

22 (a) Benefits as provided in RCW 70.47.070;

23 (b) Managed health care systems are subject to the provisions of
24 sections 1, 2, 5 through 12, 17, 18, and RCW 70.02.110 and 70.02.900;

25 (c) Persons appointed or authorized to solicit applications for
26 enrollment in the basic health plan, including employees of the health
27 care authority, must comply with chapter 48.17 RCW. For purposes of
28 this subsection (1)((~~b~~)) (c), "solicit" does not include distributing
29 information and applications for the basic health plan and responding
30 to questions; and

31 ((~~e~~)) (d) Amounts paid to a managed health care system by the
32 basic health plan for participating in the basic health plan and
33 providing health care services for nonsubsidized enrollees in the basic
34 health plan must comply with RCW 48.14.0201.

35 (2) The purpose of the 1994 amendatory language to this section in
36 chapter 309, Laws of 1994 is to clarify the intent of the legislature

1 that premiums paid on behalf of nonsubsidized enrollees in the basic
2 health plan are subject to the premium and prepayment tax. The
3 legislature does not consider this clarifying language to either raise
4 existing taxes nor to impose a tax that did not exist previously.

5 NEW SECTION. **Sec. 22.** This act may be known and cited as the
6 health care patient bill of rights.

7 NEW SECTION. **Sec. 23.** If specific funding for the purposes of
8 this act, referencing this act by bill or chapter number, is not
9 provided by June 30, 2000, in the omnibus appropriations act, this act
10 is null and void.

11 NEW SECTION. **Sec. 24.** Captions used in this act are not any part
12 of the law.

13 NEW SECTION. **Sec. 25.** Sections 1, 5 through 11, 13, 17, and 18 of
14 this act are each added to chapter 48.43 RCW.

15 NEW SECTION. **Sec. 26.** To the extent permitted by law, if any
16 provision of this act conflicts with state or federal law, such
17 provision must be construed in a manner most favorable to the enrollee.

18 NEW SECTION. **Sec. 27.** If any provision of this act or its
19 application to any person or circumstance is held invalid, the
20 remainder of the act or the application of the provision to other
21 persons or circumstances is not affected.

22 NEW SECTION. **Sec. 28.** EFFECTIVE DATE. (1) Except as provided in
23 subsections (2) and (3) of this section, this act applies to contracts
24 entered into or renewing after June 30, 2001.

25 (2) Sections 13, 14, 15, and 16 of this act take effect January 1,
26 2001.

27 (3) Section 29 of this act takes effect July 1, 2001.

28 NEW SECTION. **Sec. 29.** The following acts or parts of acts are
29 each repealed:

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

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

--- **END** ---