S-1242.1

SENATE BILL 5753

State of Washington 58th Legislature 2003 Regular Session

By Senators Deccio, Reardon and Winsley

Read first time 02/10/2003. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to reducing regulatory burdens to health carriers
2 regarding state data collection and compliance auditing requirements;
3 amending RCW 41.05.075, 48.43.505, 48.43.510, 48.43.515, 48.43.520,
4 48.43.530, and 70.02.900; reenacting and amending RCW 74.09.522; and
5 adding a new section to chapter 70.47 RCW.

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

7 **Sec. 1.** RCW 41.05.075 and 2002 c 142 s 4 are each amended to read
8 as follows:
9 (1) The administrator shall provide benefit plans designed by the
10 board through a contract or contracts with insuring entities, through
11 self-funding, self-insurance, or other methods of providing insurance
12 coverage authorized by RCW 41.05.140.
13 (2) The administrator shall establish a contract bidding process
14 that:
15 (a) Encourages competition among insuring entities;
16 (b) Maintains an equitable relationship between premiums charged
17 for similar benefits and between risk pools including premiums charged
18 for retired state and school district employees under the separate risk

pools established by RCW 41.05.022 and 41.05.080 such that insuring entities may not avoid risk when establishing the premium rates for retirees eligible for medicare;

(c) Is timely to the state budgetary process; and

(d) Sets conditions for awarding contracts to any insuring entity.

(3) The administrator shall establish a requirement for review of utilization and financial data from participating insuring entities on a quarterly basis.

(4) The administrator shall centralize the enrollment files for all employee and retired or disabled school employee health plans offered under chapter 41.05 RCW and develop enrollment demographics on a plan-specific basis.

(5) All claims data shall be the property of the state. The administrator may require of any insuring entity that submits a bid to contract for coverage all information deemed necessary including subscriber or member demographic and claims data necessary for risk assessment and adjustment calculations in order to fulfill the administrator's duties as set forth in this chapter.

(6) All contracts with insuring entities for the provision of health care benefits shall provide that the beneficiaries of such benefit plans may use on an equal participation basis the services of practitioners licensed pursuant to chapters 18.22, 18.25, 18.32, 18.53, 18.57, 18.71, 18.74, 18.83, and 18.79 RCW, as it applies to registered nurses and advanced registered nurse practitioners. However, nothing in this subsection may preclude the administrator from establishing appropriate utilization controls approved pursuant to RCW 41.05.065(2)(a), (b), and (d).

(7) To minimize data collection administrative costs, requests for any data from insuring entities may not include data elements produced or maintained by the administrator or another state agency. Specific requirements for insuring entities shall be developed in rule by the administrator and allow insuring entities sufficient time to comply with new requirements prior to conducting an audit. The timing of on-site audits of insuring entities shall be coordinated among state agencies and with national managed care accreditation organization reviews.

(8) An insuring entity's compliance with standards adopted by national managed care accreditation organizations, such as the national

committee on quality assurance, American accreditation healthcare commission, or other accreditation entity acceptable to the administrator, through accreditation or through utilizing the services of an accredited entity, shall be considered as fully meeting the requirements of the administrator for the subject areas covered under the accreditation program that are also required by the administrator. The administrator shall not subject the insuring entity to additional requirements or separate compliance auditing.

Sec. 2. RCW 48.43.505 and 2000 c 5 s 5 are each amended to read as follows:

(1) Health carriers and insurers shall adopt policies and procedures that conform administrative, business, and operational practices to protect an enrollee's right to privacy or right to confidential health care services granted under state or federal laws.

(2) ((~~The commissioner may adopt rules to implement this section after considering relevant standards adopted by national managed care accreditation organizations and the national association of insurance commissioners, and after considering the effect of those standards on the ability of carriers to undertake enrollee care management and disease management programs.~~)) A health carrier's compliance with federal requirements on privacy and security under Public Law 104-191 shall be considered as meeting the requirements of this section and the carrier shall not be subject to additional requirements by the commissioner or separate compliance auditing on the part of the commissioner.

Sec. 3. RCW 48.43.510 and 2000 c 5 s 6 are each amended to read as follows:

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

(a) A listing of covered benefits, including prescription drug benefits, if any, a copy of the current formulary, if any is used, definitions of terms such as generic versus brand name, and policies

regarding coverage of drugs, such as how they become approved or taken off the formulary, and how consumers may be involved in decisions about benefits;

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

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

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

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

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

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

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

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

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

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

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

(e) Descriptions and justifications for provider compensation

programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists;

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

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

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

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

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

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

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

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

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

(6) No carrier may preclude or discourage its providers from informing an enrollee of the care he or she requires, including various treatment options, and whether in the providers' view such care is consistent with the plan's health coverage criteria, or otherwise

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

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

(8) Each carrier must communicate enrollee information required in chapter 5, Laws of 2000 by means that ensure that a substantial portion of the enrollee population can make use of the information.

(9) The commissioner may adopt rules to implement this section. In developing rules to implement this section, the commissioner shall consider relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services. A health carrier's compliance with standards adopted by national managed care accreditation organizations, through accreditation or through utilizing the services of an accredited entity, such as the national committee on quality assurance, American accreditation healthcare commission, or other accreditation entity acceptable to the commissioner, or state agencies that purchase health care services shall be considered as fully meeting the requirements of subsections (1) through (3) of this section and the carrier shall not be subject to additional requirements by the commissioner or separate compliance auditing on the part of the commissioner.

Sec. 4. RCW 48.43.515 and 2000 c 5 s 7 are each amended to read as follows:

(1) Each enrollee in a health plan must have adequate choice among health care providers.

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

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

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

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

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

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

(8) ((~~Every carrier shall meet the standards set forth in this section and any rules adopted by the commissioner to implement this section. In developing rules to implement this section, the~~

~~commissioner shall consider relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.~~)) A health carrier's compliance with standards adopted by national managed care accreditation organizations such as the national committee on quality assurance, American accreditation healthcare commission, or other accreditation entity acceptable to the commissioner, through accreditation or through utilizing the services of an accredited entity, and state agencies that purchase health care services shall be considered as fully meeting the requirements of this section and the carrier shall not be subject to additional requirements by the commissioner or separate compliance auditing on the part of the commissioner.

Sec. 5. RCW 48.43.520 and 2000 c 5 s 8 are each amended to read as follows:

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

(2) ((~~The commissioner shall adopt, in rule, standards for this section after considering relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.~~)) A health carrier's compliance with standards adopted by national managed care accreditation organizations, through accreditation or through utilizing the services of an accredited entity such as the national committee on quality assurance, American accreditation healthcare commission, or other accreditation entity acceptable to the commissioner, or state agencies that purchase health care services shall be considered as fully meeting the requirements of this section and the carrier shall not be subject to additional requirements by the commissioner or separate compliance auditing on the part of the commissioner.

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

Sec. 6. RCW 48.43.530 and 2000 c 5 s 10 are each amended to read as follows:

(1) Each carrier that offers a health plan must have a fully operational, comprehensive grievance process that complies with the requirements of this section and any rules adopted by the commissioner to implement this section. For the purposes of this section, the commissioner shall consider grievance process standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

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

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

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

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

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

(b) Assist the enrollee with the appeal process;

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

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

(e) Consider information submitted by the enrollee;

(f) Investigate and resolve the appeal; and

(g) Provide written notice of its resolution of the appeal to the enrollee and, with the permission of the enrollee, to the enrollee's providers. The written notice must explain the carrier's decision and the supporting coverage or clinical reasons and the enrollee's right to request independent review of the carrier's decision under RCW 48.43.535.

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

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

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

(7) When an enrollee requests that the carrier reconsider its decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving through the health plan and the carrier's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier must continue to provide that health service until the appeal is resolved. If the resolution of the appeal or any review sought by the enrollee under RCW 48.43.535 affirms the carrier's decision, the enrollee may be responsible for the cost of this continued health service.

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

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

(10) Each carrier must: Track each appeal until final resolution; maintain, and make accessible to the commissioner for a period of three

years, a log of all appeals; and identify and evaluate trends in appeals.

(11) A health carrier's compliance with standards adopted by national managed care accreditation organizations, through accreditation or through utilizing the services of an accredited entity such as the national committee on quality assurance, American accreditation healthcare commission, or other accreditation entity acceptable to the commissioner, or state agencies that purchase health care services shall be considered as fully meeting the requirements of this section and the carrier shall not be subject to additional requirements by the commissioner or separate compliance auditing on the part of the commissioner.

Sec. 7. RCW 70.02.900 and 2000 c 5 s 4 are each amended to read as follows:

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

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

(3) An insurer or health carrier regulated under Title 48 RCW that is compliant with federal requirements on privacy and security under Public Law 104-191 shall be considered as fully compliant with the requirements of this chapter that conflict or expand upon those federal privacy and security requirements.

NEW SECTION. **Sec. 8.** A new section is added to chapter 70.47 RCW to read as follows:

(1) To minimize data collection administrative costs, requests for any data from managed health care systems may not include data elements already produced or maintained by the administrator or another state agency. Specific requirements for auditing managed health care systems shall be developed in rule by the administrator and allow managed health care systems sufficient time to comply with new requirements prior to conducting an audit. The timing of on-site audits of managed

health care systems shall be coordinated among state agencies and with national managed care accreditation organization reviews.

(2) A managed health care system's compliance with standards adopted by national managed care accreditation organizations, through accreditation or through utilizing the services of an accredited entity such as the national committee on quality assurance, American accreditation healthcare commission, or other accreditation entity acceptable to the administrator, shall be considered as fully meeting the requirements of the administrator for the subject areas covered under the accreditation program that are also required by the administrator. The managed health care system shall not be subject to additional requirements by the administrator or separate compliance auditing on the part of the administrator.

Sec. 9. RCW 74.09.522 and 1997 c 59 s 15 and 1997 c 34 s 1 are each reenacted and amended to read as follows:

(1) For the purposes of this section, "managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, health insuring organizations, or any combination thereof, that provides directly or by contract health care services covered under RCW 74.09.520 and rendered by licensed providers, on a prepaid capitated basis and that meets the requirements of section 1903(m)(1)(A) of Title XIX of the federal social security act or federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act.

(2) The department of social and health services shall enter into agreements with managed health care systems to provide health care services to recipients of temporary assistance for needy families under the following conditions:

(a) Agreements shall be made for at least thirty thousand recipients state-wide;

(b) Agreements in at least one county shall include enrollment of all recipients of temporary assistance for needy families;

(c) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act or federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act, recipients shall have a choice of systems

in which to enroll and shall have the right to terminate their enrollment in a system: PROVIDED, That the department may limit recipient termination of enrollment without cause to the first month of a period of enrollment, which period shall not exceed twelve months: AND PROVIDED FURTHER, That the department shall not restrict a recipient's right to terminate enrollment in a system for good cause as established by the department by rule;

(d) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act, participating managed health care systems shall not enroll a disproportionate number of medical assistance recipients within the total numbers of persons served by the managed health care systems, except as authorized by the department under federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act;

(e) In negotiating with managed health care systems the department shall adopt a uniform procedure to negotiate and enter into contractual arrangements, including standards regarding the quality of services to be provided; and financial integrity of the responding system;

(f) The department shall seek waivers from federal requirements as necessary to implement this chapter;

(g) The department shall, wherever possible, enter into prepaid capitation contracts that include inpatient care. However, if this is not possible or feasible, the department may enter into prepaid capitation contracts that do not include inpatient care;

(h) The department shall define those circumstances under which a managed health care system is responsible for out-of-plan services and assure that recipients shall not be charged for such services; and

(i) Nothing in this section prevents the department from entering into similar agreements for other groups of people eligible to receive services under this chapter.

(3) The department shall ensure that publicly supported community health centers and providers in rural areas, who show serious intent and apparent capability to participate as managed health care systems are seriously considered as contractors. The department shall coordinate its managed care activities with activities under chapter 70.47 RCW.

(4) The department shall work jointly with the state of Oregon and other states in this geographical region in order to develop

recommendations to be presented to the appropriate federal agencies and the United States congress for improving health care of the poor, while controlling related costs.

(5) The legislature finds that competition in the managed health care marketplace is enhanced, in the long term, by the existence of a large number of managed health care system options for medicaid clients. In a managed care delivery system, whose goal is to focus on prevention, primary care, and improved enrollee health status, continuity in care relationships is of substantial importance, and disruption to clients and health care providers should be minimized. To help ensure these goals are met, the following principles shall guide the department in its healthy options managed health care purchasing efforts:

(a) All managed health care systems should have an opportunity to contract with the department to the extent that minimum contracting requirements defined by the department are met, at payment rates that enable the department to operate as far below appropriated spending levels as possible, consistent with the principles established in this section.

(b) Managed health care systems should compete for the award of contracts and assignment of medicaid beneficiaries who do not voluntarily select a contracting system, based upon:

(i) Demonstrated commitment to or experience in serving low-income populations;

(ii) Quality of services provided to enrollees;

(iii) Accessibility, including appropriate utilization, of services offered to enrollees;

(iv) Demonstrated capability to perform contracted services, including ability to supply an adequate provider network;

(v) Payment rates; and

(vi) The ability to meet other specifically defined contract requirements established by the department, including consideration of past and current performance and participation in other state or federal health programs as a contractor.

(c) Consideration should be given to using multiple year contracting periods.

(d) Quality, accessibility, and demonstrated commitment to serving

low-income populations shall be given significant weight in the contracting, evaluation, and assignment process.

(e) All contractors that are regulated health carriers must meet state minimum net worth requirements as defined in applicable state laws. The department shall adopt rules establishing the minimum net worth requirements for contractors that are not regulated health carriers. This subsection does not limit the authority of the department to take action under a contract upon finding that a contractor's financial status seriously jeopardizes the contractor's ability to meet its contract obligations.

(f) Procedures for resolution of disputes between the department and contract bidders or the department and contracting carriers related to the award of, or failure to award, a managed care contract must be clearly set out in the procurement document. In designing such procedures, the department shall give strong consideration to the negotiation and dispute resolution processes used by the Washington state health care authority in its managed health care contracting activities.

(6) The department may apply the principles set forth in subsection (5) of this section to its managed health care purchasing efforts on behalf of clients receiving supplemental security income benefits to the extent appropriate.

(7) To minimize data collection administrative costs, requests for any data from managed health care systems may not include data elements already produced or maintained by the department or another state agency. Specific requirements for auditing managed health care systems shall be developed in rule by the department and allow managed health care systems sufficient time to comply with new requirements prior to conducting an audit. The timing of on-site audits of managed health care systems shall be coordinated among state agencies and with national managed care accreditation organization reviews.

(8) A managed health care system's compliance with standards adopted by national managed care accreditation organizations, through accreditation or through utilizing the services of an accredited entity, such as the national committee on quality assurance, American accreditation healthcare commission, or other accreditation entity acceptable to the department, shall be considered as fully meeting the requirements of the department for the subject areas covered under the

1 accreditation program that are also required by the department. The
2 managed health care system shall not be subject to additional
3 requirements by the department or separate compliance auditing on the
4 part of the department. If federal law limits the ability of the
5 department to fully implement the requirement under this subsection or
6 subsection (7) of this section, the department shall implement the
7 requirement to the maximum extent allowed under federal law. The
8 department shall actively seek amendment to its state plan if necessary
9 to comply with this subsection or subsection (7) of this section.

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