
SUBSTITUTE SENATE BILL 5889

State of Washington

66th Legislature

2019 Regular Session

By Senate Health & Long Term Care (originally sponsored by Senator Dhingra)

READ FIRST TIME 02/22/19.

1 AN ACT Relating to insurance communications confidentiality;
2 amending RCW 48.43.005, 48.43.505, 48.43.510, and 48.43.530; adding a
3 new section to chapter 48.43 RCW; creating a new section; and
4 providing an effective date.

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

6 NEW SECTION. **Sec. 1.** The legislature finds and declares:

7 (1) All people deserve the right to choose the health services
8 that are right for them, and the right to confidential access to
9 those health services.

10 (2) When people are assured of the ability to confidentially
11 access health care services, they are more likely to seek health
12 services, disclose health risk behaviors to a clinician, and return
13 for follow-up care.

14 (3) When denied confidential access to needed care, people may
15 delay or forgo care, leading to higher rates of unprotected sex,
16 unintended pregnancy, untreated sexually transmitted infections, and
17 mental health issues, or they may turn to public health safety net
18 funds or free clinics to receive confidential care—important
19 resources that should be reserved for people who do not have
20 insurance coverage.

1 **Sec. 2.** RCW 48.43.005 and 2016 c 65 s 2 are each amended to read
2 as follows:

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

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

10 (2) "Adverse benefit determination" means a denial, reduction, or
11 termination of, or a failure to provide or make payment, in whole or
12 in part, for a benefit, including a denial, reduction, termination,
13 or failure to provide or make payment that is based on a
14 determination of an enrollee's or applicant's eligibility to
15 participate in a plan, and including, with respect to group health
16 plans, a denial, reduction, or termination of, or a failure to
17 provide or make payment, in whole or in part, for a benefit resulting
18 from the application of any utilization review, as well as a failure
19 to cover an item or service for which benefits are otherwise provided
20 because it is determined to be experimental or investigational or not
21 medically necessary or appropriate.

22 (3) "Applicant" means a person who applies for enrollment in an
23 individual health plan as the subscriber or an enrollee, or the
24 dependent or spouse of a subscriber or enrollee.

25 (4) "Basic health plan" means the plan described under chapter
26 70.47 RCW, as revised from time to time.

27 (5) "Basic health plan model plan" means a health plan as
28 required in RCW 70.47.060(2)(e).

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

33 (7) "Board" means the governing board of the Washington health
34 benefit exchange established in chapter 43.71 RCW.

35 (8)(a) For grandfathered health benefit plans issued before
36 January 1, 2014, and renewed thereafter, "catastrophic health plan"
37 means:

38 (i) In the case of a contract, agreement, or policy covering a
39 single enrollee, a health benefit plan requiring a calendar year
40 deductible of, at a minimum, one thousand seven hundred fifty dollars

1 and an annual out-of-pocket expense required to be paid under the
2 plan (other than for premiums) for covered benefits of at least three
3 thousand five hundred dollars, both amounts to be adjusted annually
4 by the insurance commissioner; and

5 (ii) In the case of a contract, agreement, or policy covering
6 more than one enrollee, a health benefit plan requiring a calendar
7 year deductible of, at a minimum, three thousand five hundred dollars
8 and an annual out-of-pocket expense required to be paid under the
9 plan (other than for premiums) for covered benefits of at least six
10 thousand dollars, both amounts to be adjusted annually by the
11 insurance commissioner.

12 (b) In July 2008, and in each July thereafter, the insurance
13 commissioner shall adjust the minimum deductible and out-of-pocket
14 expense required for a plan to qualify as a catastrophic plan to
15 reflect the percentage change in the consumer price index for medical
16 care for a preceding twelve months, as determined by the United
17 States department of labor. For a plan year beginning in 2014, the
18 out-of-pocket limits must be adjusted as specified in section
19 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount
20 shall apply on the following January 1st.

21 (c) For health benefit plans issued on or after January 1, 2014,
22 "catastrophic health plan" means:

23 (i) A health benefit plan that meets the definition of
24 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
25 2010, as amended; or

26 (ii) A health benefit plan offered outside the exchange
27 marketplace that requires a calendar year deductible or out-of-pocket
28 expenses under the plan, other than for premiums, for covered
29 benefits, that meets or exceeds the commissioner's annual adjustment
30 under (b) of this subsection.

31 (9) "Certification" means a determination by a review
32 organization that an admission, extension of stay, or other health
33 care service or procedure has been reviewed and, based on the
34 information provided, meets the clinical requirements for medical
35 necessity, appropriateness, level of care, or effectiveness under the
36 auspices of the applicable health benefit plan.

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

39 (11) "Covered person" or "enrollee" means a person covered by a
40 health plan including an enrollee, subscriber, policyholder,

1 beneficiary of a group plan, or individual covered by any other
2 health plan.

3 (12) "Dependent" means, at a minimum, the enrollee's legal spouse
4 and dependent children who qualify for coverage under the enrollee's
5 health benefit plan.

6 (13) "Emergency medical condition" means a medical condition
7 manifesting itself by acute symptoms of sufficient severity,
8 including severe pain, such that a prudent layperson, who possesses
9 an average knowledge of health and medicine, could reasonably expect
10 the absence of immediate medical attention to result in a condition
11 (a) placing the health of the individual, or with respect to a
12 pregnant woman, the health of the woman or her unborn child, in
13 serious jeopardy, (b) serious impairment to bodily functions, or (c)
14 serious dysfunction of any bodily organ or part.

15 (14) "Emergency services" means a medical screening examination,
16 as required under section 1867 of the social security act (42 U.S.C.
17 1395dd), that is within the capability of the emergency department of
18 a hospital, including ancillary services routinely available to the
19 emergency department to evaluate that emergency medical condition,
20 and further medical examination and treatment, to the extent they are
21 within the capabilities of the staff and facilities available at the
22 hospital, as are required under section 1867 of the social security
23 act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with
24 respect to an emergency medical condition, has the meaning given in
25 section 1867(e)(3) of the social security act (42 U.S.C.
26 1395dd(e)(3)).

27 (15) "Employee" has the same meaning given to the term, as of
28 January 1, 2008, under section 3(6) of the federal employee
29 retirement income security act of 1974.

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

34 (17) "Exchange" means the Washington health benefit exchange
35 established under chapter 43.71 RCW.

36 (18) "Final external review decision" means a determination by an
37 independent review organization at the conclusion of an external
38 review.

39 (19) "Final internal adverse benefit determination" means an
40 adverse benefit determination that has been upheld by a health plan

1 or carrier at the completion of the internal appeals process, or an
2 adverse benefit determination with respect to which the internal
3 appeals process has been exhausted under the exhaustion rules
4 described in RCW 48.43.530 and 48.43.535.

5 (20) "Grandfathered health plan" means a group health plan or an
6 individual health plan that under section 1251 of the patient
7 protection and affordable care act, P.L. 111-148 (2010) and as
8 amended by the health care and education reconciliation act, P.L.
9 111-152 (2010) is not subject to subtitles A or C of the act as
10 amended.

11 (21) "Grievance" means a written complaint submitted by or on
12 behalf of a covered person regarding service delivery issues other
13 than denial of payment for medical services or nonprovision of
14 medical services, including dissatisfaction with medical care,
15 waiting time for medical services, provider or staff attitude or
16 demeanor, or dissatisfaction with service provided by the health
17 carrier.

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

31 (23) "Health care provider" or "provider" means:

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

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

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

1 (25) "Health carrier" or "carrier" means a disability insurer
2 regulated under chapter 48.20 or 48.21 RCW, a health care service
3 contractor as defined in RCW 48.44.010, or a health maintenance
4 organization as defined in RCW 48.46.020, and includes "issuers" as
5 that term is used in the patient protection and affordable care act
6 (P.L. 111-148).

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

11 (a) Long-term care insurance governed by chapter 48.84 or 48.83
12 RCW;

13 (b) Medicare supplemental health insurance governed by chapter
14 48.66 RCW;

15 (c) Coverage supplemental to the coverage provided under chapter
16 55, Title 10, United States Code;

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

19 (e) Disability income;

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

23 (g) Workers' compensation coverage;

24 (h) Accident only coverage;

25 (i) Specified disease or illness-triggered fixed payment
26 insurance, hospital confinement fixed payment insurance, or other
27 fixed payment insurance offered as an independent, noncoordinated
28 benefit;

29 (j) Employer-sponsored self-funded health plans;

30 (k) Dental only and vision only coverage;

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

38 (m) Civilian health and medical program for the veterans affairs
39 administration (CHAMPVA).

1 (27) "Individual market" means the market for health insurance
2 coverage offered to individuals other than in connection with a group
3 health plan.

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

7 (29) "Open enrollment" means a period of time as defined in rule
8 to be held at the same time each year, during which applicants may
9 enroll in a carrier's individual health benefit plan without being
10 subject to health screening or otherwise required to provide evidence
11 of insurability as a condition for enrollment.

12 (30) "Preexisting condition" means any medical condition,
13 illness, or injury that existed any time prior to the effective date
14 of coverage.

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

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

28 (33) "Small employer" or "small group" means any person, firm,
29 corporation, partnership, association, political subdivision, sole
30 proprietor, or self-employed individual that is actively engaged in
31 business that employed an average of at least one but no more than
32 fifty employees, during the previous calendar year and employed at
33 least one employee on the first day of the plan year, is not formed
34 primarily for purposes of buying health insurance, and in which a
35 bona fide employer-employee relationship exists. In determining the
36 number of employees, companies that are affiliated companies, or that
37 are eligible to file a combined tax return for purposes of taxation
38 by this state, shall be considered an employer. Subsequent to the
39 issuance of a health plan to a small employer and for the purpose of
40 determining eligibility, the size of a small employer shall be

1 determined annually. Except as otherwise specifically provided, a
2 small employer shall continue to be considered a small employer until
3 the plan anniversary following the date the small employer no longer
4 meets the requirements of this definition. A self-employed individual
5 or sole proprietor who is covered as a group of one must also: (a)
6 Have been employed by the same small employer or small group for at
7 least twelve months prior to application for small group coverage,
8 and (b) verify that he or she derived at least seventy-five percent
9 of his or her income from a trade or business through which the
10 individual or sole proprietor has attempted to earn taxable income
11 and for which he or she has filed the appropriate internal revenue
12 service form 1040, schedule C or F, for the previous taxable year,
13 except a self-employed individual or sole proprietor in an
14 agricultural trade or business, must have derived at least fifty-one
15 percent of his or her income from the trade or business through which
16 the individual or sole proprietor has attempted to earn taxable
17 income and for which he or she has filed the appropriate internal
18 revenue service form 1040, for the previous taxable year.

19 (34) "Special enrollment" means a defined period of time of not
20 less than thirty-one days, triggered by a specific qualifying event
21 experienced by the applicant, during which applicants may enroll in
22 the carrier's individual health benefit plan without being subject to
23 health screening or otherwise required to provide evidence of
24 insurability as a condition for enrollment.

25 (35) "Standard health questionnaire" means the standard health
26 questionnaire designated under chapter 48.41 RCW.

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

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

39 (38) (a) "Protected individual" means:

1 (i) An adult covered as a dependent on the enrollee's health
2 benefit plan, including an individual enrolled on the health benefit
3 plan of the individual's registered domestic partner; or

4 (ii) A minor who may obtain health care without the consent of a
5 parent or legal guardian, pursuant to state or federal law.

6 (b) "Protected individual" does not include an individual deemed
7 not competent to provide informed consent for care under RCW
8 11.88.010(1)(e).

9 (39) "Sensitive health care services" means health services
10 related to reproductive health, sexually transmitted diseases,
11 substance use disorder, gender dysphoria, gender affirming care,
12 domestic violence, and mental health.

13 **Sec. 3.** RCW 48.43.505 and 2000 c 5 s 5 are each amended to read
14 as follows:

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

20 (2) A health carrier may not require protected individuals to
21 obtain the policyholder, primary subscriber, or other covered
22 person's authorization to receive health care services or to submit a
23 claim if the protected individual has the right to consent to care.

24 (3) A health carrier must recognize the right of a protected
25 individual or enrollee to exclusively exercise rights granted under
26 this section regarding health information related to care that the
27 enrollee or protected individual has received.

28 (4) A health carrier or insurer must direct all communication
29 regarding a protected individual's receipt of sensitive health care
30 services directly to the protected individual receiving care, or to a
31 physical or email address or telephone number specified by the
32 protected individual. A carrier or insurer may not disclose nonpublic
33 personal health information concerning sensitive health care services
34 provided to a protected individual to any person, including the
35 policyholder, the primary subscriber, or any plan enrollees other
36 than the protected individual receiving care, without the express
37 written consent or verbal authorization on a recorded telephone line
38 of the protected individual receiving care. Communications subject to

1 this limitation include the following written, verbal, or electronic
2 communications:

3 (a) Bills and attempts to collect payment;

4 (b) A notice of adverse benefits determinations;

5 (c) An explanations of benefits notice;

6 (d) A carrier's request for additional information regarding a
7 claim;

8 (e) A notice of a contested claim;

9 (f) The name and address of a provider, a description of services
10 provided, and other visit information; and

11 (g) Any written, oral, or electronic communication from a carrier
12 that contains protected health information.

13 (5) Protected individuals may request that health carrier
14 communications regarding the receipt of sensitive health care
15 services be sent to another individual, including the policyholder,
16 primary subscriber, or a health care provider, for the purposes of
17 appealing adverse benefits determinations.

18 (6) Health carriers shall:

19 (a) Limit disclosure of any information, including personal
20 health information, about a protected individual who is the subject
21 of the information and shall direct communications containing such
22 information directly to the protected individual, or to a physical or
23 email address or telephone number specified by the protected
24 individual, if he or she requests such a limitation, regardless of
25 whether the information pertains to sensitive services;

26 (b) Permit protected individuals to use the form described in
27 section 4(2) of this act and must also allow enrollees and protected
28 individuals to make the request by telephone, email, or the internet;

29 (c) Ensure that requests for nondisclosure remain in effect until
30 the protected individual revokes or modifies the request in writing;

31 (d) Limit disclosure of information under this subsection
32 consistent with the protected individual's request; and

33 (e) Ensure that requests for nondisclosure are implemented no
34 later than three business days after receipt of a request.

35 (7) Health carriers may not require a protected individual to
36 waive any right to limit disclosure under this section as a condition
37 of eligibility for or coverage under a health benefit plan.

38 (8) For the protection of patient confidentiality, any
39 communication from a health carrier relating to the provision of
40 health care services, if the communications disclose protected health

1 information, including medical information or provider name and
2 address, relating to receipt of sensitive services, must be provided
3 in the form and format requested by the individual patient receiving
4 care.

5 (9) The commissioner may adopt rules to implement this section
6 after considering relevant standards adopted by national managed care
7 accreditation organizations and the national association of insurance
8 commissioners, and after considering the effect of those standards on
9 the ability of carriers to undertake enrollee care management and
10 disease management programs.

11 NEW SECTION. **Sec. 4.** A new section is added to chapter 48.43
12 RCW to read as follows:

13 (1) The commissioner shall:

14 (a) Develop a process for the regular collection of information
15 from carriers on requests for confidential communications pursuant to
16 RCW 48.43.505 for the purposes of monitoring compliance, including
17 monitoring:

18 (i) The effectiveness of the process described in RCW 48.43.505
19 in allowing protected individuals to redirect insurance
20 communications, the extent to which protected individuals are using
21 the process, and whether the process is working properly; and

22 (ii) The education and outreach activities conducted by carriers
23 to inform enrollees about their right to confidential communications.

24 (b) Establish a process for ensuring compliance; and

25 (c) Develop rules necessary to implement this act.

26 (2) The commissioner shall work with stakeholders to develop and
27 make available to the public a standardized form that a protected
28 individual may submit to a carrier to make a confidential
29 communications request. At minimum, this form must:

30 (a) Inform a protected individual about the protected
31 individual's right to confidential communications;

32 (b) Allow a protected individual to indicate where to redirect
33 communications, including a specified physical or email address or
34 specified telephone number; and

35 (c) Include a disclaimer that it may take up to three business
36 days from the date of receipt for a carrier to process the form.

37 **Sec. 5.** RCW 48.43.510 and 2012 c 211 s 26 are each amended to
38 read as follows:

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

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

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

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

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

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

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

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

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

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

37 (b) A full description of the procedures to be followed by an
38 enrollee for consulting a provider other than the primary care
39 provider and whether the enrollee's primary care provider, the

1 carrier's medical director, or another entity must authorize the
2 referral;

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

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

9 (e) Descriptions and justifications for provider compensation
10 programs, including any incentives or penalties that are intended to
11 encourage providers to withhold services or minimize or avoid
12 referrals to specialists;

13 (f) An annual accounting of all payments made by the carrier
14 which have been counted against any payment limitations, visit
15 limitations, or other overall limitations on a person's coverage
16 under a plan; however, the individual requesting an annual accounting
17 may only receive information about that individual's own care, and
18 may not receive information pertaining to protected individuals who
19 have requested confidential communications pursuant to RCW 48.43.505;

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

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

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

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

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

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

39 (b) Monitors and reports annually to enrollees on standardized
40 measures of health care and satisfaction of all enrollees in the

1 health plan. The state department of health shall recommend
2 appropriate standardized measures for this purpose, after
3 consideration of national standardized measurement systems adopted by
4 national managed care accreditation organizations and state agencies
5 that purchase managed health care services; and

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

9 (6) No carrier may preclude or discourage its providers from
10 informing an enrollee of the care he or she requires, including
11 various treatment options, and whether in the providers' view such
12 care is consistent with the plan's health coverage criteria, or
13 otherwise covered by the enrollee's medical coverage agreement with
14 the carrier. No carrier may prohibit, discourage, or penalize a
15 provider otherwise practicing in compliance with the law from
16 advocating on behalf of an enrollee with a carrier. Nothing in this
17 section shall be construed to authorize a provider to bind a carrier
18 to pay for any service.

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

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

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

37 **Sec. 6.** RCW 48.43.530 and 2012 c 211 s 20 are each amended to
38 read as follows:

1 (1) Each carrier and health plan must have fully operational,
2 comprehensive grievance and appeal processes, and for plans that are
3 not grandfathered, fully operational, comprehensive, and effective
4 grievance and review of adverse benefit determination processes that
5 comply with the requirements of this section and any rules adopted by
6 the commissioner to implement this section. For the purposes of this
7 section, the commissioner must consider applicable grievance and
8 appeal or review of adverse benefit determination process standards
9 adopted by national managed care accreditation organizations and
10 state agencies that purchase managed health care services, and for
11 health plans that are not grandfathered health plans as approved by
12 the United States department of health and human services or the
13 United States department of labor. In the case of coverage offered in
14 connection with a group health plan, if either the carrier or the
15 health plan complies with the requirements of this section and RCW
16 48.43.535, then the obligation to comply is satisfied for both the
17 carrier and the plan with respect to the health insurance coverage.

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

23 (3) Each carrier and health plan must provide written notice to
24 an enrollee or the enrollee's designated representative, and the
25 enrollee's provider, of its decision to deny, modify, reduce, or
26 terminate payment, coverage, authorization, or provision of health
27 care services or benefits, including the admission to or continued
28 stay in a health care facility. Such notice must be sent directly to
29 a protected individual receiving care when accessing sensitive health
30 care services or when a protected individual has requested
31 confidential communication pursuant to RCW 48.43.505(5).

32 (4) An enrollee's written or oral request that a carrier
33 reconsider its decision to deny, modify, reduce, or terminate
34 payment, coverage, authorization, or provision of health care
35 services or benefits, including the admission to, or continued stay
36 in, a health care facility must be processed as follows:

37 (a) When the request is made under a grandfathered health plan,
38 the plan and the carrier must process it as an appeal;

1 (b) When the request is made under a health plan that is not
2 grandfathered, the plan and the carrier must process it as a review
3 of an adverse benefit determination; and

4 (c) Neither a carrier nor a health plan, whether grandfathered or
5 not, may require that an enrollee file a complaint or grievance prior
6 to seeking appeal of a decision or review of an adverse benefit
7 determination under this subsection.

8 (5) To process an appeal, each plan that is not grandfathered and
9 each carrier offering that plan must:

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

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

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

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

23 (e) Consider information submitted by the enrollee;

24 (f) Investigate and resolve the appeal; and

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

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

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

35 (b) The carrier's and grandfathered plan's appeal or for plans
36 that are not grandfathered, adverse benefit determination review
37 process, including information, as appropriate, about how to exercise
38 the enrollee's rights to obtain a second opinion, and how to continue
39 receiving services as provided in this section.

1 (7) When an enrollee requests that the carrier or health plan
2 reconsider its decision to modify, reduce, or terminate an otherwise
3 covered health service that an enrollee is receiving through the
4 health plan and the carrier's or health plan's decision is based upon
5 a finding that the health service, or level of health service, is no
6 longer medically necessary or appropriate, the carrier and health
7 plan must continue to provide that health service until the appeal,
8 or for health plans that are not grandfathered, the review of an
9 adverse benefit determination, is resolved. If the resolution of the
10 appeal, review of an adverse benefit determination, or any review
11 sought by the enrollee under RCW 48.43.535 affirms the carrier's or
12 health plan's decision, the enrollee may be responsible for the cost
13 of this continued health service.

14 (8) Each carrier and health plan must provide a clear explanation
15 of the grievance and appeal, or for plans that are not grandfathered,
16 the process for review of an adverse benefit determination process
17 upon request, upon enrollment to new enrollees, and annually to
18 enrollees and subcontractors.

19 (9) Each carrier and health plan must ensure that each grievance,
20 appeal, and for plans that are not grandfathered, grievance and
21 review of adverse benefit determinations, process is accessible to
22 enrollees who are limited English speakers, who have literacy
23 problems, or who have physical or mental disabilities that impede
24 their ability to file a grievance, appeal or review of an adverse
25 benefit determination.

26 (10)(a) Each plan that is not grandfathered and the carrier that
27 offers it must: Track each appeal until final resolution; maintain,
28 and make accessible to the commissioner for a period of three years,
29 a log of all appeals; and identify and evaluate trends in appeals.

30 (b) Each grandfathered plan and the carrier that offers it must:
31 Track each review of an adverse benefit determination until final
32 resolution; maintain and make accessible to the commissioner, for a
33 period of six years, a log of all such determinations; and identify
34 and evaluate trends in requests for and resolution of review of
35 adverse benefit determinations.

36 (11) In complying with this section, plans that are not
37 grandfathered and the carriers offering them must treat a rescission
38 of coverage, whether or not the rescission has an adverse effect on
39 any particular benefit at that time, and any decision to deny

1 coverage in an initial eligibility determination as an adverse
2 benefit determination.

3 NEW SECTION. **Sec. 7.** If any provision of this act or its
4 application to any person or circumstance is held invalid, the
5 remainder of the act or the application of the provision to other
6 persons or circumstances is not affected.

7 NEW SECTION. **Sec. 8.** This act takes effect January 1, 2020.

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