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**SENATE BILL 5889**

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**State of Washington**

**66th Legislature**

**2019 Regular Session**

**By** Senator Dhingra

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 of the protected individual receiving care.  
38 Communications subject to this limitation include the following  
39 written, verbal, or electronic communications:

1 (a) Bills and attempts to collect payment;  
2 (b) A notice of adverse benefits determinations;  
3 (c) An explanations of benefits notice;  
4 (d) A carrier's request for additional information regarding a  
5 claim;  
6 (e) A notice of a contested claim;  
7 (f) The name and address of a provider, a description of services  
8 provided, and other visit information; and  
9 (g) Any written, oral, or electronic communication from a carrier  
10 that contains protected health information.

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

16 (6) Health carriers shall:

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

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

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

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

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

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

36 (8) For the protection of patient confidentiality, any  
37 communication from a health carrier relating to the provision of  
38 health care services, if the communications disclose protected health  
39 information, including medical information or provider name and  
40 address, relating to receipt of sensitive services, must be provided

1 in the form and format requested by the individual patient receiving  
2 care.

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

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

11 (1) The commissioner shall:

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

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

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

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

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

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

28 (a) Inform a protected individual about the protected  
29 individual's right to confidential communications;

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

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

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

37 (1) A carrier that offers a health plan may not offer to sell a  
38 health plan to an enrollee or to any group representative, agent,

1 employer, or enrollee representative without first offering to  
2 provide, and providing upon request, the following information before  
3 purchase or selection:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37 (b) Monitors and reports annually to enrollees on standardized  
38 measures of health care and satisfaction of all enrollees in the  
39 health plan. The state department of health shall recommend  
40 appropriate standardized measures for this purpose, after

1 consideration of national standardized measurement systems adopted by  
2 national managed care accreditation organizations and state agencies  
3 that purchase managed health care services; and

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

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

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

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

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

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

37 (1) Each carrier and health plan must have fully operational,  
38 comprehensive grievance and appeal processes, and for plans that are  
39 not grandfathered, fully operational, comprehensive, and effective

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

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

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

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

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

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

39 (c) Neither a carrier nor a health plan, whether grandfathered or  
40 not, may require that an enrollee file a complaint or grievance prior

1 to seeking appeal of a decision or review of an adverse benefit  
2 determination under this subsection.

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

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

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

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

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

18 (e) Consider information submitted by the enrollee;

19 (f) Investigate and resolve the appeal; and

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

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

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

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

35 (7) When an enrollee requests that the carrier or health plan  
36 reconsider its decision to modify, reduce, or terminate an otherwise  
37 covered health service that an enrollee is receiving through the  
38 health plan and the carrier's or health plan's decision is based upon  
39 a finding that the health service, or level of health service, is no  
40 longer medically necessary or appropriate, the carrier and health



1 plan must continue to provide that health service until the appeal,  
2 or for health plans that are not grandfathered, the review of an  
3 adverse benefit determination, is resolved. If the resolution of the  
4 appeal, review of an adverse benefit determination, or any review  
5 sought by the enrollee under RCW 48.43.535 affirms the carrier's or  
6 health plan's decision, the enrollee may be responsible for the cost  
7 of this continued health service.

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

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

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

24 (b) Each grandfathered plan and the carrier that offers it must:  
25 Track each review of an adverse benefit determination until final  
26 resolution; maintain and make accessible to the commissioner, for a  
27 period of six years, a log of all such determinations; and identify  
28 and evaluate trends in requests for and resolution of review of  
29 adverse benefit determinations.

30 (11) In complying with this section, plans that are not  
31 grandfathered and the carriers offering them must treat a rescission  
32 of coverage, whether or not the rescission has an adverse effect on  
33 any particular benefit at that time, and any decision to deny  
34 coverage in an initial eligibility determination as an adverse  
35 benefit determination.

36 NEW SECTION. **Sec. 7.** If any provision of this act or its  
37 application to any person or circumstance is held invalid, the  
38 remainder of the act or the application of the provision to other  
39 persons or circumstances is not affected.

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

--- **END** ---