
HOUSE BILL 2782

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By Representatives Zellinsky, R. Johnson, Mielke, Winsley, Anderson, Paris, Wineberry, D. Sommers and Wood

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1 AN ACT Relating to health maintenance organizations; and amending
2 RCW 48.46.020, 48.46.275, 48.46.290, and 48.46.530.

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

4 **Sec. 1.** RCW 48.46.020 and 1990 c 119 s 1 are each amended to read
5 as follows:

6 As used in this chapter, the terms defined in this section shall
7 have the meanings indicated unless the context indicates otherwise.

8 (1) "Health maintenance organization" means any organization
9 receiving a certificate of registration by the commissioner under this
10 chapter which provides comprehensive health care services to enrolled
11 participants of such organization on a group practice per capita
12 prepayment basis or on a prepaid individual practice plan, except for
13 an enrolled participant's responsibility for copayments, coinsurance,
14 and/or deductibles, either directly or through contractual or other

1 arrangements with other institutions, entities, or persons, and which
2 qualifies as a health maintenance organization pursuant to RCW
3 48.46.030 and 48.46.040.

4 (2) "Comprehensive health care services" means basic consultative,
5 diagnostic, and therapeutic services rendered by licensed health
6 professionals together with emergency and preventive care, inpatient
7 hospital, outpatient and physician care, at a minimum, and any
8 additional health care services offered by the health maintenance
9 organization.

10 (3) "Enrolled participant" means a person who or group of persons
11 which has entered into a contractual arrangement or on whose behalf a
12 contractual arrangement has been entered into with a health maintenance
13 organization to receive health care services.

14 (4) "Health professionals" means health care practitioners who are
15 regulated by the state of Washington.

16 (5) "Health maintenance agreement" means an agreement for services
17 between a health maintenance organization which is registered pursuant
18 to the provisions of this chapter and enrolled participants of such
19 organization which provides enrolled participants with comprehensive
20 health services rendered to enrolled participants by health
21 professionals, groups, facilities, and other personnel associated with
22 the health maintenance organization.

23 (6) "Consumer" means any member, subscriber, enrollee, beneficiary,
24 or other person entitled to health care services under terms of a
25 health maintenance agreement, but not including health professionals,
26 employees of health maintenance organizations, partners, or
27 shareholders of stock corporations licensed as health maintenance
28 organizations.

29 (7) "Meaningful role in policy making" means a procedure approved
30 by the commissioner which provides consumers or elected representatives

1 of consumers a means of submitting the views and recommendations of
2 such consumers to the governing board of such organization coupled with
3 reasonable assurance that the board will give regard to such views and
4 recommendations.

5 (8) "Meaningful grievance procedure" means a procedure for
6 investigation of consumer grievances in a timely manner aimed at mutual
7 agreement for settlement according to procedures approved by the
8 commissioner, and which may include arbitration procedures.

9 (9) "Provider" means any health professional, hospital, or other
10 institution, organization, or person that furnishes any health care
11 services and is licensed or otherwise authorized to furnish such
12 services.

13 (10) "Department" means the state department of social and health
14 services.

15 (11) "Commissioner" means the insurance commissioner.

16 (12) "Group practice" means a partnership, association,
17 corporation, or other group of health professionals:

18 (a) The members of which may be individual health professionals,
19 clinics, or both individuals and clinics who engage in the coordinated
20 practice of their profession; and

21 (b) The members of which are compensated by a prearranged salary,
22 or by capitation payment or drawing account that is based on the number
23 of enrolled participants.

24 (13) "Individual practice health care plan" means an association of
25 health professionals in private practice who associate for the purpose
26 of providing prepaid comprehensive health care services on a fee-for-
27 service or capitation basis.

28 (14) "Uncovered expenditures" means the costs to the health
29 maintenance organization of health care services that are the
30 obligation of the health maintenance organization for which an enrolled

1 participant would also be liable in the event of the health maintenance
2 organization's insolvency and for which no alternative arrangements
3 have been made as provided herein. The term does not include
4 expenditures for covered services when a provider has agreed not to
5 bill the enrolled participant even though the provider is not paid by
6 the health maintenance organization, or for services that are
7 guaranteed, insured, or assumed by a person or organization other than
8 the health maintenance organization.

9 (15) "Copayment" means an amount specified in a subscriber
10 agreement which is an obligation of an enrolled participant for a
11 specific service which is not fully prepaid.

12 (16) "Deductible" means the amount an enrolled participant is
13 responsible to pay out-of-pocket before the health maintenance
14 organization begins to pay the costs associated with treatment.

15 (17) "Fully subordinated debt" means those debts that meet the
16 requirements of RCW 48.46.235(3) and are recorded as equity.

17 (18) "Net worth" means the excess of total admitted assets as
18 defined in RCW 48.12.010 over total liabilities but the liabilities
19 shall not include fully subordinated debt.

20 (19) "Participating provider" means a provider as defined in
21 subsection (9) of this section who contracts with the health
22 maintenance organization or with its contractor or subcontractor and
23 has agreed to provide health care services to enrolled participants
24 with an expectation of receiving payment, other than copayment or
25 deductible, directly or indirectly, from the health maintenance
26 organization.

27 (20) "Carrier" means a health maintenance organization, an insurer,
28 a health care services contractor, or other entity responsible for the
29 payment of benefits or provision of services under a group or
30 individual agreement.

1 (21) "Replacement coverage" means the benefits provided by a
2 succeeding carrier.

3 (22) "Insolvent" or "insolvency" means that the organization has
4 been declared insolvent and is placed under an order of liquidation by
5 a court of competent jurisdiction.

6 (23) "Coinsurance" means a percentage amount specified in a
7 subscriber agreement that is an obligation of an enrolled participant
8 for a specific service which is not fully prepaid.

9 **Sec. 2.** RCW 48.46.275 and 1989 c 338 s 4 are each amended to read
10 as follows:

11 Each health maintenance agreement issued or renewed after January
12 1, 1990, that provides benefits for hospital or medical care shall
13 provide benefits for screening or diagnostic mammography services,
14 provided that such services are delivered upon the recommendation of
15 the patient's physician or advanced registered nurse practitioner as
16 authorized by the board of nursing pursuant to chapter 18.88 RCW or
17 physician's assistant pursuant to chapter 18.71A RCW.

18 All services must be provided by the health maintenance
19 organization or rendered upon referral by the health maintenance
20 organization. This section shall not be construed to prevent the
21 application of standard agreement provisions applicable to other
22 benefits such as deductible, coinsurance, or copayment provisions.
23 This section does not limit the authority of a health maintenance
24 organization to negotiate rates and contract with specific providers
25 for the delivery of mammography services. This section shall not apply
26 to medicare supplement policies or supplemental contracts covering a
27 specified disease or other limited benefits.

1 **Sec. 3.** RCW 48.46.290 and 1987 c 283 s 5 are each amended to read
2 as follows:

3 (1) Each health maintenance organization providing services or
4 benefits for hospital or medical care coverage in this state under
5 group health maintenance agreements which are issued, delivered, or
6 renewed in this state on or after July 1, 1986, shall offer optional
7 supplemental coverage for mental health treatment to the enrolled
8 participant and the enrolled participant's covered dependents.

9 (2) Benefits shall be provided under the optional supplemental
10 coverage for mental health treatment whether treatment is rendered by
11 the health maintenance organization or the health maintenance
12 organization refers the enrolled participant or the enrolled
13 participant's covered dependents for treatment to: (a) A physician
14 licensed under chapter 18.71 or 18.57 RCW; (b) a psychologist licensed
15 under chapter 18.83 RCW; (c) a community mental health agency licensed
16 by the department of social and health services pursuant to chapter
17 71.24 RCW; or (d) a state hospital as defined in RCW 72.23.010. The
18 treatment shall be covered at the usual and customary rates for such
19 treatment. The insurer, health care service contractor, or health
20 maintenance organization providing optional coverage under the
21 provisions of this section for mental health services may establish
22 separate usual and customary rates for services rendered by physicians
23 licensed under chapter 18.71 or 18.57 RCW, psychologists licensed under
24 chapter 18.83 RCW, and community mental health centers licensed under
25 chapter 71.24 RCW and state hospitals as defined in RCW 72.23.010.
26 However, the treatment may be subject to contract provisions with
27 respect to reasonable deductible amounts, coinsurance, or copayments.
28 In order to qualify for coverage under this section, a licensed
29 community mental health agency shall have in effect a plan for quality
30 assurance and peer review, and the treatment shall be supervised by a

1 physician licensed under chapter 18.71 or 18.57 RCW or by a
2 psychologist licensed under chapter 18.83 RCW.

3 (3) The group health maintenance agreement may provide that all the
4 coverage for mental health treatment is waived for all covered members
5 if the contract holder so states in advance in writing to the health
6 maintenance organization.

7 (4) This section shall not apply to a group health maintenance
8 agreement that has been entered into in accordance with a collective
9 bargaining agreement between management and labor representatives prior
10 to March 1, 1987.

11 **Sec. 4.** RCW 48.46.530 and 1989 c 331 s 4 are each amended to read
12 as follows:

13 (1) Except as provided in this section, a health maintenance
14 agreement entered into or renewed after December 31, 1989, shall offer
15 optional coverage for the treatment of temporomandibular joint
16 disorders.

17 (a) Health maintenance organizations offering medical coverage only
18 may limit benefits in such coverages to medical services related to
19 treatment of temporomandibular joint disorders. No health maintenance
20 organizations offering medical and dental coverage may limit benefits
21 in such coverage to dental services related to treatment of
22 temporomandibular joint disorders. No health maintenance organization
23 offering medical coverage only may define all temporomandibular joint
24 disorders as purely dental in nature.

25 (b) Health maintenance organizations offering optional
26 temporomandibular joint disorder coverage as provided in this section
27 may, but are not required to, offer lesser or no temporomandibular
28 joint disorder coverage as part of their basic group disability
29 contract.

1 (c) Benefits and coverage offered under this section may be subject
2 to negotiation to promote broad flexibility in potential benefit
3 coverage. This flexibility shall apply to services to be reimbursed,
4 determination of treatments to be considered medically necessary,
5 systems through which services are to be provided, including referral
6 systems and use of other providers, and related issues.

7 (2) Unless otherwise directed by law, the insurance commissioner
8 shall adopt rules, to be implemented on January 1, 1993, establishing
9 minimum benefits, terms, definitions, conditions, limitations, and
10 provisions for the use of reasonable deductibles, coinsurance, and
11 copayments.

12 (3) A health maintenance organization need not make the offer of
13 coverage required by this section to an employer or other group that
14 offers to its eligible enrollees a self-insured health plan not subject
15 to mandated benefit statutes under Title 48 RCW that does not provide
16 coverage for temporomandibular joint disorders.