S-3423.1

SENATE BILL 6340

State of Washington 52nd Legislature 1992 Regular Session

By Senators Sellar, Moore, Pelz and Matson

Read first time 01/27/92. Referred to Committee on Financial Institutions & Insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) "Commissioner" means the insurance commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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