1 **<u>SHB 1046</u>** - H AMD **FAILED 2/10/95 054**
2 By Representatives Dellwo and others
3 On page 7, line 3, strike
4 "(13) RCW 43.72.100 and 1993 c 492 s 428;"
5
6 Renumber the remaining subsections consecutively and correct the
7 title.
8

<u>EFFECT:</u> Strikes "Certified Health Plan Duties" repealer. If adopted the Certified Health Plan Duties provision of the Washington Health Services Act of 1993 would be maintained in statute. [See text below]

RCW 43.72.100 Certified health plans--Duties. A certified health plan shall:

(1) Provide the benefits included in the uniform benefits package to enrolled Washington residents for a prepaid per capita community-rated premium not to exceed the maximum premium established by the commission and provide such benefits through managed care in accordance with rules adopted by the commission;

(2) Offer supplemental benefits to enrolled Washington residents for a prepaid per capita community-rated premium and provide such benefits through managed care in accordance with rules adopted by the commission;

(3) Accept for enrollment any state resident within the plan's service area and provide or assure the provision of all services within the uniform benefits package and offer supplemental benefits regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The insurance commissioner may grant a temporary exemption from this subsection, if, upon application by a certified health plan, the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a certified health plan is required to continue enrollment of additional eligible individuals;

(4) If the plan provides benefits through contracts with, ownership of, or management of health care facilities and contracts with or employs health care providers, demonstrate to the satisfaction of the insurance commissioner in consultation with the department of health and the commission that its facilities and personnel are adequate to provide the benefits prescribed in the uniform benefits package and offer supplemental benefits to enrolled Washington residents, and that it is financially capable of providing such residents with, or has made adequate contractual arrangements with health care providers and facilities to provide enrollees with such benefits;

(5) Comply with portability of benefits requirements prescribed by the commission;

(6) Comply with administrative rules prescribed by the commission, the insurance commissioner, and other state agencies governing certified health plans;

(7) Provide all enrollees with instruction and informational materials to increase individual and family awareness of injury and illness prevention; encourage assumption of personal responsibility for protecting personal

health; and stimulate discussion about the use and limits of medical care in improving the health of individuals and communities;

(8) Disclose to enrollees the charity care requirements under chapter 70.170 RCW;

(9) Include in all of its contracts with health care providers and health care facilities a provision prohibiting such providers and facilities from billing enrollees for any amounts in excess of applicable enrollee point of service cost-sharing obligations for services included in the uniform benefits package and supplemental benefits;

(10) Include in all of its contracts issued for uniform benefits package and supplemental benefits coverage a subrogation provision that allows the certified health plan to recover the costs of uniform benefits package and supplemental benefits services incurred to care for an enrollee injured by a negligent third party. The costs recovered shall be limited to:

(a) If the certified health plan has not intervened in the action by an injured enrollee against a negligent third party, then the amount of costs the certified health plan can recover shall be limited to the excess remaining after the enrollee has been fully compensated for his or her loss minus a proportionate share of the enrollee's costs and fees in bringing the action. The proportionate share shall be determined by:

(i) The fees and costs approved by the court in which the action was initiated; or

(ii) The written agreement between the attorney and client that established fees and costs when fees and costs are not addressed by the court.

When fees and costs have been approved by a court, after notice to the certified health plan, the certified health plan shall have the right to be heard on the matter of attorneys' fees and costs or its proportionate share;

(b) If the certified health plan has intervened in the action by an injured enrollee against a negligent third party, then the amount of costs the certified health plan can recover shall be the excess remaining after the enrollee has been fully compensated for his or her loss or the amount of the plan's incurred costs, whichever is less;

(11) Establish and maintain a grievance procedure approved by the commissioner, to provide a reasonable and effective resolution of complaints initiated by enrollees concerning any matter relating to the provision of benefits under the uniform benefits package and supplemental benefits, access to health care services, and quality of services. Each certified health plan shall respond to complaints filed with the insurance commissioner within fifteen working days. The insurance commissioner in consultation with the commission shall establish standards for resolution of grievances;

(12) Comply with the provisions of chapter 48.30 RCW prohibiting unfair and deceptive acts and practices to the extent such provisions are not specifically modified or superseded by the provisions of chapter 492, Laws of 1993 and be prohibited from offering or supplying incentives that would have the effect of avoiding the requirements of subsection (3) of this section;

(13) Have culturally sensitive health promotion programs that include approaches that are specifically effective for persons of color and accommodating to different cultural value systems, gender, and age;

(14) Permit every category of health care provider to provide health services or care for conditions included in the uniform benefits package to the extent that:

(a) The provision of such health services or care is within the health care providers' permitted scope of practice; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of health services;

(ii) Management and administrative procedures; and

(iii) Provision of cost-effective and clinically efficacious health services;

(15) Establish the geographic boundaries in which they will obligate themselves to deliver the services required under the uniform benefits package and include such information in their application for certification, but the commissioner shall review such boundaries and may disapprove, in conformance with guidelines adopted by the commission, those that have been clearly drawn to be exclusionary within a health care catchment area;

(16) Annually report the names and addresses of all officers, directors, or trustees of the certified health plan during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals;

(17) Annually report the number of residents enrolled and terminated during the previous year. Additional information regarding the enrollment and termination pattern for a certified health plan may be required by the commissioner to determine compliance with the open enrollment and free access requirements of chapter 492, Laws of 1993; and

(18) Disclose any financial interests held by officers and directors in any facilities associated with or operated by the certified health plan.[1993 c 492 ú 428.]