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SB 6034 - S AMD 049
By Senator McDonald

S/O BEYOND SCOPE - 3/7/95

On page 1, line 7, after "463;" strike "and"

On page 1, line 8, after "464" insert "; and
(3) RCW 43.72.050 and 1993 c 492 s 407"

On page 1, after line 8, insert the following:

"**Sec. 2.** RCW 43.72.010 and 1994 c 4 s 1 are each amended to read as follows:

In this chapter, unless the context otherwise requires:

(1) "Certified health plan" or "plan" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, a health maintenance organization as defined in RCW 48.46.020, or an entity certified in accordance with RCW 48.43.020 through 48.43.120.

(2) "Chair" means the presiding officer of the Washington health services commission.

(3) "Commission" or "health services commission" means the Washington health services commission.

(4) ((~~"Community rate" means the rating method used to establish the premium for the uniform benefits package adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region and family size as determined by the commission.~~

~~(5)~~)) "Continuous quality improvement and total quality management" means a continuous process to improve health services while reducing costs.

((~~(6)~~)) (5) "Employee" means a resident who is in the employment of an employer, as defined by chapter 50.04 RCW.

((~~(7)~~)) (6) "Enrollee" means any person who is a Washington resident enrolled in a certified health plan.

((~~(8)~~)) (7) "Enrollee point of service cost-sharing" means amounts paid to certified health plans directly providing services, health care

providers, or health care facilities by enrollees for receipt of specific uniform benefits package services, and may include copayments, coinsurance, or deductibles, that together must be actuarially equivalent across plans and within overall limits established by the commission.

((~~(9)~~)) (8) "Enrollee premium sharing" means that portion of the premium that is paid by enrollees or their family members.

((~~(10)~~)) (9) "Federal poverty level" means the federal poverty guidelines determined annually by the United States department of health and human services or successor agency.

((~~(11)~~)) (10) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations, but does not include Christian Science sanatoriums operated, listed, or certified by the First Church of Christ Scientist, Boston, Massachusetts.

((~~(12)~~)) (11) "Health care provider" or "provider" means:

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

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

((~~(13)~~)) (12) "Health insurance purchasing cooperative" or "cooperative" means a member-owned and governed nonprofit organization certified in accordance with RCW 43.72.080 and 48.43.160.

((~~(14)~~)) (13) "Long-term care" means institutional, residential, outpatient, or community-based services that meet the individual needs of persons of all ages who are limited in their functional capacities or have disabilities and require assistance with performing two or more activities of daily living for an extended or indefinite period of

time. These services include case management, protective supervision, in-home care, nursing services, convalescent, custodial, chronic, and terminally ill care.

((~~(15)~~)) (14) "Major capital expenditure" means any project or expenditure for capital construction, renovations, or acquisition, including medical technological equipment, as defined by the commission, costing more than one million dollars.

((~~(16)~~)) (15) "Managed care" means an integrated system of insurance, financing, and health services delivery functions that: (a) Assumes financial risk for delivery of health services and uses a defined network of providers; or (b) assumes financial risk for delivery of health services and promotes the efficient delivery of health services through provider assumption of some financial risk including capitation, prospective payment, resource-based relative value scales, fee schedules, or similar method of limiting payments to health care providers.

((~~(17) "Maximum~~)) (16) "Enrollee financial participation" means the income-related total annual payments that may be required of an enrollee per family who chooses one of the three lowest priced uniform benefits packages offered by plans in a geographic region including both premium sharing and enrollee point of service cost-sharing.

((~~(18)~~)) (17) "Persons of color" means Asians/Pacific Islanders, African, Hispanic, and Native Americans.

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

((~~(20)~~)) (19) "Qualified employee" means an employee who is employed at least thirty hours during a week or one hundred twenty hours during a calendar month.

((~~(21)~~)) (20) "Registered employer health plan" means a health plan established by a private employer of more than seven thousand active employees in this state solely for the benefit of such employees and their dependents and that meets the requirements of RCW 43.72.120. Nothing contained in this subsection shall be deemed to preclude the

plan from providing benefits to retirees of the employer.

((~~(22)~~)) (21) "Supplemental benefits" means those appropriate and effective health services that are not included in the uniform benefits package or that expand the type or level of health services available under the uniform benefits package and that are offered to all residents in accordance with the provisions of RCW 43.72.160 and 43.72.170.

((~~(23)~~)) (22) "Technology" means the drugs, devices, equipment, and medical or surgical procedures used in the delivery of health services, and the organizational or supportive systems within which such services are provided. It also means sophisticated and complicated machinery developed as a result of ongoing research in the basic biological and physical sciences, clinical medicine, electronics, and computer sciences, as well as specialized professionals, medical equipment, procedures, and chemical formulations used for both diagnostic and therapeutic purposes.

((~~(24)~~)) (23) "Uniform benefits package" or "package" means those appropriate and effective health services, defined by the commission under RCW 43.72.130, that must be offered to all Washington residents through certified health plans.

((~~(25)~~)) (24) "Washington resident" or "resident" means a person who intends to reside in the state permanently or indefinitely and who did not move to Washington for the primary purpose of securing health services under RCW 43.72.090 through 43.72.240, 43.72.300, 43.72.310, 43.72.800, and chapters 48.43 and 48.85 RCW. "Washington resident" also includes people and their accompanying family members who are residing in the state for the purpose of engaging in employment for at least one month, who did not enter the state for the primary purpose of obtaining health services. The confinement of a person in a nursing home, hospital, or other medical institution in the state shall not by itself be sufficient to qualify such person as a resident.

Sec. 3. RCW 43.72.040 and 1994 c 4 s 3 are each amended to read as follows:

The commission has the following powers and duties:

(1) Ensure that all residents of Washington state are enrolled in a certified health plan to receive the uniform benefits package, regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment, or economic status.

(2) Endeavor to ensure that all residents of Washington state have access to appropriate, timely, confidential, and effective health services, and monitor the degree of access to such services. If the commission finds that individuals or populations lack access to certified health plan services, the commission shall:

(a) Authorize appropriate state agencies, local health departments, community or migrant health clinics, public hospital districts, or other nonprofit health service entities to take actions necessary to assure such access. This includes authority to contract for or directly deliver services described within the uniform benefits package to special populations; or

(b) Notify appropriate certified health plans and the insurance commissioner of such findings. The commission shall adopt by rule standards by which the insurance commissioner may, in such event, require certified health plans in closest proximity to such individuals and populations to extend their catchment areas to those individuals and populations and offer them enrollment.

(3) Adopt necessary rules in accordance with chapter 34.05 RCW to carry out the purposes of chapter 492, Laws of 1993. An initial set of draft rules establishing at least the commission's organization structure, the uniform benefits package, and standards for certified health plan certification, must be submitted in draft form to appropriate committees of the legislature by December 1, 1994.

(4) Establish and modify as necessary, in consultation with the state board of health and the department of health, and coordination with the planning process set forth in RCW 43.70.520 a uniform set of health services based on the recommendations of the health care cost control and access commission established under House Concurrent Resolution No. 4443 adopted by the legislature in 1990.

(5) Establish and modify as necessary the uniform benefits package as provided in RCW 43.72.130, which shall be offered to enrollees of a certified health plan. ((~~The benefit package shall be provided at no more than the maximum premium specified in subsection (6) of this section.~~

~~(6)(a) Establish for each year a community-rated maximum premium for the uniform benefits package that shall operate to control overall health care costs. The maximum premium cost of the uniform benefits package in the base year 1995 shall be established upon an actuarial determination of the costs of providing the uniform benefits package~~

~~and such other cost impacts as may be deemed relevant by the commission. Beginning in 1996, the growth rate of the premium cost of the uniform benefits package for each certified health plan shall be allowed to increase by a rate no greater than the average growth rate in the cost of the package between 1990 and 1993 as actuarially determined, reduced by two percentage points per year until the growth rate is no greater than the five-year rolling average of growth in Washington per capita personal income, as determined by the office of financial management.~~

~~(b) In establishing the community-rated maximum premium under this subsection, the commission shall review various methods for establishing the community-rated maximum premium and shall recommend such methods to the legislature by December 1, 1994.~~

~~The commission may develop and recommend a rate for employees that provides nominal, if any, variance between the rate for individual employees and employees with dependents to minimize any economic incentive to an employer to discriminate between prospective employees based upon whether or not they have dependents for whom coverage would be required.~~

~~(c) If the commission adds or deletes services or benefits to the uniform benefits package in subsequent years, it may increase or decrease the maximum premium to reflect the actual cost experience of a broad sample of providers of that service in the state, considering the factors enumerated in (a) of this subsection and adjusted actuarially. The addition of services or benefits shall not result in a redetermination of the entire cost of the uniform benefits package.~~

~~(d) The level of state expenditures for the uniform benefits package shall be limited to the appropriation of funds specifically for this purpose.~~

~~(7)~~)) (6) Determine the need for medical risk adjustment mechanisms to minimize financial incentives for certified health plans to enroll individuals who present lower health risks and avoid enrolling individuals who present higher health risks, and to minimize financial incentives for employer hiring practices that discriminate against individuals who present higher health risks. In the design of medical risk distribution mechanisms under this subsection, the commission shall (a) balance the benefits of price competition with the need to protect certified health plans from any unsustainable negative effects of adverse selection; (b) consider the development of a system that

creates a risk profile of each certified health plan's enrollee population that does not create disincentives for a plan to control benefit utilization, that requires contributions from plans that enjoy a low-risk enrollee population to plans that have a high-risk enrollee population, and that does not permit an adjustment of the premium charged for the uniform benefits package or supplemental coverage based upon either receipt or contribution of assessments; and (c) consider whether registered employer health plans should be included in any medical risk adjustment mechanism. Proposed medical risk adjustment mechanisms shall be submitted to the legislature as provided in RCW 43.72.180.

((~~(8)~~)) (7) Design a mechanism to assure minors have access to confidential health care services as currently provided in RCW 70.24.110 and 71.34.030.

((~~(9)~~)) (8) Monitor the actual growth in total annual health services costs.

((~~(10)~~)) (9) Monitor the increased application of technology as required by chapter 492, Laws of 1993 and take necessary action to ensure that such application is made in a cost-effective and efficient manner and consistent with existing laws that protect individual privacy.

((~~(11)~~)) (10) Establish reporting requirements for certified health plans that own or manage health care facilities, health care facilities, and health care providers to periodically report to the commission regarding major capital expenditures of the plans. The commission shall review and monitor such reports and shall report to the legislature regarding major capital expenditures on at least an annual basis. The Washington health care facilities authority and the commission shall develop standards jointly for evaluating and approving major capital expenditure financing through the Washington health care facilities authority, as authorized pursuant to chapter 70.37 RCW. By December 1, 1994, the commission and the authority shall submit jointly to the legislature such proposed standards. The commission and the authority shall, after legislative review, but no later than June 1, 1995, publish such standards. Upon publication, the authority may not approve financing for major capital expenditures unless approved by the commission.

((~~(12)~~)) (11) Establish ((~~maximum~~)) enrollee financial participation levels. The levels shall be related to enrollee

household income.

((~~(13)~~)) (12) Establish rules requiring employee enrollee premium sharing, as defined in RCW 43.72.010((~~(9)~~)) (8), be paid through deductions from wages or earnings.

((~~(14)~~)) (13) For health services provided under the uniform benefits package and supplemental benefits, adopt standards for enrollment, and standardized billing and claims processing forms. The standards shall ensure that these procedures minimize administrative burdens on health care providers, health care facilities, certified health plans, and consumers. Subject to federal approval or phase-in schedules whenever necessary or appropriate, the standards also shall apply to state-purchased health services, as defined in RCW 41.05.011.

((~~(15)~~)) (14) Propose that certified health plans adopt certain practice indicators or risk management protocols for quality assurance, utilization review, or provider payment. The commission may consider indicators or protocols recommended according to RCW 43.70.500 for these purposes.

((~~(16)~~)) (15) Propose other guidelines to certified health plans for utilization management, use of technology and methods of payment, such as diagnosis-related groups and a resource-based relative value scale. Such guidelines shall be voluntary and shall be designed to promote improved management of care, and provide incentives for improved efficiency and effectiveness within the delivery system.

((~~(17)~~)) (16) Adopt standards and oversee and develop policy for personal health data and information system as provided in chapter 70.170 RCW.

((~~(18)~~)) (17) Adopt standards that prevent conflict of interest by health care providers as provided in RCW 18.130.320.

((~~(19)~~)) (18) At the appropriate juncture and in the fullness of time, consider the extent to which medical research and health professions training activities should be included within the health service system set forth in chapter 492, Laws of 1993.

((~~(20)~~)) (19) Evaluate and monitor the extent to which racial and ethnic minorities have access to and receive health services within the state, and develop strategies to address barriers to access.

((~~(21)~~)) (20) Develop standards for the certification process to certify health plans and employer health plans to provide the uniform benefits package, according to the provisions for certified health plans and registered employer health plans under chapter 492, Laws of

1993.

((~~(22) Develop rules for implementation of individual and employer participation under RCW 43.72.210 and 43.72.220 specifically applicable to persons who work in this state but do not live in the state or persons who live in this state but work outside of the state. The rules shall be designed so that these persons receive coverage and financial requirements that are comparable to that received by persons who both live and work in the state.~~

~~(23)~~)) (21) After receiving advice from the health services effectiveness committee, adopt rules that must be used by certified health plans, disability insurers, health care service contractors, and health maintenance organizations to determine whether a procedure, treatment, drug, or other health service is no longer experimental or investigative.

((~~(24)~~)) (22) Establish a process for purchase of uniform benefits package services by enrollees when they are out-of-state.

((~~(25)~~)) (23) Develop recommendations to the legislature as to whether state and school district employees, on whose behalf health benefits are or will be purchased by the health care authority pursuant to chapter 41.05 RCW, should have the option to purchase health benefits through health insurance purchasing cooperatives on and after July 1, 1997. In developing its recommendations, the commission shall consider:

(a) The impact of state or school district employees purchasing through health insurance purchasing cooperatives on the ability of the state to control its health care costs; and

(b) Whether state or school district employees purchasing through health insurance purchasing cooperatives will result in inequities in health benefits between or within groups of state and school district employees.

((~~(26)~~)) (24) Establish guidelines for providers dealing with terminal or static conditions, taking into consideration the ethics of providers, patient and family wishes, costs, and survival possibilities.

((~~(27)~~)) (25) Evaluate the extent to which Taft-Hartley health care trusts provide benefits to certain individuals in the state; review the federal laws under which these trusts are organized; and make appropriate recommendations to the governor and the legislature on or before December 1, 1994, as to whether these trusts should be brought

under the provisions of chapter 492, Laws of 1993 when it is fully implemented, and if the commission recommends inclusion of the trusts, how to implement such inclusion.

((~~(28)~~)) (26) Evaluate whether Washington is experiencing a higher percentage in in-migration of residents from other states and territories than would be expected by normal trends as a result of the availability of unsubsidized and subsidized health care benefits for all residents and report to the governor and the legislature their findings.

((~~(29)~~)) (27) In developing the uniform benefits package and other standards pursuant to this section, consider the likelihood of the establishment of a national health services plan adopted by the federal government and its implications.

((~~(30)~~)) (28) Evaluate the effect of reforms under chapter 492, Laws of 1993 on access to care and economic development in rural areas.

To the extent that the exercise of any of the powers and duties specified in this section may be inconsistent with the powers and duties of other state agencies, offices, or commissions, the authority of the commission shall supersede that of such other state agency, office, or commission, except in matters of personal health data, where the commission shall have primary data system policy-making authority and the department of health shall have primary responsibility for the maintenance and routine operation of personal health data systems.

Sec. 4. RCW 43.72.100 and 1993 c 492 s 428 are each amended to read as follows:

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.

Sec. 5. RCW 43.72.110 and 1993 c 492 s 429 are each amended to read as follows:

(1) For the purposes of this section "limited certified dental plan" or "dental plan" means a limited health ((~~[care]~~)) care service contractor governed by RCW 48.44.035 offering dental care services only and that complies with all certified health plan requirements for managed care, ((~~community rating,~~)) portability, and nondiscrimination as provided in RCW 43.72.100.

(2) A dental plan may provide coverage for dental services directly to individuals or to employers for the benefit of employees. If an individual or an employer purchases dental care services from a dental plan, the certified health plan covering the individual or the employees need not provide dental services required under the uniform benefits package. A certified health plan may subcontract with a dental plan to provide the dental benefits required under the uniform benefits package.

Sec. 6. RCW 43.72.120 and 1993 c 492 s 430 are each amended to read as follows:

((~~Consistent with the provisions of RCW 43.72.220,~~)) A registered employer health plan shall:

(1) Register with the insurance commissioner by filing its plan of management and operation including but not limited to information required by the commissioner sufficient for a determination by the commissioner that such plan meets the requirements of this section and any rules adopted by the health services commission and the insurance commissioner pertaining to such plans.

(2) Provide the benefits included in the uniform benefits package to employees and their dependents for a prepaid((~~, 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.

(3) Offer supplemental benefits to employees and their dependents for a prepaid((~~, community-rated~~)) premium and provide such benefits through managed care in accordance with rules adopted by the commission. Benefits offered by such plan need not comply with the provisions of RCW 43.72.160 and 43.72.170.

(4) 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, socioeconomic status, or other condition or situation, or the

provisions of RCW 49.60.174(2).

(5) 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 uniform benefits package and any supplemental benefits or has made adequate contractual arrangements with health care providers and facilities to provide employees and their dependents with such benefits.

(6) Comply with portability of benefits requirements prescribed by the commission for registered employer health plans.

(7) Comply with administrative rules prescribed by the commission, the insurance commissioner, and other state agencies governing registered employer health plans.

(8) Provide all employees and their dependents enrolled in the plan 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.

(9) Include in all of its contracts with health care providers and health care facilities a provision prohibiting such providers and facilities from billing employees and their dependents enrolled in the plan 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 plan to recover the costs of uniform benefits package and supplemental benefit services incurred to care for a plan enrollee injured by a negligent third party. The costs recovered shall be limited to:

(a) If the plan has not intervened in the action by an injured plan enrollee against a negligent third party, then the amount of costs the plan can recover shall be limited to the excess remaining after the plan 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 plan, the plan shall have the right to be heard on the matter of attorneys' fees and costs or its proportionate share;

(b) If the plan has intervened in the action by an injured enrollee against a negligent third party, then the amount of costs the 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 insurance commissioner, to provide a reasonable and effective resolution of complaints initiated by plan 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 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 by enrollees of registered employer health plans.

(12) 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.

(13) 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.

(14) Pay to the state treasurer a tax equivalent to the tax applied to taxpayers under RCW 48.14.0201 in accordance with rules adopted by

the department of revenue.

(15) File their uniform benefits package and supplemental benefits with the insurance commissioner who may disapprove and order a modification of such package or benefits if such package or benefits fail to meet any standards or rules adopted by the commission pertaining to maximum premiums, enrollee financial participation, point of service cost-sharing, benefit design, or health service delivery.

(16) Comply with and shall be subject to RCW 48.43.170, 43.72.300, and 43.72.310.

(17) Pay an annual fee to the insurance commissioner's office in an amount established by rule of the commissioner necessary for the performance of the commissioner's responsibilities under this section consistent with and subject to the collection, depositing, and spending provisions applicable to fees collected pursuant to RCW 48.02.190.

(18) File an annual report with the commissioner containing such information as the commissioner may require to determine compliance with this section.

(19) In addition to any other penalties prescribed by law, be subject to the penalties contained in RCW 48.43.010 for violations of this section.

Sec. 7. RCW 43.72.170 and 1993 c 492 s 453 are each amended to read as follows:

(1) Premium rates for uniform benefits package and supplemental benefits shall not be excessive or inadequate, and shall not discriminate in a manner prohibited by RCW 43.72.100(3). ((~~Premium rates, enrollee point of service cost-sharing, or maximum enrollee financial participation amounts for a uniform benefits package may not exceed the limits established by the health services commission in accordance with RCW 43.72.040. Premium rates for uniform benefits package and supplemental benefits shall be developed on a community-rated basis as determined by the health services commission.~~))

(2) Prior to using, every certified health plan shall file with the commissioner its enrollee point of service, cost-sharing amounts, enrollee financial participation amounts, rates, its rating plan, and any other information used to determine the specific premium to be charged any enrollee and every modification of any of the foregoing.

(3) Every such filing shall indicate the type and extent of the health services contemplated and must be accompanied by sufficient

information to permit the commissioner to determine whether it meets the requirements of this chapter. A plan shall offer in support of any filing:

(a) Any historical data and actuarial projections used to establish the rate filed;

(b) An exhibit detailing the major elements of operating expense for the types of health services affected by the filing;

(c) An explanation of how investment income has been taken into account in the proposed rates;

(d) Any other information that the plan deems relevant; and

(e) Any other information that the commissioner requires by rule.

(4) If a plan has insufficient loss experience to support its proposed rates, it may submit loss experience for similar exposures of other plans within the state.

(5) Every filing shall state its proposed effective date.

(6) Actuarial formulas, statistics, and assumptions submitted in support of a rate or form filing by a plan or submitted to the commissioner at the commissioner's request shall be withheld from public inspection in order to preserve trade secrets or prevent unfair competition.

(7) No plan may make or issue a benefits package except in accordance with its filing then in effect.

(8) The commissioner shall review a filing as soon as reasonably possible after made, to determine whether it meets the requirements of this section.

(9)(a) No filing may become effective within thirty days after the date of filing with the commissioner, which period may be extended by the commissioner for an additional period not to exceed fifteen days if the commissioner gives notice within such waiting period to the plan that the commissioner needs additional time to consider the filing.

(b) A filing shall be deemed to meet the requirements of this section unless disapproved by the commissioner within the waiting period or any extension period.

(c) If within the waiting or any extension period, the commissioner finds that a filing does not meet the requirements of this section, the commissioner shall disapprove the filing, shall notify the plan of the grounds for disapproval, and shall prohibit the use of the disapproved filing.

(10) If at any time after the applicable review period provided in

this section, the commissioner finds that a filing does not meet the requirements of this section, the commissioner shall, after notice and hearing, issue an order specifying in what respect the commissioner finds that such filing fails to meet the requirements of this section, and stating when, within a reasonable period thereafter, the filings shall be deemed no longer effective.

The order shall not affect any benefits package made or issued prior to the expiration of the period set forth in the order.

Sec. 8. RCW 48.43.040 and 1993 c 492 s 435 are each amended to read as follows:

(1) The insurance commissioner shall verify that the certified health plan and its providers are charging no more than the ((~~maximum~~)) premiums and enrollee financial participation amounts as filed during the course of financial and market conduct examinations or more frequently if justified in the opinion of the insurance commissioner or upon request by the health services commission.

(2) The certified health plans shall file the premium schedules including employer contributions, enrollee premium sharing, and enrollee point of service cost-sharing amounts with the insurance commissioner, within thirty days of establishment ((~~by the health services commission~~)).

(3) No certified health plan or its provider may charge any fees, assessments, or charges in addition to the premium amount ((~~or in excess of the maximum enrollee financial participation limits established by the health services commission~~)). The certified health plan that directly provides health care services may charge and collect the enrollee point of service cost-sharing fees as established in the uniform benefits package or other approved benefit plan."

SB 6034 - S AMD
By Senator McDonald

On page 1, line 2 of the title, after "employers;" insert "amending RCW 43.72.010, 43.72.040, 43.72.100, 43.72.110, 43.72.120, 43.72.170, and 48.43.040;"

On page 1, beginning on line 2 of the title, strike "and 43.72.220"

and insert ", 43.72.220, and 43.72.050"

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