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HOUSE BILL 2153

State of Washington 55th Legislature 1997 Regular Session

By Representatives Conway, Murray, Kenney, Wood, Kastama, Anderson, Fisher, Cody, Keiser, O'Brien, Dunshee, Blalock, Gombosky, Doumit, Costa, Cooper, Tokuda, Veloria, Wolfe, Dickerson, Chopp, Appelwick, Butler, Gardner and Ogden

Read first time 02/24/97. Referred to Committee on Health Care.

1 AN ACT Relating to establishing grievance and appeals procedures
2 for health carriers; amending RCW 48.43.055, 48.46.020, and 48.46.100;
3 and adding a new chapter to Title 48 RCW.

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

5 NEW SECTION. **Sec. 1.** The legislature finds that health carrier
6 grievance procedures should be standardized in order to provide
7 enrollees with a clear, consistent, and efficient means of resolving
8 complaints about the provision of health care. Health carrier
9 grievance procedures should offer consumers the opportunity to have
10 their complaint fairly reviewed first by the health carrier and, if
11 appealed, by an impartial hearing officer. Consumers should also be
12 notified of their right to file a complaint with the office of the
13 insurance commissioner throughout the grievance process. The
14 legislature further recognizes the authority of the office of the
15 insurance commissioner to adopt rules that govern health carrier
16 managed care procedures.

17 NEW SECTION. **Sec. 2.** The definitions in this section apply
18 throughout this chapter unless the context clearly requires otherwise.

(1) "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, in which failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(2) "Grievance" means an oral or written complaint submitted by or on behalf of an enrollee regarding the availability, delivery, or quality of health care services as described in section 3 of this act.

(3) "Grievance procedure" means a procedure for health carriers to respond to consumer complaints and conduct investigations of consumer complaints according to the standards and rules adopted by the office of the insurance commissioner.

(4) "Health plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(5) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or 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.

(6) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(7) "Health carrier" means a person or entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a disability insurance company, a health care service contractor, a health maintenance organization, and a fraternal benefit society.

(8) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the necessity and appropriateness of the initial proposed health care service.

NEW SECTION. **Sec. 3.** (1) The insurance commissioner shall adopt by rule a standardized grievance procedure for enrollees of all health carriers. The standard grievance procedure must be available for all enrollees to file complaints about any health carrier practices that impact enrollee access to, satisfaction with, or quality of health care services, treatments, or providers. Enrollees' rights to appeal health carrier decisions may not be limited in scope and must include, but not be limited to:

(a) Waiting times for getting an appointment;

(b) Distance or time needed to travel to an appointment;

(c) Waiting times when the patient arrives at an appointment;

(d) Languages spoken by providers;

(e) Access to specialists;

(f) Cleanliness and safety of providers' facilities;

(g) Qualification and experience of providers;

(h) Choice of provider;

(i) Manner in which patient is treated;

(j) Access to appropriate services and treatment; and

(k) Timeliness with which referrals, treatments, and services are approved and provided.

(2) The office of the insurance commissioner shall adopt rules to ensure that the standardized grievance procedure:

(a) Fully informs consumers about their rights, including their right to file additional complaints with the appropriate state government agencies, and identify the appropriate agencies for filing complaints;

(b) Allows grievances to be filed orally or in writing;

(c) Provides for action upon nonemergency grievances within twenty days, and responds to emergency grievances within twenty-four hours;

(d) Ensures grievances are reviewed by qualified personnel;

(e) Provides consumers with rights to receive a second opinion about the course of treatment;

(f) Allows consumers to be represented by their provider, family member, attorney, or other designated person, except as otherwise prohibited by law;

(g) Gives both oral and written notification of the decision and the reasons for the decision made;

(h) Maintains recordkeeping on all grievances;

1 (i) Provides the enrollee with access to all records concerning the
2 enrollee's grievance, excluding any records made confidential by any
3 other section of law;
4 (j) Involves no more than three levels of review, including the
5 enrollee's initial request for plan assistance or review whether orally
6 or in writing; and
7 (k) Informs the enrollee at each stage of the grievance procedure
8 of the enrollee's right to file additional complaints with the
9 appropriate state government agencies, and identifies the appropriate
10 agencies for filing complaints.
11 (3) Each health carrier shall designate qualified personnel to
12 review grievances who meet the standards adopted by rule by the office
13 of the insurance commissioner.
14 (4) The health carrier shall assure that the grievance process is
15 accessible to enrollees who do not speak English, who have literacy
16 problems, and who have physical or mental disabilities that impede
17 their access to file a grievance. The office of the insurance
18 commissioner shall adopt rules to ensure health carriers make the
19 grievance process accessible to all enrollees.
20 (5) All health carriers shall file evidence of their implementation
21 of the standardized grievance procedure in writing to the office of the
22 insurance commissioner by January 1st annually. Health carriers may be
23 excused from resubmitting grievance procedures if there have been no
24 changes since the health carrier's previous submission. The filing
25 must be available to the general public by request to the office of the
26 insurance commissioner. Grievance procedures must be given in a
27 separate brochure to each enrollee at the time of enrollment and sent
28 annually to all health carrier enrollees.

29 NEW SECTION. **Sec. 4.** (1) An enrollee's provider is not subject to
30 liability for the negligent denial of benefits by the health carrier,
31 if the provider reasonably informs the enrollee of the benefits, costs,
32 risks, and alternatives pertaining to such treatment; appeals the
33 decision of the health carrier denying such benefits, in writing,
34 stating the reasons why such care or treatment is reasonable and
35 necessary for the enrollee; and cooperates and assists the enrollee
36 with appeals of the decision denying such treatment to the extent the
37 provider can assist under law. Such written appeal by the provider

1 must be considered in grievance or complaint investigation and any
2 mediation proceeding.
3 (2) A health carrier is liable in tort as would be a health care
4 provider in a medical negligence case if and when the health carrier is
5 negligent in its decision to refuse to pay for care to which the
6 enrollee is entitled under the enrollee's policy and that refusal
7 causes personal injury or damages to the enrollee.

8 **Sec. 5.** RCW 48.43.055 and 1995 c 265 s 20 are each amended to read
9 as follows:
10 Each health carrier as defined under RCW 48.43.005 shall file with
11 the commissioner its grievance procedures ((~~for review and adjudication~~
12 ~~of complaints initiated by covered persons or health care providers.~~
13 ~~Procedures filed under this section shall provide a fair review for~~
14 ~~consideration of complaints. Every health carrier shall provide~~
15 ~~reasonable means whereby any person aggrieved by actions of the health~~
16 ~~carrier may be heard in person or by their authorized representative on~~
17 ~~their written request for review. If the health carrier fails to grant~~
18 ~~or reject such request within thirty days after it is made, the~~
19 ~~complaining person may proceed as if the complaint had been rejected~~))
20 as described in chapter 48.-- RCW (sections 1 through 4 of this act).
21 A complaint that has been rejected by the health carrier may be
22 submitted to nonbinding mediation. Mediation shall be conducted
23 pursuant to mediation rules similar to those of the American
24 arbitration association, the center for public resources, the judicial
25 arbitration and mediation service, RCW 7.70.100, or any other rules of
26 mediation agreed to by the parties.

27 **Sec. 6.** RCW 48.46.020 and 1990 c 119 s 1 are each amended to read
28 as follows:
29 As used in this chapter, the terms defined in this section shall
30 have the meanings indicated unless the context indicates otherwise.
31 (1) "Health maintenance organization" means any organization
32 receiving a certificate of registration by the commissioner under this
33 chapter which provides comprehensive health care services to enrolled
34 participants of such organization on a group practice per capita
35 prepayment basis or on a prepaid individual practice plan, except for
36 an enrolled participant's responsibility for copayments and/or
37 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
31 of consumers a means of submitting the views and recommendations of
32 such consumers to the governing board of such organization coupled with
33 reasonable assurance that the board will give regard to such views and
34 recommendations.
35 (8) "Meaningful grievance procedure" means a procedure for
36 investigation of consumer grievances ((~~in a timely manner aimed at~~
37 ~~mutual agreement for settlement~~)) according to procedures ((~~approved by~~
38 ~~the commissioner, and~~)), which may include ((~~arbitration~~)) nonbinding

mediation procedures as described in chapter 48.-- RCW (sections 1 through 4 of this act).

(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.

Sec. 7. RCW 48.46.100 and 1975 1st ex.s. c 290 s 11 are each amended to read as follows:

A health maintenance organization shall establish and maintain a grievance procedure, approved by the commissioner, ((~~to provide reasonable and effective resolution of complaints initiated by enrolled participants concerning any matter relating to the interpretation of any provision of such enrolled participants' health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, cancellations, or nonrenewals of enrolled participants' coverage; and the quality of the health care services rendered, and~~)) which may include procedures for ((~~arbitration~~)) <u>nonbinding mediation as described in chapter 48.-- RCW (sections 1 through 4 of this act)</u>.

1 NEW SECTION. **Sec. 8.** Sections 1 through 4 of this act constitute
2 a new chapter in Title 48 RCW.

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