S-3449.4

SENATE BILL 6486

State of Washington 55th Legislature 1998 Regular Session

By Senators Wood, Wojahn, Winsley, Long, Fairley, Thibaudeau, Kohl and Oke

Read first time 01/20/98. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to managed care consumer protection; reenacting and amending RCW 48.43.005; and adding new sections to chapter 48.43 RCW.

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

NEW SECTION. **Sec. 1.** Chapter . . ., Laws of 1998 (this act) shall be known and may be cited as the managed care consumer protection act.

NEW SECTION. **Sec. 2.** It is the intent of the legislature that enrollees in managed care plans receive quality health care designed to maintain and improve their health status. To that end, the purpose of chapter . . ., Laws of 1998 (this act) is to ensure that:

(1) Enrollees have full and timely access to clinically and culturally appropriate health care personnel and facilities;

(2) Enrollees have adequate choice among health care professionals who are accessible and qualified;

(3) Enrollees have access to comprehensive pharmaceutical services;

(4) Enrollees have access to information regarding limits on coverage of experimental treatments;

(5) Enrollees are provided with a high quality of preventative and other health care within a managed care plan, designed to maintain and improve an enrollee's health status;

(6) Medical decisions are made by the appropriate medical personnel;

(7) Health care professionals within a plan are practitioners in good standing;

(8) Managed care plan data are available as appropriate;

(9) There is full public access to information regarding health care service delivery within plans;

(10) There is a fair vehicle for resolving enrollee complaints in a managed care system;

(11) There is timely resolution of enrollee grievances and appeals;

(12) Managed care plan advertisements are true, accurate, and not misleading; and

(13) Enrollees have access to the civil justice system when injured by decisions made in a managed care system.

Sec. 3. RCW 48.43.005 and 1997 c 231 s 202 and 1997 c 55 s 1 are each reenacted and amended to read as follows:

Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Adjusted community rate" means the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities.

(2) "Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community.

(3) "Basic health plan" means the plan described under chapter 70.47 RCW, as revised from time to time.

((~~(3)~~)) (4) "Basic health plan model plan" means a health plan as required in RCW 70.47.060(2)(d).

((~~(4)~~)) (5) "Basic health plan services" means that schedule of covered health services, including the description of how those benefits are to be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

((~~(5)~~)) (6) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

((~~(6)~~)) (7) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

((~~(7)~~)) (8) "Covered person" or "enrollee" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

((~~(8)~~)) (9) "Dependent" means, at a minimum, the enrollee's legal spouse and unmarried dependent children who qualify for coverage under the enrollee's health benefit plan.

((~~(9)~~)) (10) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty or more hours. The term includes a self-employed individual, including a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not work less than thirty hours per week and derives at least seventy-five percent of his or her income from a trade or business through which he or she has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form. Persons covered under a health benefit plan pursuant to the consolidated omnibus budget reconciliation act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements of chapter 265, Laws of 1995.

((~~(10)~~)) (11) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if 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.

((~~(11)~~)) (12) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

((~~(12)~~)) (13) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

((~~(13)~~)) (14) "Experimental treatment" means treatment that, while not commonly used for a particular condition or illness, nevertheless is recognized for treatment of the particular condition or illness, and there is no clearly superior, nonexperimental treatment alternative available to the enrollee.

(15) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding: (a) Denial of payment for medical services or nonprovision of medical services included in the covered person's health benefit plan, or (b) service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

((~~(14)~~)) (16) "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.

((~~(15)~~)) (17) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 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.

((~~(16)~~)) (18) "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.

((~~(17)~~)) (19) "Health care treatment decision" means a determination made regarding whether health care services are actually provided by the health plan and a decision that affects the quality of the diagnosis, care, or treatment provided to enrollees.

(20) "Health carrier" or "carrier" 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, or a health maintenance organization as defined in RCW 48.46.020.

((~~(18)~~)) (21) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care services offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

((~~(19)~~)) (22) "Life-threatening condition" means a disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted.

(23) "Managed care plan" means a health plan, including a medicare supplement and limited health plan described in subsection (21)(b) and (c) of this section, offered by a health carrier that provides for the delivery of health care services using a system or techniques to affect access to and control payment for health care services. Such a system or techniques may include one or more of the following:

(a) Prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services;

(b) Contracts with selected health care providers;

(c) Financial incentives or disincentives for enrollees to use specific providers, services, or service sites;

(d) Controlled access to and coordination of services by a case manager; and

(e) Carrier efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care. Managed care plan does not include traditional indemnity insurance policies.

(24) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

((~~(20)~~)) (25) "Open enrollment" means the annual sixty-two day period during the months of July and August during which every health carrier offering individual health plan coverage must accept onto individual coverage any state resident within the carrier's service area regardless of health condition who submits an application in accordance with RCW 48.43.035(1).

((~~(21)~~)) (26) "Ordinary care" means, in the case of a health carrier, that degree of care that a health carrier of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a health carrier, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances.

(27) "Participating provider" means a provider who, under a contract with the health carrier or with the health carrier's contractor or subcontractor, has agreed to provide health care services

to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

(28) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(22)~~)) (29) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

((~~(23)~~)) (30) "Primary care provider" means a participating provider designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for speciality care and maintain supervision of health care services rendered to the covered person.

(31) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

((~~(24)~~)) (32) "Small employer" means any person, firm, corporation, partnership, association, political subdivision except school districts, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a

small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term "small employer" includes a self-employed individual or sole proprietor. The term "small employer" also includes a self-employed individual or sole proprietor who derives at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year.

((~~(25)~~)) (33) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

((~~(26)~~)) (34) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

NEW SECTION. **Sec. 4.** Chapter . . ., Laws of 1998 (this act) applies to all managed care plans and all health carriers offering a managed care plan operating within Washington state.

NEW SECTION. **Sec. 5.** (1) Each managed care plan must include a sufficient number and type of primary care providers and specialists throughout the service area to meet the needs of enrollees and to provide meaningful choice. Each managed care plan must offer:

(a) An adequate number of accessible acute care hospital services within a reasonable distance or travel time;

(b) An adequate number of accessible primary care providers within a reasonable distance or travel time. Primary care providers includes family practice and general practice physicians, internists, obstetrician/gynecologists, and pediatricians;

(c) An adequate number of accessible specialists and subspecialists within a reasonable distance or travel time. If the type of medical

specialist needed for a specific condition is not represented on the specialty panel, enrollees must have access to nonparticipating health care professionals;

(d) Available specialty medical services, including physical therapy, occupational therapy, and rehabilitation services; and

(e) Available nonpanel specialists, when a patient's unique medical circumstances warrant it.

(2) Each managed care plan must allow enrollees, at the carrier's expense and for at least sixty days, to continue receiving services from a primary care provider whose contract with the plan is terminated without cause.

(3) Each health carrier must provide telephone access to managed care plan enrollees for sufficient time during business and evening hours to ensure enrollee access for routine care, and twenty-four hour telephone access to either the carrier or a participating provider, for emergency care or authorization for care.

(4) Each health carrier must have reasonable standards for waiting times for managed care plan enrollees to obtain appointments with participating providers.

The standards must include appointment scheduling guidelines based on the type of health care service, including prenatal care appointments, well-child visits and immunizations, routine physicals, follow-up appointments for chronic conditions, and urgent care.

(5) Each carrier must develop an access plan to meet the needs of vulnerable and underserved populations among its managed care enrollees.

(a) The plan must provide culturally appropriate services to the greatest extent possible.

(b) When a significant number of enrollees in the plan speak a first language other than English, the plan must provide access to personnel fluent in languages other than English, to the greatest extent possible.

(c) The carrier must develop standards for continuity of care following enrollment, including sufficient information on how to access care within the plan.

(6) Each managed care plan must hold harmless enrollees against claims from participating providers for payment of cost of covered health services.

NEW SECTION. **Sec. 6.** (1) Each enrollee in a managed care plan must have adequate choice among health care professionals who are accessible and qualified.

(2) Each managed care plan must allow an enrollee to choose his or her own primary care provider from a list of participating providers. Each carrier must update this list as participating providers are added or removed, and include:

(a) A sufficient number of primary care providers who are accepting new enrollees; and

(b) A mix of primary care providers sufficient to meet the needs of the enrolled population's varied characteristics, including age, gender, race, and health status.

(3) Each health carrier must have a process whereby an enrollee in a managed care plan whose medical condition so warrants may be authorized to use a medical specialist as a primary care provider. This may include enrollees suffering from chronic diseases as well as those with other special needs.

(4) Each managed care plan must provide for continuity of care and appropriate referral of enrollees to specialists within the plan, when specialty care is warranted.

(a) Enrollees must have access to medical specialists on a timely basis.

(b) Enrollees must be provided with a choice of specialists when a referral is made.

(5) Each managed care plan must provide a point-of-service option that allows an enrollee to choose to receive service from a nonparticipating health care professional or provider. The point-of-service option may require that an enrollee pay a reasonable portion of the costs of the out-of-plan care.

(6) Each managed care plan must provide, upon the request of an enrollee, access by the enrollee to a second opinion from a participating provider regarding any medical diagnosis or treatment plan.

NEW SECTION. **Sec. 7.** (1) Each managed care plan must provide coverage of all United States food and drug administration approved drugs and devices, whether or not that drug or device has been approved for the specific treatment or condition, so long as the primary care

provider or medical specialist treating an enrollee determines the drug or device is medically necessary for the enrollee's condition.

(2) Each carrier must establish and operate a drug utilization review program to enhance quality of care for managed care plan enrollees by assuring appropriate drug therapy. The program must include the following:

(a) A retrospective review of prescription drugs furnished to enrollees, that incorporates:

(i) Clinically relevant criteria and standards for drug therapy;

(ii) Nonproprietary criteria and standards, developed and revised through an open, professional consensus process; and

(iii) Interventions that focus on improving therapeutic outcomes;

(b) Periodic examination of data on outpatient prescription drugs to ensure quality therapeutic outcomes for enrollees;

(c) Education of participating providers, enrollees, and pharmacists regarding the appropriate use of prescription drugs; and

(d) Measures to ensure that the confidentiality of the relationship between enrollees and providers are protected at all times.

(3) Prospective review of drug therapy may only deny services in cases of enrollee ineligibility, coverage limitations, or fraud.

(4) The prescribing provider must determine the appropriate drug therapy for an enrollee. Substitutions may not be made without the direct approval of the prescriber.

NEW SECTION. **Sec. 8.** (1) A managed care plan that limits coverage for experimental treatment must describe and disclose the limits, including:

(a) The criteria the plan uses to determine whether a service is experimental; and

(b) Who is authorized to make such a determination.

(2) A carrier that denies coverage of an experimental treatment for a managed care plan enrollee who has a terminal condition or illness must provide the enrollee with a denial letter within twenty working days of the submitted request. The letter must include:

(a) The name and title of the individual making the denial decision;

(b) A statement setting forth the specific medical and scientific reasons for denying coverage;

(c) A description of alternative treatment, services, or supplies covered by the plan, if any; and

(d) A copy of the plan's grievance and appeal procedure.

NEW SECTION. **Sec. 9.** (1) Each carrier must have comprehensive quality assurance standards adequate to identify, evaluate, and correct problems relating to access, continuity, and quality of care for managed care plan enrollees. These standards must include:

(a) An ongoing, written, internal quality assurance program;

(b) Specific written guidelines for quality of care studies and monitoring, including attention to vulnerable populations;

(c) Performance and clinical outcome-based criteria;

(d) A procedure for remedial action to correct quality problems, including written procedures for taking appropriate corrective action;

(e) A plan for data gathering and assessment; and

(f) A peer review process.

(2) Each carrier must have written policies and procedures governing the selection of participating providers in any managed care plan. The policies and procedures must:

(a) Establish minimum professional requirements;

(b) Be developed in consultation with qualified health care professionals;

(c) Include verification of a provider's license, history of suspension or revocation, and liability claims history; and

(d) Provide for the periodic, written reevaluation of each participating provider at reasonable intervals following his or her initial acceptance.

Reevaluations must include updates of the previous review criteria and an assessment of the performance pattern based on criteria including enrollee clinical outcomes, number of complaints, and malpractice actions.

(3) A managed care plan may not use a health care provider outside of the provider's legally authorized scope of practice.

NEW SECTION. **Sec. 10.** (1) Upon request of any person, including current or potential enrollees, or the insurance commissioner, a health carrier must provide written information regarding any managed care plan it offers, including, but not limited to, information on plan structure, decision-making processes, confidentiality procedures,

health care benefits and exclusions, cost and cost-sharing requirements, a list of participating providers, and grievance and appeal procedures.

(2) A health carrier must collect and report annually to the insurance commissioner specified data regarding any managed care plan it offers, including:

(a) Gross outpatient and hospital utilization data;

(b) Enrollee clinical outcome data;

(c) The number and types of enrollee grievances or complaints during the year, the status of decisions, and the average time required to reach a decision; and

(d) The number, amount, and disposition of legal claims for adverse medical outcomes filed in the preceding year against the managed care plan or any of its participating providers.

(3) Each health carrier must have written policies and procedures governing medical records and enrollee communications to protect the privacy of managed care plan enrollees and ensure the confidentiality of specified enrollee information, including, but not limited to, prior medical history and claims information, except where disclosure of this information is otherwise required by law.

(4) A health carrier is prohibited from releasing individual enrollee record information, except where otherwise required by law, unless such a release is authorized in writing by the enrollee.

NEW SECTION. **Sec. 11.** (1) Each health carrier must appoint a medical director who is a licensed physician in the state of Washington. The medical director is responsible for treatment policies, protocols, quality assurance activities, and utilization management decisions for any managed care plan offered by the carrier.

(2) Each health carrier must inform potential and current enrollees in any managed care plan if the contract between the carrier and any participating providers includes incentives or bonuses for restriction of services.

NEW SECTION. **Sec. 12.** (1) Each health carrier must provide written notification to each managed care plan enrollee, in a language the enrollee understands, of the enrollee’s right to file a grievance. Notification must be provided:

(a) Before a person’s enrollment in the plan; and

(b) At the time care is denied or limited under the plan. This notice must also identify the reason for the denial or limitation, the name of the individual responsible for the decision, the criteria for determination, and include a detailed description of the grievance procedure.

(2) No more than thirty days after a grievance is filed with a carrier, the carrier must notify the person who filed the grievance of the outcome, and of the process whereby an adverse grievance decision may be appealed. In cases involving an imminent, emergent, or serious threat to the health of the enrollee, the notification must be provided within seventy-two hours of the filing of the grievance.

(3) Each health carrier must annually report to the insurance commissioner regarding grievances filed under this section. The report must include:

(a) The number of grievances and appeals processed by the carrier during the preceding year;

(b) The outcomes or current status of the grievances and appeals; and

(c) The average time taken to resolve grievances and appeals.

NEW SECTION. **Sec. 13.** (1) A health carrier must:

(a) Permit a person whose appeal of an adverse grievance decision is denied by the carrier to seek review of that determination by an independent review organization assigned to the appeal in accordance with rules adopted by the commissioner under section 14 of this act;

(b) Provide to the appropriate independent review organization not later than the third business day after the date that the carrier receives a request for review a copy of:

(i) Any medical records of the enrollee that are relevant to the review;

(ii) Any documents used by the plan in making the determination to be reviewed by the organization;

(iii) Any documentation and written information submitted to the carrier in support of the appeal; and

(iv) A list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal;

(c) Comply with the independent review organization's determination with respect to the medical necessity or appropriateness of health care items and services for an enrollee; and

(d) Pay for the independent review.

(2) Confidential information in the custody of a carrier may be provided to an independent review organization, subject to rules adopted by the commissioner.

NEW SECTION. **Sec. 14.** (1) The commissioner shall:

(a) Adopt rules for:

(i) The certification, selection, and operation of independent review organizations to perform independent review described by section 13 of this act; and

(ii) The suspension and revocation of the certification;

(b) Designate annually each organization that meets the standards as an independent review organization;

(c) Charge health carriers fees as necessary to fund the operations of independent review organizations; and

(d) Provide ongoing oversight of the independent review organizations to ensure continued compliance with this chapter and the rules adopted under this chapter.

(2) The rules required by subsection (1)(a) of this section must ensure:

(a) The timely response of an independent review organization selected under this chapter;

(b) The confidentiality of medical records transmitted to an independent review organization for use in independent reviews;

(c) The qualifications and independence of each health care provider or physician making review determinations for an independent review organization;

(d) The fairness of the procedures used by an independent review organization in making the determinations; and

(e) Timely notice to enrollees of the results of the independent review, including the clinical basis for the determination.

(3) The rules adopted under subsection (1)(a) of this section must include rules that require each independent review organization to make its determination:

(a) Not later than the earlier of:

(i) The fifteenth day after the date the independent review organization receives the information necessary to make the determination; or

(ii) The twentieth day after the date the independent review organization receives the request that the determination be made; and

(b) In the case of a life-threatening condition, not later than the earlier of:

(i) The fifth day after the date the independent review organization receives the information necessary to make the determination; or

(ii) The eighth day after the date the independent review organization receives the request that the determination be made.

(4) To be certified as an independent review organization under this chapter, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

(a) For an applicant that is publicly held, the name of each stockholder or owner of more than five percent of any stock or options;

(b) The name of any holder of bonds or notes of the applicant that exceed one hundred thousand dollars;

(c) The name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the affiliation or control;

(d) The name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed under (c) of this subsection and a description of any relationship the named individual has with:

(i) A health benefit plan;

(ii) A health carrier;

(iii) A utilization review agent;

(iv) A nonprofit health corporation;

(v) A health care provider; or

(vi) A group representing any of the entities described by (d)(i) through (v) of this subsection;

(e) The percentage of the applicant’s revenues that are anticipated to be derived from reviews conducted under section 13 of this act;

(f) A description of the areas of expertise of the health care professionals making review determinations for the applicant; and

(g) The procedures to be used by the independent review organization in making review determinations with respect to reviews conducted under section 13 of this act.

(5) The independent review organization shall annually submit the information required by subsection (4) of this section. If at any time there is a material change in the information included in the application under subsection (4) of this section, the independent review organization shall submit updated information to the commissioner.

(6) An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a health carrier or a trade or professional association of health carriers.

(7) An independent review organization conducting a review under section 13 of this act is not liable for damages arising from the determination made by the organization. This subsection does not apply to an act or omission of the independent review organization that is made in bad faith or that involves gross negligence.

NEW SECTION. **Sec. 15.** A health carrier shall not place any advertisement before the public that is false, inaccurate, or misleading. Such advertising is a matter affecting the public interest for the purposes of applying chapter 19.86 RCW, and is not reasonable in relation to the development and preservation of business. A violation of this section constitutes an unfair or deceptive act or practice in trade or commerce for the purpose of applying chapter 19.86 RCW.

NEW SECTION. **Sec. 16.** (1) A health carrier shall exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an enrollee that is proximately caused by the carrier’s failure to exercise such ordinary care.

(2) A health carrier is also liable for damages for harm to an enrollee that is proximately caused by the health care treatment decisions made by the carrier’s:

(a) Employees;

(b) Agents;

(c) Ostensible agents; or

(d) Representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually

exercised influence or control that results in the failure to exercise ordinary care.

(3) It is a defense to an action asserted against a health carrier that:

(a) Neither the health carrier, nor any employee, agent, ostensible agent, or representative for whose conduct the health carrier is liable under subsection (2) of this section, controlled, influenced, or participated in the health care treatment decision; and

(b) The health carrier did not deny or delay payment for any treatment prescribed or recommended by a provider to the enrollee.

(4) The standards in subsections (1) and (2) of this section create no obligation on the part of the health insurance carrier to provide to an enrollee treatment that is not covered by the health plan of the carrier.

(5) This section does not create any liability on the part of an employer or an employer group purchasing organization that purchases coverage or assumes risk on behalf of its employees.

(6) A health carrier may not remove a physician or health care provider from its plan or refuse to renew the physician or health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

(7) A health carrier may not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company that includes an indemnification or hold harmless clause for the acts or conduct of the health carrier.

(8) Nothing in any law of this state prohibiting a health carrier from practicing medicine or being licensed to practice medicine may be asserted as a defense by the health carrier in an action brought against it under this section or any other law.

(9) In an action against a health carrier, a finding that a physician or other health care provider is an employee, agent, ostensible agent, or representative of the health carrier shall not be based solely on proof that the person’s name appears in a listing of approved physicians or health care providers made available to enrollees under a health plan.

(10) This chapter does not apply to workers’ compensation insurance coverage under Title 51 RCW.

NEW SECTION. **Sec. 17.** (1) A person may not maintain a cause of action under section 16 of this act against a health carrier unless the affected enrollee or the enrollee's representative:

(a) Has exhausted the appeals and review applicable under sections 12 and 13 of this act; or

(b) Before instituting the action:

(i) Gives written notice of the claim as provided by subsection (2) of this section; and

(ii) Agrees to submit the claim to a review by an independent review organization under section 14 of this act, as required by subsection (3) of this section.

(2) The notice required by subsection (1)(b)(i) of this section must be delivered or mailed to the health carrier against whom the action is made not later than the thirtieth day before the date the claim is filed.

(3) The enrollee or the enrollee's representative must submit the claim to a review by an independent review organization if the health carrier against whom the claim is made requests the review not later than the fourteenth day after the date the notice under subsection (1)(b)(i) of this section is received by the health carrier. If the health carrier does not request the review within the period specified by this subsection, the enrollee or the enrollee's representative is not required to submit the claim to independent review before maintaining the action.

(4) Subject to subsection (5) of this section, if the enrollee has not complied with subsection (1) of this section, the court shall not dismiss an action under this section, but the court may order the parties to submit to an independent review or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed thirty days for those purposes. Such orders of the court are the sole remedy available to a party complaining of an enrollee's failure to comply with subsection (1) of this section.

(5) The enrollee is not required to comply with subsection (3) of this section, and no abatement or other order under subsection (4) of this section for failure to comply may be imposed if the enrollee has filed a pleading alleging in substance that:

(a) Harm to the enrollee has already occurred because of the conduct of the health carrier or because of an act or omission of an

employee, agent, ostensible agent, or representative of the carrier for whose conduct it is liable under section 16(2) of this act; and

(b) The review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier, finds after hearing that such pleading was not made in good faith, in which case the court may enter an order under subsection (4) of this section.

(6) If the enrollee or the enrollee's representative seeks to exhaust the appeals and review or provides notice, as required by subsection (1) of this section, before the statute of limitations applicable to a claim against a managed care entity has expired, the limitations period is tolled until the later of:

(a) The thirtieth day after the date the enrollee or the enrollee's representative has exhausted the process for appeals and review; or

(b) The fortieth day after the date the enrollee or the enrollee's representative gives notice under subsection (1)(b)(i) of this section.

(7) This section does not prohibit an enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the enrollee's health in serious jeopardy.

NEW SECTION. **Sec. 18.** Sections 1 and 4 through 17 of this act are each added to chapter 48.43 RCW.

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