6199-S2 AMH HC AMH-4973.2

2SSB 6199 - H COMM AMD **ADOPTED AS AMENDED 3/3/00**
By Committee on Health Care

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** PATIENT RIGHTS. It is the intent of the legislature that enrollees covered by health plans receive quality health care designed to maintain and improve their health. The purpose of this act is to ensure that health plan enrollees:

(1) Have improved access to information regarding their health plans;

(2) Have sufficient and timely access to appropriate health care services, and choice among health care providers;

(3) Are assured that health care decisions are made by appropriate medical personnel;

(4) Have access to a quick and impartial process for appealing plan decisions;

(5) Are protected from unnecessary invasions of health care privacy; and

(6) Are assured that personal health care information will be used only as necessary to obtain and pay for health care or to improve the quality of care.

NEW SECTION. **Sec. 2.** A new section is added to chapter 70.02 RCW to read as follows:

HEALTH INFORMATION PRIVACY. Third-party payors shall not release health care information disclosed under this chapter, except to the extent that health care providers are authorized to do so under RCW 70.02.050.

Sec. 3. RCW 70.02.110 and 1991 c 335 s 402 are each amended to read as follows:

HEALTH INFORMATION PRIVACY. (1) In making a correction or amendment, the health care provider shall:

(a) Add the amending information as a part of the health record; and

(b) Mark the challenged entries as corrected or amended entries and indicate the place in the record where the corrected or amended information is located, in a manner practicable under the circumstances.

(2) If the health care provider maintaining the record of the patient's health care information refuses to make the patient's proposed correction or amendment, the provider shall:

(a) Permit the patient to file as a part of the record of the patient's health care information a concise statement of the correction or amendment requested and the reasons therefor; and

(b) Mark the challenged entry to indicate that the patient claims the entry is inaccurate or incomplete and indicate the place in the record where the statement of disagreement is located, in a manner practicable under the circumstances.

(3) A health care provider who receives a request from a patient to amend or correct the patient's health care information, as provided in RCW 70.02.100, shall forward any changes made in the patient's health care information or health record, including any statement of disagreement, to any third-party payor or insurer to which the health care provider has disclosed the health care information that is the subject of the request.

Sec. 4. RCW 70.02.900 and 1991 c 335 s 901 are each amended to read as follows:

HEALTH INFORMATION PRIVACY. (1) This chapter does not restrict a health care provider, a third-party payor, or an insurer regulated under Title 48 RCW from complying with obligations imposed by federal or state health care payment programs or federal or state law.

(2) This chapter does not modify the terms and conditions of disclosure under Title 51 RCW and chapters 13.50, 26.09, 70.24, 70.39, 70.96A, 71.05, and 71.34 RCW and rules adopted under these provisions.

NEW SECTION. **Sec. 5.** HEALTH INFORMATION PRIVACY. (1) Health carriers and insurers shall adopt policies and procedures that conform administrative, business, and operational practices to protect an enrollee's right to privacy or right to confidential health care services granted under state or federal laws.

(2) The commissioner may adopt rules to implement this section after considering relevant standards adopted by national managed care accreditation organizations and the national association of insurance commissioners, and after considering the effect of those standards on the ability of carriers to undertake enrollee care management and disease management programs.

NEW SECTION. **Sec. 6.** INFORMATION DISCLOSURE. (1) A carrier that offers a health plan may not offer to sell a health plan to an enrollee or to any group representative, agent, employer, or enrollee representative without first offering to provide, and providing upon request, the following information before purchase or selection:

(a) A listing of covered benefits, including prescription drug benefits, if any, a copy of the current formulary, if any is used, definitions of terms such as generic versus brand name, and policies regarding coverage of drugs, such as how they become approved or taken off the formulary, and how consumers may be involved in decisions about benefits;

(b) A listing of exclusions, reductions, and limitations to covered benefits, and any definition of medical necessity or other coverage criteria upon which they may be based;

(c) A statement of the carrier’s policies for protecting the confidentiality of health information;

(d) A statement of the cost of premiums and any enrollee cost-sharing requirements;

(e) A summary explanation of the carrier’s grievance process;

(f) A statement regarding the availability of a point-of-service option, if any, and how the option operates; and

(g) A convenient means of obtaining lists of participating primary care and specialty care providers, including disclosure of network arrangements that restrict access to providers within any plan network. The offer to provide the information referenced in this subsection (1) must be clearly and prominently displayed on any information provided to any prospective enrollee or to any prospective group representative, agent, employer, or enrollee representative.

(2) Upon the request of any person, including a current enrollee, prospective enrollee, or the insurance commissioner, a carrier must provide written information regarding any health care plan it offers, that includes the following written information:

(a) Any documents, instruments, or other information referred to in the medical coverage agreement;

(b) A full description of the procedures to be followed by an enrollee for consulting a provider other than the primary care provider and whether the enrollee's primary care provider, the carrier's medical director, or another entity must authorize the referral;

(c) Procedures, if any, that an enrollee must first follow for obtaining prior authorization for health care services;

(d) A written description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between a carrier and a provider or network;

(e) Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists;

(f) An annual accounting of all payments made by the carrier which have been counted against any payment limitations, visit limitations, or other overall limitations on a person's coverage under a plan;

(g) A copy of the carrier's grievance process for claim or service denial and for dissatisfaction with care; and

(h) Accreditation status with one or more national managed care accreditation organizations, and whether the carrier tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data.

(3) Each carrier shall provide to all enrollees and prospective enrollees a list of available disclosure items.

(4) Nothing in this section requires a carrier or a health care provider to divulge proprietary information to an enrollee, including the specific contractual terms and conditions between a carrier and a provider.

(5) No carrier may advertise or market any health plan to the public as a plan that covers services that help prevent illness or promote the health of enrollees unless it:

(a) Provides all clinical preventive health services provided by the basic health plan, authorized by chapter 70.47 RCW;

(b) Monitors and reports annually to enrollees on standardized measures of health care and satisfaction of all enrollees in the health

plan. The state department of health shall recommend appropriate standardized measures for this purpose, after consideration of national standardized measurement systems adopted by national managed care accreditation organizations and state agencies that purchase managed health care services; and

(c) Makes available upon request to enrollees its integrated plan to identify and manage the most prevalent diseases within its enrolled population, including cancer, heart disease, and stroke.

(6) No carrier may preclude or discourage its providers from informing an enrollee of the care he or she requires, including various treatment options, and whether in the providers' view such care is consistent with the plan's health coverage criteria, or otherwise covered by the enrollee's medical coverage agreement with the carrier. No carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of an enrollee with a carrier. Nothing in this section shall be construed to authorize a provider to bind a carrier to pay for any service.

(7) No carrier may preclude or discourage enrollees or those paying for their coverage from discussing the comparative merits of different carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier.

(8) Each carrier must communicate enrollee information required in this act by means that ensure that a substantial portion of the enrollee population can make use of the information.

(9) The commissioner may adopt rules to implement this section. In developing rules to implement this section, the commissioner shall consider relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

NEW SECTION. **Sec. 7.** ACCESS TO APPROPRIATE HEALTH SERVICES. (1) Each enrollee in a health plan must have adequate choice among health care providers.

(2) Each carrier must allow an enrollee to choose a primary care provider who is accepting new enrollees from a list of participating providers. Enrollees also must be permitted to change primary care providers at any time with the change becoming effective no later than

the beginning of the month following the enrollee’s request for the change.

(3) Each carrier must have a process whereby an enrollee with a complex or serious medical or psychiatric condition may receive a standing referral to a participating specialist for an extended period of time.

(4) Each carrier must provide for appropriate and timely referral of enrollees to a choice of specialists within the plan if specialty care is warranted. If the type of medical specialist needed for a specific condition is not represented on the specialty panel, enrollees must have access to nonparticipating specialty health care providers.

(5) Each carrier shall provide enrollees with direct access to the participating chiropractor of the enrollee’s choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection shall prevent carriers from restricting enrollees to seeing only providers who have signed participating provider agreements or from utilizing other managed care and cost containment techniques and processes. For purposes of this subsection, "covered chiropractic health care" means covered benefits and limitations related to chiropractic health services as stated in the plan’s medical coverage agreement, with the exception of any provisions related to prior referral for services.

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

(7) Each carrier must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract for at least sixty days following notice of termination to the enrollees or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. The provider’s relationship with the carrier or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the carrier assign new enrollees to the terminated provider.

(8) Every carrier shall meet the standards set forth in this section and any rules adopted by the commissioner to implement this

section. In developing rules to implement this section, the commissioner shall consider relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

NEW SECTION. **Sec. 8.** HEALTH CARE DECISIONS. (1) Carriers that offer a health plan shall maintain a documented utilization review program description and written utilization review criteria based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. Carriers shall make clinical protocols, medical management standards, and other review criteria available upon request to participating providers.

(2) The commissioner shall adopt, in rule, standards for this section after considering relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

(3) A carrier shall not be required to use medical evidence or standards in its utilization review of religious nonmedical treatment or religious nonmedical nursing care.

NEW SECTION. **Sec. 9.** RETROSPECTIVE DENIAL OF SERVICES. (1) A health carrier that offers a health plan shall not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan’s written policies at the time the care was rendered.

(2) The commissioner shall adopt, in rule, standards for this section after considering relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

NEW SECTION. **Sec. 10.** GRIEVANCE PROCESS. (1) Each carrier that offers a health plan must have a fully operational, comprehensive grievance process that complies with the requirements of this section and any rules adopted by the commissioner to implement this section. For the purposes of this section, the commissioner shall consider grievance process standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

(2) Each carrier must process as a complaint an enrollee's expression of dissatisfaction about customer service or the quality or availability of a health service. Each carrier must implement procedures for registering and responding to oral and written complaints in a timely and thorough manner.

(3) Each carrier must provide written notice to an enrollee or the enrollee's designated representative, and the enrollee's provider, of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility.

(4) Each carrier must process as an appeal an enrollee's written or oral request that the carrier reconsider: (a) Its resolution of a complaint made by an enrollee; or (b) its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility. A carrier must not require that an enrollee file a complaint prior to seeking appeal of a decision under (b) of this subsection.

(5) To process an appeal, each carrier must:

(a) Provide written notice to the enrollee when the appeal is received;

(b) Assist the enrollee with the appeal process;

(c) Make its decision regarding the appeal within thirty days of the date the appeal is received. An appeal must be expedited if the enrollee's provider or the carrier's medical director reasonably determines that following the appeal process response timelines could seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours of the date the appeal is received;

(d) Cooperate with a representative authorized in writing by the enrollee;

(e) Consider information submitted by the enrollee;

(f) Investigate and resolve the appeal; and

(g) Provide written notice of its resolution of the appeal to the enrollee and, with the permission of the enrollee, to the enrollee's providers. The written notice must explain the carrier's decision and the supporting coverage or clinical reasons and the enrollee's right to request independent review of the carrier's decision under section 11 of this act.

(6) Written notice required by subsection (3) of this section must explain:

(a) The carrier's decision and the supporting coverage or clinical reasons; and

(b) The carrier's appeal process, including information, as appropriate, about how to exercise the enrollee's rights to obtain a second opinion, and how to continue receiving services as provided in this section.

(7) When an enrollee requests that the carrier reconsider its decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving through the health plan and the carrier's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier must continue to provide that health service until the appeal is resolved. If the resolution of the appeal or any review sought by the enrollee under section 11 of this act affirms the carrier's decision, the enrollee may be responsible for the cost of this continued health service.

(8) Each carrier must provide a clear explanation of the grievance process upon request, upon enrollment to new enrollees, and annually to enrollees and subcontractors.

(9) Each carrier must ensure that the grievance process is accessible to enrollees who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance.

(10) Each carrier must: Track each appeal until final resolution; maintain, and make accessible to the commissioner for a period of three years, a log of all appeals; and identify and evaluate trends in appeals.

NEW SECTION. **Sec. 11.** INDEPENDENT REVIEW OF HEALTH CARE DISPUTES. (1) There is a need for a process for the fair consideration of disputes relating to decisions by carriers that offer a health plan to deny, modify, reduce, or terminate coverage of or payment for health care services for an enrollee.

(2) An enrollee may seek review by a certified independent review organization of a carrier's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service, after exhausting the carrier's grievance process and receiving a decision

that is unfavorable to the enrollee, or after the carrier has exceeded the timelines for grievances provided in section 10 of this act, without good cause and without reaching a decision.

(3) The commissioner must establish and use a rotational registry system for the assignment of a certified independent review organization to each dispute. The system should be flexible enough to ensure that an independent review organization has the expertise necessary to review the particular medical condition or service at issue in the dispute.

(4) Carriers must provide to the appropriate certified independent review organization, not later than the third business day after the date the carrier receives a request for review, a copy of:

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

(b) Any documents used by the carrier in making the determination to be reviewed by the certified independent review organization;

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

(d) 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. Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to rules adopted by the commissioner.

(5) The medical reviewers from a certified independent review organization will make determinations regarding the medical necessity or appropriateness of, and the application of health plan coverage provisions to, health care services for an enrollee. The medical reviewers' determinations must be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of Washington. Except as provided in this subsection, the certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the medical coverage agreement. Medical reviewers may override the health plan's medical necessity or appropriateness standards if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice.

(6) Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both the carrier and the enrollee or the enrollee's representative.

(7) Carriers must timely implement the certified independent review organization's determination, and must pay the certified independent review organization's charges.

(8) When an enrollee requests independent review of a dispute under this section, and the dispute involves a carrier's decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving at the time the request for review is submitted and the carrier's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier must continue to provide the health service if requested by the enrollee until a determination is made under this section. If the determination affirms the carrier's decision, the enrollee may be responsible for the cost of the continued health service.

(9) A certified independent review organization may notify the office of the insurance commissioner if, based upon its review of disputes under this section, it finds a pattern of substandard or egregious conduct by a carrier.

(10)(a) The commissioner shall adopt rules to implement this section after considering relevant standards adopted by national managed care accreditation organizations.

(b) This section is not intended to supplant any existing authority of the office of the insurance commissioner under this title to oversee and enforce carrier compliance with applicable statutes and rules.

NEW SECTION. **Sec. 12.** A new section is added to chapter 43.70 RCW to read as follows:

INDEPENDENT REVIEW ORGANIZATIONS. (1) The department shall adopt rules providing a procedure and criteria for certifying one or more organizations to perform independent review of health care disputes described in section 11 of this act.

(2) The rules must require that the organization ensure:

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

(b) That each health care provider, physician, or contract specialist making review determinations for an independent review organization is qualified. Physicians, other health care providers, and, if applicable, contract specialists must be appropriately licensed, certified, or registered as required in Washington state or in at least one state with standards substantially comparable to Washington state. Reviewers may be drawn from nationally recognized centers of excellence, academic institutions, and recognized leading practice sites. Expert medical reviewers should have substantial, recent clinical experience dealing with the same or similar health conditions. The organization must have demonstrated expertise and a history of reviewing health care in terms of medical necessity, appropriateness, and the application of other health plan coverage provisions;

(c) That any physician, health care provider, or contract specialist making a review determination in a specific review is free of any actual or potential conflict of interest or bias. Neither the expert reviewer, nor the independent review organization, nor any officer, director, or management employee of the independent review organization may have any material professional, familial, or financial affiliation with any of the following: The health carrier; professional associations of carriers and providers; the provider; the provider's medical or practice group; the health facility at which the service would be provided; the developer or manufacturer of a drug or device under review; or the enrollee;

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

(e) That each independent review organization make its determination:

(i) Not later than the earlier of:

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

(B) The twentieth day after the date the independent review organization receives the request that the determination be made. In exceptional circumstances, when the independent review organization has not obtained information necessary to make a determination, a determination may be made by the twenty-fifth day after the date the organization received the request for the determination; and

(ii) In cases of a condition that could seriously jeopardize the enrollee's health or ability to regain maximum function, not later than the earlier of:

(A) Seventy-two hours after the date the independent review organization receives the information necessary to make the determination; or

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

(f) That timely notice is provided to enrollees of the results of the independent review, including the clinical basis for the determination;

(g) That the independent review organization has a quality assurance mechanism in place that ensures the timeliness and quality of review and communication of determinations to enrollees and carriers, and the qualifications, impartiality, and freedom from conflict of interest of the organization, its staff, and expert reviewers; and

(h) That the independent review organization meets any other reasonable requirements of the department directly related to the functions the organization is to perform under this section and section 11 of this act.

(3) To be certified as an independent review organization under this chapter, an organization must submit to the department an application in the form required by the department. 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 carrier;

(ii) A utilization review agent;

(iii) A nonprofit or for-profit health corporation;

(iv) A health care provider;

(v) A drug or device manufacturer; 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 11 of this act;

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

(g) The procedures to be used by the independent review organization in making review determinations regarding reviews conducted under section 11 of this act.

(4) If at any time there is a material change in the information included in the application under subsection (3) of this section, the independent review organization shall submit updated information to the department.

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

(6) An independent review organization, and individuals acting on its behalf, are immune from suit in a civil action when performing functions under this act. However, this immunity does not apply to an act or omission made in bad faith or that involves gross negligence.

(7) Independent review organizations must be free from interference by state government in its functioning except as provided in subsection (8) of this section.

(8) The rules adopted under this section shall include provisions for terminating the certification of an independent review organization for failure to comply with the requirements for certification. The department may review the operation and performance of an independent review organization in response to complaints or other concerns about compliance.

(9) In adopting rules for this section, the department shall take into consideration standards for independent review organizations adopted by national accreditation organizations. The department may accept national accreditation or certification by another state as evidence that an organization satisfies some or all of the requirements for certification by the department as an independent review organization.

NEW SECTION. **Sec. 13.** CARRIER MEDICAL DIRECTOR. Any carrier that offers a health plan and any self-insured health plan subject to the jurisdiction of Washington state shall designate a medical director who is licensed under chapter 18.57 or 18.71 RCW. However, a naturopathic or complementary alternative health plan, which provides solely complementary alternative health care to individuals, groups, or health plans, may have a medical director licensed under chapter 18.36A RCW. A health plan or self-insured health plan that offers only religious nonmedical treatment or religious nonmedical nursing care shall not be required to have a medical director.

Sec. 14. RCW 51.04.020 and 1994 c 164 s 24 are each amended to read as follows:

The director shall:

(1) Establish and adopt rules governing the administration of this title;

(2) Ascertain and establish the amounts to be paid into and out of the accident fund;

(3) Regulate the proof of accident and extent thereof, the proof of death and the proof of relationship and the extent of dependency;

(4) Supervise the medical, surgical, and hospital treatment to the intent that it may be in all cases efficient and up to the recognized standard of modern surgery;

(5) Issue proper receipts for moneys received and certificates for benefits accrued or accruing;

(6) Investigate the cause of all serious injuries and report to the governor from time to time any violations or laxity in performance of protective statutes or regulations coming under the observation of the department;

(7) Compile statistics which will afford reliable information upon which to base operations of all divisions under the department;

(8) Make an annual report to the governor of the workings of the department;

(9) Be empowered to enter into agreements with the appropriate agencies of other states relating to conflicts of jurisdiction where the contract of employment is in one state and injuries are received in the other state, and insofar as permitted by the Constitution and laws of the United States, to enter into similar agreements with the provinces of Canada; and

(10) Designate a medical director who is licensed under chapter 18.57 or 18.71 RCW.

Sec. 15. RCW 74.09.050 and 1979 c 141 s 335 are each amended to read as follows:

The secretary shall appoint such professional personnel and other assistants and employees, including professional medical screeners, as may be reasonably necessary to carry out the provisions of this chapter. The medical screeners shall be supervised by one or more physicians who shall be appointed by the secretary or his or her designee. The secretary shall appoint a medical director who is licensed under chapter 18.57 or 18.71 RCW.

NEW SECTION. **Sec. 16.** A new section is added to chapter 41.05 RCW to read as follows:

HEALTH CARE AUTHORITY MEDICAL DIRECTOR. The administrator shall designate a medical director who is licensed under chapter 18.57 or 18.71 RCW.

NEW SECTION. **Sec. 17.** CARRIER LIABILITY. (1)(a) A health carrier shall adhere to the accepted standard of care for health care providers under chapter 7.70 RCW when arranging for the provision of medically necessary health care services to its enrollees. A health carrier shall be liable for any and all harm proximately caused by its failure to follow that standard of care when the failure resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, an enrollee.

(b) A health carrier is also liable for damages under (a) of this subsection for harm to an enrollee proximately caused by health care treatment decisions that result from a failure to follow the accepted standard of care made by its:

(i) Employees;

(ii) Agents; or

(iii) Ostensible agents 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.

(2) The provisions of this section may not be waived, shifted, or modified by contract or agreement and responsibility for the provisions shall be a duty that cannot be delegated. Any effort to waive, modify,

delegate, or shift liability for a breach of the duty established by this section, through a contract for indemnification or otherwise, is invalid.

(3) This section does not create any new cause of action, or eliminate any presently existing cause of action, with respect to health care providers and health care facilities that are included in and subject to the provisions of chapter 7.70 RCW.

(4) It is a defense to any action or liability asserted under this section against a health carrier that:

(a) The health care service in question is not a benefit provided under the plan or the service is subject to limitations under the plan that have been exhausted;

(b) Neither the health carrier, nor any employee, agent, or ostensible agent for whose conduct the health carrier is liable under subsection (1)(b) of this section, controlled, influenced, or participated in the health care decision; or

(c) The health carrier did not deny or unreasonably delay payment for treatment prescribed or recommended by a participating health care provider for the enrollee.

(5) This section does not create any liability on the part of an employer, an employer group purchasing organization that purchases coverage or assumes risk on behalf of its employers, or a governmental agency that purchases coverage on behalf of individuals and families. The governmental entity established to offer and provide health insurance to public employees, public retirees, and their covered dependents under RCW 41.05.140 is subject to liability under this section.

(6) 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.

(7)(a) A person may not maintain a cause of action under this section against a health carrier unless:

(i) The affected enrollee has suffered substantial harm. As used in this subsection, "substantial harm" means loss of life, loss or significant impairment of limb, bodily or cognitive function, significant disfigurement, or severe or chronic physical pain; and

(ii) The affected enrollee or the enrollee's representative has exercised the opportunity established in section 11 of this act to seek independent review of the health care treatment decision.

(b) This subsection (7) does not prohibit an enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or other relief available under law, if its requirements place the enrollee's health in serious jeopardy.

(8) In an action against a health carrier, a finding that a health care provider is an employee, agent, or ostensible agent of such a 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.

(9) Any action under this section shall be commenced within three years of the completion of the independent review process.

(10) This section does not apply to workers' compensation insurance under Title 51 RCW.

NEW SECTION. **Sec. 18.** DELEGATION OF DUTIES. Each carrier is accountable for and must oversee any activities required by this act that it delegates to any subcontractor. No contract with a subcontractor executed by the health carrier or the subcontractor may relieve the health carrier of its obligations to any enrollee for the provision of health care services or of its responsibility for compliance with statutes or rules.

NEW SECTION. **Sec. 19.** APPLICATION. This act applies to: Health plans as defined in RCW 48.43.005 offered, renewed, or issued by a carrier; medical assistance provided under RCW 74.09.522; the basic health plan offered under chapter 70.47 RCW; and health benefits provided under chapter 41.05 RCW.

NEW SECTION. **Sec. 20.** A new section is added to chapter 41.05 RCW to read as follows:

Each health plan that provides medical insurance offered under this chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, are subject to the provisions of sections 1, 2, 5 through 12, 17, 18, and RCW 70.02.110 and 70.02.900.

Sec. 21. RCW 70.47.130 and 1997 c 337 s 8 are each amended to read as follows:

(1) The activities and operations of the Washington basic health plan under this chapter, including those of managed health care systems to the extent of their participation in the plan, are exempt from the provisions and requirements of Title 48 RCW except:

(a) Benefits as provided in RCW 70.47.070;

(b) Managed health care systems are subject to the provisions of sections 1, 2, 5 through 12, 17, 18, and RCW 70.20.110 and 70.02.900;

(c) Persons appointed or authorized to solicit applications for enrollment in the basic health plan, including employees of the health care authority, must comply with chapter 48.17 RCW. For purposes of this subsection (1)((~~(b)~~)) (c), "solicit" does not include distributing information and applications for the basic health plan and responding to questions; and

((~~(c)~~)) (d) Amounts paid to a managed health care system by the basic health plan for participating in the basic health plan and providing health care services for nonsubsidized enrollees in the basic health plan must comply with RCW 48.14.0201.

(2) The purpose of the 1994 amendatory language to this section in chapter 309, Laws of 1994 is to clarify the intent of the legislature that premiums paid on behalf of nonsubsidized enrollees in the basic health plan are subject to the premium and prepayment tax. The legislature does not consider this clarifying language to either raise existing taxes nor to impose a tax that did not exist previously.

NEW SECTION. **Sec. 22.** This act may be known and cited as the health care patient bill of rights.

NEW SECTION. **Sec. 23.** If specific funding for the purposes of this act, referencing this act by bill or chapter number, is not provided by June 30, 2000, in the omnibus appropriations act, this act is null and void.

NEW SECTION. **Sec. 24.** Captions used in this act are not any part of the law.

NEW SECTION. **Sec. 25.** Sections 1, 5 through 11, 13, 17, and 18 of this act are each added to chapter 48.43 RCW.

NEW SECTION. **Sec. 26.** To the extent permitted by law, if any provision of this act conflicts with state or federal law, such provision must be construed in a manner most favorable to the enrollee.

NEW SECTION. **Sec. 27.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 28.** EFFECTIVE DATE. (1) Except as provided in subsections (2) and (3) of this section, this act applies to contracts entered into or renewing after June 30, 2001.

(2) Sections 13, 14, 15, and 16 of this act take effect January 1, 2001.

(3) Section 29 of this act takes effect July 1, 2001.

NEW SECTION. **Sec. 29.** The following acts or parts of acts are each repealed:

(1) RCW 48.43.075 (Informing patients about their care--Health carriers may not preclude or discourage) and 1996 c 312 s 2; and

(2) RCW 48.43.095 (Information provided to an enrollee or a prospective enrollee) and 1996 c 312 s 4."

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By Committee on Health Care

On page 1, line 1 of the title, after "protection;" strike the remainder of the title and insert "amending RCW 70.02.110, 70.02.900, 51.04.020, 74.09.050, and 70.47.130; adding new sections to chapter 48.43 RCW; adding a new section to chapter 70.02 RCW; adding a new section to chapter 43.70 RCW; adding new sections to chapter 41.05 RCW; creating new sections; repealing RCW 48.43.075 and 48.43.095; and providing effective dates."

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