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HOUSE BILL 1888

State of Washington 56th Legislature 1999 Regular Session

By Representatives Murray, Cody, Dunshee, Conway, Hurst, Dickerson, Veloria, Lovick, Regala, Romero, Keiser, Santos, Schual-Berke, Kessler, Rockefeller, Ogden, Kenney, Wood, Morris, Edmonds and Linville

Read first time 02/09/1999. Referred to Committee on Health Care.

AN ACT Relating to health care patient protection; adding new sections to chapter 48.43 RCW; and repealing RCW 48.43.075, 48.43.095, and 48.43.105.

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

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NEW SECTION. **Sec. 1.** PATIENT RIGHTS. It is the intent of the legislature that patients 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 patients:

(1) Have sufficient and timely access to clinically and culturally appropriate health care services designed to maintain and improve health;

(2) Have adequate choice among qualified health care professionals;

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

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

(5) Have access to a quick and impartial process for appealing plan denials of health care coverage;

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

(7) 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; and

(8) Are protected from unfair and deceptive practices.

NEW SECTION. **Sec. 2.** CHOICE OF HEALTH CARE PROVIDER. (1) Each enrollee in a health plan must have adequate choice among qualified health care providers.

(2) Each health plan must allow an enrollee to choose a primary care provider who is accepting new enrollees from a list of participating providers who substantially share the varied characteristics of the enrolled population.

(3) Each health carrier must have a process whereby an enrollee 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 and those with other special needs.

(4) Each health plan 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 speciality panel, enrollees must have access to nonparticipating speciality health care providers.

(5) Each health plan must provide for continuity of care by:

(a) Assuring that primary care providers are responsible for at least:

(i) Supervision, coordination, and provision of health services to meet the needs of each enrollee; and

(ii) Initiation and coordination of referrals for specialty care;

(b) Allowing enrollees, already undergoing an active course of treatment that began while enrolled in the plan, to continue receiving services for a reasonable period from a participating provider who is not affiliated with the enrollee’s primary care provider’s network; and

(c) Educating enrollees about the carrier’s process for assuring continuity of care.

(6) Each health 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.

(7) To ensure enrollees’ choice of provider and to meet the health care needs of enrollees for covered benefits without unreasonable

delay, each health plan must include a sufficient number and type of health care providers and facilities throughout the plan's service area. Each health plan must provide enrollees with access to an adequate number of acute care hospital services, primary care providers, specialists and subspecialists, and specialty medical services, including physical therapy, occupational therapy, and rehabilitation services within a reasonable distance or travel time.

(8) Each health plan offered by a carrier must provide a point-of-service option that allows an enrollee to choose to receive service from a nonparticipating health care provider or facility. The point-of-service option may require that an enrollee pay a reasonable portion of the costs of the out-of-network care.

(9) Each health carrier must have reasonable standards for waiting times for health plan enrollees to obtain appointments with participating providers. The standards must include appointment scheduling guidelines based upon the type of health care service, including: Preventive, nonsymptomatic care; routine, nonurgent symptomatic care; urgent care; and emergency care.

(10) Each health carrier must provide enrollees with adequate telephone access to information necessary for enrolles to receive health services needed for covered health conditions without unreasonable delay.

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

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

(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 practicable.

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

(13) Each health plan must, at the carrier's expense, allow enrollees to continue receiving services from 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 no longer than 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 health plan 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 health plan assign new enrollees to the terminated provider.

(14) Each health plan must hold enrollees harmless against claims from participating providers for payment of costs of covered health services other than enrollees' cost-sharing obligations. A health service that is the subject of an unresolved grievance is a covered service for the purposes of this section.

(15) Every health carrier shall meet the standards set forth in this section and any rules adopted by the commissioner to implement this section. For the purposes of 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. 3.** QUALITY HEALTH CARE. A carrier must have a fully operational, comprehensive, written, quality improvement program that addresses access, continuity, and quality of care for all health plan enrollees. The commissioner shall adopt in rule quality improvement program requirements after considering relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

NEW SECTION. **Sec. 4.** HEALTH CARE DECISIONS. Each health carrier, in its review of inpatient medical and surgical benefits and outpatient medical and surgical benefits for residents of this state, shall meet the standards set forth in this section.

(2) Any decision to deny an admission, length of stay, or extension of stay, and any decision to deny, modify, or discontinue a health service or procedure must be made by a participating provider who has reasonable access to board-certified specialty providers in making such determinations.

(3) Carriers 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.

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

NEW SECTION. **Sec. 5.** MEDICAL DIRECTORS. No health carrier may appoint a medical director who is not a licensed physician in the state of Washington. The medical director is responsible for all medical decisions, treatment policies, protocols, quality assurance activities, and utilization management decisions for any health plan offered by the carrier. The medical quality assurance commission shall develop a definition of unprofessional conduct as it applies to the conduct of a physician practicing as a health carrier medical director.

NEW SECTION. **Sec. 6.** HEALTH INFORMATION PRIVACY. (1) Each health carrier must develop and implement policies and procedures governing the collection, use, and disclosure of health information. These policies and procedures must include methods for enrollees to access information and amend incorrect information, for enrollees to restrict the disclosure of sensitive information, and for enrollees to obtain information about the carrier's health information policies. In addition, these policies and procedures must include methods for carrier oversight and enforcement of information policies, for carrier storage and disposal of health information, and for carrier conformance to state and federal laws governing the collection, use, and disclosure of personally identifiable health information. Each carrier must provide a summary notice of its health information policies to enrollees, including the enrollee's right to restrict the collection, use, and disclosure of health information.

(2) Except as otherwise required by statute or rule, a health carrier is, and all persons acting at the direction of or on behalf of a carrier or in receipt of an enrollee's personally identifiable health information are, prohibited from collecting, using, or disclosing personally identifiable health information unless authorized in writing by the person who is the subject of the information. At a minimum, such authorization must be valid for a limited time and purpose; be specific as to purpose and type of information to be collected, used,

or disclosed; and identify the persons who will be receiving the information.

(3) Any person who is the subject of an unauthorized collection, use, or disclosure of personally identifiable health information is entitled to the remedies provided under RCW 9.73.060 governing violations of the right to privacy.

(4) The commissioner shall adopt rules to implement this section and shall take into consideration health information privacy standards recommended by the national association of insurance commissioners and other related professional organizations.

NEW SECTION. **Sec. 7.** INFORMATION DISCLOSURE. (1) It is a false and deceptive act for a health carrier to offer to sell a health plan to an enrollee or to any group representative, agent, employer, or enrollee representative or to an individual in a group plan if that person is not given the following information before purchase or selection:

(a) A listing of covered benefits, including prescription drugs, if any;

(b) A listing of exclusions, reductions, and limitations to covered benefits, including policies and practices related to any drug formulary, 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 containing the cost of premiums and enrollee point-of-service cost-sharing requirements;

(e) A summary explanation of grievance and appeal procedures;

(f) A statement affirming the availability of a point-of-service option and how the option operates; and

(g) A convenient means of obtaining a list of participating providers, including disclosure of network arrangements that restrict access to providers within any plan network.

(2) Upon the request of any person, including a current enrollee, prospective enrollee, or the insurance commissioner, a health carrier and the Washington state health care authority, established by chapter 41.05 RCW, in relation to the uniform medical plan 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 enrollment 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) Circumstances under which the plan may retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies;

(f) A copy of all grievance procedures for claim or service denial and for dissatisfaction with care; and

(g) 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.

(3) Each health carrier and the Washington state health care authority shall provide to all enrollees and prospective enrollees a list of available disclosure items.

(4) Nothing in this section requires a carrier to divulge proprietary information to an enrollee.

(5) No carrier may advertise, market, or present 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;

(b) Monitors and reports annually to enrollees on standardized measures of health care and satisfaction of all enrollees in the health plan as defined by the state department of health, after consideration of national standardized measurement systems adopted by national managed care accreditation organizations and state agencies that purchase managed health care services;

(c) Has a certificate of approved partnership with the state department of health or a local health jurisdiction, attesting to the

plan’s active participation in community-wide efforts to maintain and improve the health status of its enrollees through activities such as public health educational programs; and

(d) 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 health carrier may preclude or discourage its providers from informing patients 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 patient’s service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for any service.

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

NEW SECTION. **Sec. 8.** GRIEVANCE PROCESS. (1) Each health carrier 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 health carrier must provide written notice to an enrollee and the enrollee’s provider of its decision to modify, discontinue, or deny a health service for the enrollee.

(3) Each health carrier must process as a grievance:

(a) An enrollee’s complaint about the quality or availability of a health service;

(b) An enrollee’s complaint about an issue other than the quality or availability of a health service that the health carrier has not resolved within response timelines established by the commissioner in rules; and

(c) An enrollee's request that the carrier reconsider: (i) Its decision to modify, or (ii) its initial resolution of a complaint or grievance made by an enrollee.

(4) To process a grievance, each carrier must:

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

(b) Assist the enrollee with the grievance process;

(c) Expedite a grievance if the enrollee's provider or the carrier's medical director determines, or if other evidence indicates that following the grievance process response timelines could seriously jeopardize the enrollee's health or ability to regain maximum function;

(d) Cooperate with a representative chosen by the enrollee;

(e) Consider information submitted by the enrollee;

(f) Investigate and resolve the grievance; and

(g) Provide written notice of its resolution of the grievance to the enrollee.

(5) Written notice required by subsections (2) and (4) of this section must explain:

(a) The carrier's decision and the supporting coverage or clinical reasons, including any alternative health service that may be appropriate; and

(b) The carrier's grievance process, including information, as appropriate, about how to exercise enrollee's rights to obtain a second opinion, how to continue receiving services as provided in this section, and how to discuss a grievance resolution with an impartial carrier representative authorized to review and modify the grievance resolution.

(6) When an enrollee requests that the carrier reconsider its decision to modify or discontinue a health service that an enrollee is receiving through the plan, the health carrier must continue to provide that health service until the grievance is resolved. If the resolution affirms the carrier's decision, the enrollee may be responsible for the cost of this continued health service.

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

(8) Each carrier must: Track each grievance until final resolution; maintain, and make accessible to the commissioner for a period of three years, a log of all grievances; and identify and

evaluate trends in grievances as part of the quality improvement program described in section 3 of this act.

NEW SECTION. **Sec. 9.** INDEPENDENT REVIEW OF HEALTH CARE DISPUTES. (1) A process for the fair consideration of consumer complaints relating to decisions by the health plan to deny or limit coverage of or payment for health care is needed. The commissioner shall adopt rules that:

(a) Permit a person, whose appeal of an adverse decision is denied by a carrier, to seek review of that determination by an independent review organization assigned to the appeal;

(b) Require carriers to provide to the appropriate independent review organization not later than the third business day after the date 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; and

(c) Require carriers to comply with the independent review organization's determination regarding the medical necessity or appropriateness of, or the application of other health plan coverage criterion to, health care items and services for an enrollee, and to pay for the independent review.

(2) 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.

NEW SECTION. **Sec. 10.** INDEPENDENT REVIEW OF ORGANIZATIONS. (1) The commissioner shall:

(a) Adopt rules for:

(i) The certification, selection, and operation of independent review organizations to perform independent review of health care disputes described by section 9 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 independent review organizations to ensure continued compliance with this section and section 9 of this act and the rules adopted under those sections.

(2) The rules adopted under subsection (1)(a) of this section must ensure:

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

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

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

(d) 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 require that each independent review organization 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 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 9 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 regarding reviews conducted under section 9 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 9 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. 11.** UNFAIR AND DECEPTIVE ACTS. (1) A health carrier shall not engage in unfair or deceptive acts or practices as such acts and practices are prohibited under chapter 48.30 RCW. Such acts and practices include but are not limited to the placement of 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.

(2) The commissioner may by rule define and prohibit other acts and practices by health carriers found by the commissioner to be unfair and deceptive and harmful to consumers.

NEW SECTION. **Sec. 12.** DELEGATION REQUIREMENTS. (1) Each carrier is accountable for and must oversee any activities required by this act that it delegates to any subcontractor. No carrier may delegate any activity required by this act unless the carrier has a written and fully operational delegation policy that ensures that the subcontractor fulfills the requirements of this chapter.

(2) No contract with a subcontractor executed by the health carrier 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. 13.** SHORT TITLE. This act may be known and cited as the health care patient bill of rights.

NEW SECTION. **Sec. 14.** CAPTIONS AND TABLE OF CONTENTS NOT LAW. Captions and the table of contents used in this act are not any part of the law.

NEW SECTION. **Sec. 15.** CONFLICTS OF LAW. If any provision of this chapter conflicts with state or federal law, such provision must be construed in a manner most favorable to the enrollee.

NEW SECTION. **Sec. 16.** CODIFICATION DIRECTIVE. Sections 1 through 15 of this act are each added to chapter 48.43 RCW.

NEW SECTION. **Sec. 17.** REPEALER. 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;

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

(3) RCW 48.43.105 (Preparation of documents that compare health carriers--Immunity--Due diligence) and 1996 c 312 s 5.

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