H-3055.1

HOUSE BILL 2307

State of Washington 56th Legislature 1999 1 Special Session

By Representative Sullivan

Read first time . Referred to Committee on .

AN ACT Relating to health care patient rights and protections; reenacting and amending RCW 70.47.060; adding new sections to chapter 48.43 RCW; adding a new section to chapter 7.70 RCW; adding a new section to chapter 70.47 RCW; creating new sections; and repealing RCW 48.43.075, 48.43.095, and 48.43.105.

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

NEW SECTION. **Sec. 1.** PATIENT RIGHTS. (1) 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 chapter . . ., Laws of 1999 1st sp. sess. (this act) is to ensure that health plan patients:

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

(b) Have access to a quick and impartial grievance process;

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

(d) 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

(e) Have access to an emergency health plan.

(2) Effective January 1, 2000, chapter . . ., Laws of 1999 1st sp. sess. (this act) applies to: Health plans 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 public employee health benefits provided under chapter 41.05 RCW.

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

(2) Each health carrier 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 carrier 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.

(5) Each health carrier 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.

(6) The commissioner shall adopt rules to implement this section that promote clear communication with consumers and take into consideration standards recommended by national managed care accreditation organizations and state agencies that purchase managed health care services.

NEW SECTION. **Sec. 3.** HEALTH INFORMATION PRIVACY. (1) Each 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 about themselves and to amend any information that is inaccurate, for enrollees to restrict the disclosure of sensitive information about themselves, 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 their own health information.

(2) Except as otherwise required by statute or rule, or a carrier's disclosure made pursuant to requirements in RCW 70.02.050 and 70.02.900 for health care providers, a 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 types of information to be collected, used, or disclosed; and identify the persons who will be receiving the information.

(3) Nothing in this section shall be construed to prevent: (a) The creation, use, or release of anonymous data that has been coded or encrypted to protect the identity of the individual; or (b) the release by a carrier of personally identifiable health information for health research subject to the requirements of the federal "common rule" at 21 C.F.R. Secs. 50 and 56 and 45 C.F.R. Sec. 46.

(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.

(5) The commissioner shall enforce the provisions of chapter 70.02 RCW as they apply to carriers.

NEW SECTION. **Sec. 4.** INFORMATION DISCLOSURE. (1) A carrier that offers a health plan may not enroll a person in a health plan or offer to sell a health plan to an enrollee or to a group representative, agent, employer, or enrollee representative if that person is not given the following information before purchase or selection:

(a) A listing of covered benefits, including prescription drug categories, definitions of terms such as generic versus brand name, and policies regarding coverage of drugs, such as how they become approved or are 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, 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 the carrier's grievance process and right to an independent review as set forth in sections 6 and 7 of this act;

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

(f) Circumstances under which the plan may retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies;

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

(h) 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 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, 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 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 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 carrier. No carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient 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 patients 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) The commissioner shall adopt rules to implement this section that promote clear communication with consumers and take into consideration standards recommended by national managed care accreditation organizations and state agencies that purchase managed health care services.

NEW SECTION. **Sec. 5.** GRIEVANCE PROCESS. (1) Each carrier must have a fully operational, comprehensive grievance process that complies with the requirements of this section. The commissioner shall adopt rules to implement this section that promote clear communication with consumers and take into consideration standards recommended by national managed care accreditation organizations and state agencies that purchase managed health care services.

(2) Each 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 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 carrier has not resolved within response timelines established by the commissioner by rule; and

(c) An enrollee's request that the carrier reconsider: (i) Its decision to modify, discontinue, or deny a health service; 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 and, with the permission of the enrollee, to the enrollee's providers.

(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 an 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 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 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.

(9) No penalty, fine, sanction, or obligation resulting from a grievance may be imposed on a provider until any related provider complaints filed under RCW 48.43.055 have been adjudicated.

NEW SECTION. **Sec. 6.** INDEPENDENT REVIEW OF HEALTH CARE DISPUTES. (1) There is a need for a process for the fair consideration of consumer complaints relating to decisions by the carrier to modify, discontinue, or deny coverage of or payment for health care. The commissioner shall adopt rules that:

(a) Permit a person to seek review of a carrier's decision to modify, discontinue, or deny a health service by an independent review organization, after the carrier has completed its grievance procedures and its decision is unfavorable to the enrollee, or the carrier has exceeded the timelines for grievances established by the commissioner, without good cause and without reaching a decision;

(b) Establish and use a rotational registry system for the assignment of a certified independent review organization to each appeal;

(c) 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

(d) 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 criteria 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. 7.** INDEPENDENT REVIEW ORGANIZATIONS. (1) The commissioner shall:

(a) Adopt rules providing a procedure to certify an organization that may contract to perform independent review of health care disputes described in section 6 of this act. The organization shall:

(i) Be formed by health care providers who have demonstrated expertise and a history of reviewing health care in terms of medical necessity, appropriateness, and the application to other health plan coverage criterion;

(ii) Be advised by a consumer advisory board that is broadly representative of the patient population whose claims are to be reviewed; and

(iii) Meet other reasonable requirements of the commissioner directly related to the functions the organization is to perform under section 6 of this act;

(b) Designate every two years organizations selected in accordance with this subsection to perform the functions listed in section 6 of this act; and

(c) Ensure that the organization is free from interference by state government in its functioning except to ensure that it complies with the certification it has received from the commissioner and chapter . . ., Laws of 1999 1st sp. sess. (this act).

(2) The commissioner must adopt rules to certify organizations described under subsection (1)(a) of this section. The rules 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 cases of a condition that could seriously jeopardize the enrollee's health or ability to regain maximum function, not later than the earlier of:

(i) Seventy-two hours 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 carrier;

(ii) A utilization review agent;

(iii) A nonprofit health corporation;

(iv) A health care provider; or

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

(e) The percentage of the applicant's revenues that are anticipated to be derived from reviews conducted under section 6 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 6 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 carrier or a trade or professional association of carriers.

(7) An independent review organization, and individuals acting on its behalf, are immune from suit in a civil action when performing functions under chapter . . ., Laws of 1999 1st sp. sess. (this act). However, this immunity does not apply to an act or omission made in bad faith or that involves gross negligence.

(8) Rules adopted for this section must promote clear communication with consumers. In adopting the rules, the commissioner must take into consideration standards recommended by national managed care accreditation organizations and state agencies that purchase managed health care services.

NEW SECTION. **Sec. 8.** A new section is added to chapter 7.70 RCW to read as follows:

CARRIER LIABILITY. (1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Enrollee" means an individual covered by a health plan, including dependents.

(b) "Health care provider" means the same as defined in RCW 48.43.005.

(c) "Health care treatment decision" means a determination made regarding whether a health care service or services covered by the health plan are actually provided by the health plan and a decision

that affects the quality of the diagnosis, care, or treatment provided to the plan's enrollees.

(d) "Health carrier" means the same as defined in RCW 48.43.005.

(e) "Health plan" means the same as defined in RCW 48.43.005, except that it includes a policy, contract, or agreement offered by any person, not just a health carrier.

(f) "Managed care entity" means an entity other than a health carrier that delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of the services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer or a pharmacy under chapter 18.64 RCW.

(g) "Accepted standard of care" means when a health carrier or managed care entity or a person who is an employee, agent, or ostensible agent of a health carrier or managed care entity is making health care treatment decisions, that degree of care under chapter 7.70 RCW that a reasonably prudent health care provider would use under the same or similar circumstances.

(2)(a) A health carrier or a managed care entity for a health plan shall follow the accepted standard of care for health care providers when making health care treatment decisions and is liable for damages for harm to an enrollee proximately caused by its failure to follow the accepted standard of care. For other acts or omissions, a health carrier or managed care entity, and its employees, agents, or ostensible agents, is liable for damages for harm to an enrollee, proximately caused by its failure to exercise ordinary care.

(b) A health carrier or a managed care entity for a health plan is also liable for damages for harm to an enrollee proximately caused by health care treatment decisions 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 that result from a failure to follow the accepted standard of care.

(3) It is a defense to any action asserted under this section against a health carrier or managed care entity for a health plan that:

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

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

(4) 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 employers.

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

(6)(a) A person may not maintain a cause of action under this section against a health carrier or managed care entity unless the affected enrollee or the enrollee's representative has exercised the opportunity established in section 7 of this act to seek independent review of the health care treatment decision.

(b) The enrollee is not required to comply with (a) of this subsection and no abatement or other penalty for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(i) Harm to the enrollee has already occurred because of the conduct of the health carrier or managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of the carrier or entity for whose conduct it is liable; or

(ii) The review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier or entity, finds after hearing that the pleading was not made in good faith.

(c) This subsection 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.

(7) 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 providers made available to enrollees under a health plan.

(8) Any action under this section shall be commenced within three years of the completion of the independent review process, if applicable, under subsection (6) of this section, or within three years of the accrual of the cause of action if the independent review process under subsection (6) of this section is not applicable.

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

Sec. 9. RCW 70.47.060 and 1998 c 314 s 17 and 1998 c 148 s 1 are each reenacted and amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be necessary for basic health care. In addition, the administrator may, to the extent that funds are available, offer as basic health plan services chemical dependency services, mental health services and organ transplant services; however, no one service or any combination of these three services shall increase the actuarial value of the basic health plan benefits by more than five percent excluding inflation, as determined by the office of financial management. All subsidized and nonsubsidized enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive covered basic health care services in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care and shall include all services necessary for prenatal, postnatal, and well-child care. However, with respect to coverage for groups of subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider. The schedule of services shall also include a separate schedule of basic health care services for children, eighteen years of age and younger, for those subsidized or nonsubsidized enrollees who choose to secure basic coverage through the

plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under ((~~the mandated benefits act of 1984, RCW 48.47.030~~)) chapter 48.47 RCW, and such other factors as the administrator deems appropriate. In addition to coverage set forth in this section, an emergency health plan must be offered, as required in section 10 of this act.

However, with respect to coverage for subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that the services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider.

(2)(a) To design and implement a structure of periodic premiums due the administrator from subsidized enrollees that is based upon gross family income, giving appropriate consideration to family size and the ages of all family members. The enrollment of children shall not require the enrollment of their parent or parents who are eligible for the plan. The structure of periodic premiums shall be applied to subsidized enrollees entering the plan as individuals pursuant to subsection (9) of this section and to the share of the cost of the plan due from subsidized enrollees entering the plan as employees pursuant to subsection (10) of this section.

(b) To determine the periodic premiums due the administrator from nonsubsidized enrollees. Premiums due from nonsubsidized enrollees shall be in an amount equal to the cost charged by the managed health care system provider to the state for the plan plus the administrative cost of providing the plan to those enrollees and the premium tax under RCW 48.14.0201.

(c) An employer or other financial sponsor may, with the prior approval of the administrator, pay the premium, rate, or any other amount on behalf of a subsidized or nonsubsidized enrollee, by arrangement with the enrollee and through a mechanism acceptable to the administrator.

(d) To develop, as an offering by every health carrier providing coverage identical to the basic health plan, as configured on January 1, 1996, a basic health plan model plan with uniformity in enrollee cost-sharing requirements.

(3) To design and implement a structure of enrollee cost sharing due a managed health care system from subsidized and nonsubsidized enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, and may utilize copayments, deductibles, and other cost-sharing mechanisms, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(4) To limit enrollment of persons who qualify for subsidies so as to prevent an overexpenditure of appropriations for such purposes. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment until the administrator finds the danger no longer exists.

(5) To limit the payment of subsidies to subsidized enrollees, as defined in RCW 70.47.020. The level of subsidy provided to persons who qualify may be based on the lowest cost plans, as defined by the administrator.

(6) To adopt a schedule for the orderly development of the delivery of services and availability of the plan to residents of the state, subject to the limitations contained in RCW 70.47.080 or any act appropriating funds for the plan.

(7) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state. Contracts with participating managed health care systems shall ensure that basic health plan enrollees who become eligible for medical assistance may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

(8) To receive periodic premiums from or on behalf of subsidized and nonsubsidized enrollees, deposit them in the basic health plan

operating account, keep records of enrollee status, and authorize periodic payments to managed health care systems on the basis of the number of enrollees participating in the respective managed health care systems.

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan as subsidized or nonsubsidized enrollees, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and on a reasonable schedule defined by the authority, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. Funds received by a family as part of participation in the adoption support program authorized under RCW 26.33.320 and 74.13.100 through 74.13.145 shall not be counted toward a family's current gross family income for the purposes of this chapter. When an enrollee fails to report income or income changes accurately, the administrator shall have the authority either to bill the enrollee for the amounts overpaid by the state or to impose civil penalties of up to two hundred percent of the amount of subsidy overpaid due to the enrollee incorrectly reporting income. The administrator shall adopt rules to define the appropriate application of these sanctions and the processes to implement the sanctions provided in this subsection, within available resources. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to reenroll in the plan.

(10) To accept applications from business owners on behalf of themselves and their employees, spouses, and dependent children, as subsidized or nonsubsidized enrollees, who reside in an area served by the plan. The administrator may require all or the substantial majority of the eligible employees of such businesses to enroll in the plan and establish those procedures necessary to facilitate the orderly enrollment of groups in the plan and into a managed health care system. The administrator may require that a business owner pay at least an amount equal to what the employee pays after the state pays its portion

of the subsidized premium cost of the plan on behalf of each employee enrolled in the plan. Enrollment is limited to those not eligible for medicare who wish to enroll in the plan and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. The administrator shall adjust the amount determined to be due on behalf of or from all such enrollees whenever the amount negotiated by the administrator with the participating managed health care system or systems is modified or the administrative cost of providing the plan to such enrollees changes.

(11) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the administrator shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant.

(12) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed health care systems and to the plan. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

(13) To evaluate the effects this chapter has on private employer-based health care coverage and to take appropriate measures consistent with state and federal statutes that will discourage the reduction of such coverage in the state.

(14) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

(15) To provide, consistent with available funding, assistance for rural residents, underserved populations, and persons of color.

(16) In consultation with appropriate state and local government agencies, to establish criteria defining eligibility for persons confined or residing in government-operated institutions.

NEW SECTION. **Sec. 10.** A new section is added to chapter 70.47 RCW to read as follows:

(1) The administrator must offer emergency health plan coverage designed as follows:

(a) Copayments and other cost sharing must be the same as the nonsubsidized basic health plan, as set forth in RCW 70.47.060, except for the requirement of a one thousand dollar annual deductible.

(b) The schedule of benefits must be the same as the nonsubsidized basic health plan, as set forth in RCW 70.47.060, except for the exclusion of chemical dependency services, mental health services, organ transplant services, and prenatal and maternity services.

(c) Except as required by federal law, participating health carriers may impose a nine-month waiting period for coverage of a preexisting condition if such condition existed, was diagnosed, or was treated during the six-month period prior to enrollment.

(d) Monthly premiums for this coverage must not exceed fifty percent of the average aggregate monthly cost of the subsidized basic health plan coverage.

(e) Enrollees are limited to thirty-six months of consecutive enrollment.

(2) Any health carrier that contracts with the Washington state health care authority to provide employee benefits pursuant to chapter 41.05 RCW must offer this coverage in a manner required by the administrator in rule.

NEW SECTION. **Sec. 11.** This act may be known and cited as the health care patient bill of rights.

NEW SECTION. **Sec. 12.** Captions used in this act are not any part of the law.

NEW SECTION. **Sec. 13.** Sections 1 through 7 and 14 of this act are each added to chapter 48.43 RCW.

NEW SECTION. **Sec. 14.** To the extent permitted by 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. 15.** 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. 16.** 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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