H-4310.2

SUBSTITUTE HOUSE BILL 2331

State of Washington 56th Legislature 2000 Regular Session

By House Committee on Health Care (originally sponsored by Representatives Campbell, Schual-Berke, H. Sommers, Linville, Doumit, Cody, Wolfe, Conway, Quall, Eickmeyer, Morris, Gombosky, Ruderman, Edmonds, Poulsen, Dunshee, Fisher, Scott, Regala, McIntire, Kastama, Kessler, Wood, Lantz, Ogden, Santos, Edwards, O'Brien, Romero, Stensen, Cooper, Reardon, Tokuda, Veloria, Rockefeller, Lovick, Kenney, Kagi, Haigh, Miloscia, Anderson, Constantine, Dickerson, Keiser, Hurst, Murray, McDonald and D. Sommers)

Read first time 01/28/2000. Referred to Committee on .

1 AN ACT Relating to health care patient protection; amending RCW
2 70.02.110, 70.02.900, 51.04.020, and 74.09.050; adding new sections to
3 chapter 48.43 RCW; adding a new section to chapter 70.02 RCW; adding a
4 new section to chapter 43.70 RCW; adding a new section to chapter 41.05
5 RCW; creating new sections; repealing RCW 48.43.075, 48.43.095, and
6 48.43.105; and providing an effective date.

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

8 NEW SECTION. **Sec. 1.** PATIENT RIGHTS. It is the intent of the
9 legislature that enrollees covered by health plans receive quality
10 health care designed to maintain and improve their health. The purpose
11 of this act is to ensure that health plan enrollees:
12 (1) Have improved access to information regarding their health
13 plans;
14 (2) Have sufficient and timely access to appropriate health care
15 services, and choice among health care providers;
16 (3) Are assured that health care decisions are made by appropriate
17 medical personnel;
18 (4) Have access to a quick and impartial process for appealing plan
19 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 and insurers regulated under Title 48 RCW 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

1 care provider has disclosed the health care information that is the
2 subject of the request.

3 **Sec. 4.** RCW 70.02.900 and 1991 c 335 s 901 are each amended to
4 read as follows:
5 HEALTH INFORMATION PRIVACY. (1) This chapter does not restrict a
6 health care provider, a third-party payor, or an insurer regulated
7 under Title 48 RCW from complying with obligations imposed by federal
8 or state health care payment programs or federal or state law.
9 (2) This chapter does not modify the terms and conditions of
10 disclosure under Title 51 RCW and chapters 13.50, 26.09, 70.24, 70.39,
11 70.96A, 71.05, and 71.34 RCW and rules adopted under these provisions.

12 NEW SECTION. **Sec. 5.** HEALTH INFORMATION PRIVACY. (1) Health
13 carriers and insurers shall adopt policies and procedures that conform
14 administrative, business, and operational practices to protect an
15 enrollee's right to privacy or right to confidential health care
16 services granted under state or federal laws.
17 (2) The commissioner may adopt rules to implement this section
18 after considering relevant standards adopted by national managed care
19 accreditation organizations and the national association of insurance
20 commissioners.

21 NEW SECTION. **Sec. 6.** INFORMATION DISCLOSURE. (1) A carrier that
22 offers a health plan may not offer to sell a health plan to an enrollee
23 or to any group representative, agent, employer, or enrollee
24 representative without first offering to provide, and providing upon
25 request, the following information before purchase or selection:
26 (a) A listing of covered benefits, including prescription drug
27 benefits, if any, a copy of the current formulary, if any is used,
28 definitions of terms such as generic versus brand name, and policies
29 regarding coverage of drugs, such as how they become approved or taken
30 off the formulary, and how consumers may be involved in decisions about
31 benefits;
32 (b) A listing of exclusions, reductions, and limitations to covered
33 benefits, and any definition of medical necessity or other coverage
34 criteria upon which they may be based;
35 (c) A statement of the carrier's policies for protecting the
36 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 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) 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;

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

(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; and

(h) Accreditation status with one or more national managed care accreditation organizations, and whether the carrier tracks its health

1 care effectiveness performance using the health employer data
2 information set (HEDIS), whether it publicly reports its HEDIS data,
3 and how interested persons can access its HEDIS data.

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

6 (4) Nothing in this section requires a carrier or a health care
7 provider to divulge proprietary information to an enrollee.

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

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

13 (b) Monitors and reports annually to enrollees on standardized
14 measures of health care and satisfaction of all enrollees in the health
15 plan. The state department of health shall recommend appropriate
16 standardized measures for this purpose, after consideration of national
17 standardized measurement systems adopted by national managed care
18 accreditation organizations and state agencies that purchase managed
19 health care services; and

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

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

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

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 must also 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.

(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 provider of the enrollee's choice. However, the carrier's payment to a nonparticipating provider offering the second opinion may be limited to the amount that the carrier would pay a participating provider for a second opinion. The enrollee is responsible for payment of any charges in excess of the amount paid to the nonparticipating provider by the carrier.

(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 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 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) Each 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.

(9) Each carrier must ensure that the grievance process is accessible to enrollees who do not speak English, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance.

(10) Every 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. 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 the state agencies that purchase managed health care services.

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 the 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, or if other evidence indicates 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.

(6) Written notice required by subsections (3) and (5) 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 appeal process, including information, as appropriate, about how to exercise the enrollee's rights to obtain a second opinion, how to continue receiving services as provided in this section, and how to discuss an appeal resolution with an impartial carrier representative authorized to review and modify the appeal resolution.

(7) When an enrollee requests that the carrier reconsider its decision to modify, reduce, or terminate a health service that an enrollee is receiving through the health plan, 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: 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.** 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,

1 reduce, or terminate coverage of or payment for health care services
2 for an enrollee.
3 (2) The commissioner shall adopt rules that permit an enrollee or
4 their authorized representative to seek review of a carrier's decision
5 to deny, modify, reduce, or terminate coverage of or payment for health
6 care services after the carrier has issued its appeal decision under
7 section 10 of this act and its decision is unfavorable to the enrollee,
8 or the carrier has exceeded the timelines for appeal provided in
9 section 10 of this act without good cause and without reaching a
10 decision.
11 (3)(a) When a determination as to whether the carrier's decision to
12 deny, modify, reduce, or terminate coverage of or payment for health
13 care services was appropriate depends in whole or in part upon the use
14 of medical judgment, then the dispute must be submitted to independent
15 review.
16 (b) When a determination as to whether the carrier's decision to
17 deny, modify, reduce, or terminate coverage of or payment for health
18 care services was appropriate depends exclusively upon an
19 interpretation of the health plan contract or coverage agreement and
20 not upon the use of medical judgment, the commissioner must review the
21 dispute.
22 (c) The commissioner must determine whether a dispute should be
23 submitted to independent review or retained by the commissioner as
24 provided in this subsection within three working days of receipt of an
25 enrollee's request for review of a carrier's appeal decision.
26 (4) The commissioner shall adopt rules for independent review that:
27 (a) Establish and use a rotational registry system for the
28 assignment of a certified independent review organization to a dispute.
29 The system should be flexible enough to ensure that an independent
30 review organization has the medical expertise necessary to review the
31 particular medical condition or services at issue in the dispute;
32 (b) Require carriers to provide to the appropriate independent
33 review organization not later than the third business day after the
34 date the carrier receives a request for review a copy of:
35 (i) Any medical records of the enrollee that are relevant to the
36 review;
37 (ii) Any documents used by the carrier in making the determination
38 to be reviewed by the organization;

1 (iii) Any documentation and written information submitted to the
2 carrier in support of the appeal; and
3 (iv) A list of each physician or health care provider who has
4 provided care to the enrollee and who may have medical records relevant
5 to the appeal;
6 (c) Authorize reviewers to make determinations regarding the
7 medical necessity or appropriateness of, or the application of health
8 plan coverage provisions to, health care services for an enrollee.
9 Independent review is not intended to override health plan contract
10 provisions that clearly exclude coverage of particular types of medical
11 services or procedures, or treatment of particular health conditions.
12 The medical reviewers' determinations must be based upon their expert
13 medical judgment, after consideration of relevant medical, scientific,
14 and cost-effectiveness evidence, and medical standards of practice in
15 the state of Washington.
16 (5) The commissioner shall adopt rules for review of disputes under
17 subsection (3)(b) of this section that require:
18 (a) Carriers to provide to the commissioner, not later than the
19 third business day after the date the carrier receives a request for
20 review, a copy of any medical records of the enrollee that are relevant
21 to the review, or documents used by the carrier in making the
22 determination being reviewed; and
23 (b) That the commissioner make his or her determination no later
24 than the twentieth day after the date the commissioner receives the
25 request for review under this section. In cases of a condition that
26 could seriously jeopardize the enrollee's life, health, or ability to
27 regain maximum function, the determination must be made no later than
28 seventy-two hours after the date the commissioner receives the
29 information necessary to make the determination, or the eighth day
30 after the commissioner receives the request that the determination be
31 made, whichever is earlier.
32 (6) Carriers must timely implement the independent review
33 organization's or commissioner's determination, and must pay for the
34 independent review.
35 (7) Health information or other confidential or proprietary
36 information in the custody of a carrier may be provided to an
37 independent review organization or the commissioner, subject to rules
38 adopted by the commissioner.

(8) When an enrollee requests review under this section, and the dispute involves a carrier's decision to modify, reduce, or terminate a health service that an enrollee is receiving through a health plan, the carrier must continue to provide that 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 this continued health service.

(9) This section does not apply to enrollees in programs with existing independent review requirements, such as the federal employees health benefits program and the federal medicare plus choice program.

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

INDEPENDENT REVIEW ORGANIZATIONS. (1) The department of health shall:

(a) 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. The organization shall:

(i) Assign expert reviewers who are licensed physicians or other appropriate health care providers with substantial, recent clinical experience dealing with the same or similar health conditions, and have demonstrated expertise and a history of reviewing health care in terms of medical necessity, appropriateness, and the application to other health plan coverage provisions; and

(ii) Meet 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; and

(b) Ensure that the organization is free from interference by state government in its functioning except as provided in subsection (8) of this section.

(2) The rules adopted under subsection (1)(a) of this section must require independent review organizations to 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. Physicians and other health care providers must be appropriately licensed, certified, or registered as required in Washington state or in at least one state with standards comparable to

Washington state. Reviewers may be drawn from nationally recognized centers of excellence, academic institutions, and recognized leading practice sites. Any health care provider or physician making a review determination in a specific review must be 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, or the independent practice group proposing the therapy; the health facility at which the therapy would be provided; the developer or manufacturer of a drug or device under review; or the enrollee;

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

(d) Timely notice to enrollees of the results of the independent review, including the clinical basis for the determination; and

(e) 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, the qualifications, impartiality, and freedom from conflict of interest of the organization, its staff, and expert reviewers.

(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. 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

(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:

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

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

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

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

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

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

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

21 (i) A carrier;

22 (ii) A utilization review agent;

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

24 (iv) A health care provider;

25 (v) A drug or device manufacturer; or

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

28 (e) The percentage of the applicant's revenues that are anticipated
29 to be derived from reviews conducted under section 11 of this act;

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

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

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

(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 this act. However, this immunity does not apply to an act or omission made in bad faith or that involves gross negligence.

(8) The rules adopted under subsection (1)(a) of 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 medical plan may have a medical director licensed under chapter 18.36A RCW.

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

(a) "Carrier affiliate" means an entity that makes decisions for or recommendations to a health carrier regarding the medical necessity or appropriateness of health care services for payment or coverage purposes.

(i) "Carrier affiliate" includes but is not limited to companies providing utilization review, pharmacy benefits management, and disease management services.

(ii) "Carrier affiliate" does not include groups of health care providers, or combinations of health care providers and health care facilities, formed primarily for the purpose of providing or arranging for health care services to individuals to the extent that those entities are conducting utilization review of services provided by the group's providers or any other provider for whose services the group has assumed full or partial financial responsibility.

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

(c) "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.

(2)(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 made by its:

(i) Employees;

(ii) Carrier affiliates;

(iii) Agents; or

(iv) 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. For the purposes of this section, health

care providers and facilities that are included in and subject to the provisions of chapter 7.70 RCW, and groups of health care providers and facilities referenced in subsection (1)(a)(ii) of this section shall not be considered carrier affiliates, agents, or ostensible agents.

(3) 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, carrier affiliate, agent, or ostensible agent for whose conduct the health carrier is liable under subsection (2)(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.

(4) 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, except any governmental entity created to provide medical insurance offered to public employees and their covered dependents under RCW 41.05.140.

(5) 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.

(6)(a) A person may not maintain a cause of action under this section against a health carrier unless 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) 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 substantial harm to the enrollee has already occurred because of the conduct of the health carrier or because of an act or omission of an employee, carrier affiliate, agent, or ostensible agent of the carrier for whose conduct it is liable. As used in this

1 subsection, "substantial harm" means loss of life, loss or significant
2 impairment of limb or bodily function, significant disfigurement, or
3 severe or chronic physical pain.
4 (c) This subsection (6) does not prohibit an enrollee from pursuing
5 other appropriate remedies, including injunctive relief, a declaratory
6 judgment, or other relief available under law, if its requirements
7 place the enrollee's health in serious jeopardy.
8 (7) In an action against a health carrier, a finding that a health
9 care provider is an employee, carrier affiliate, agent, or ostensible
10 agent of such a health carrier shall not be based solely on proof that
11 the person's name appears in a listing of approved physicians or health
12 care providers made available to enrollees under a health plan.
13 (8) Any action under this section shall be commenced within three
14 years of the completion of the independent review process, if
15 applicable, under subsection (6) of this section, or within three years
16 of the accrual of the cause of action if the independent review process
17 under subsection (6) of this section is not applicable.
18 (9) This section does not apply to workers' compensation insurance
19 under Title 51 RCW.

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

28 NEW SECTION. **Sec. 19.** This act may be known and cited as the
29 health care patient bill of rights.

30 NEW SECTION. **Sec. 20.** Captions used in this act are not any part
31 of the law.

32 NEW SECTION. **Sec. 21.** Sections 1, 5 through 11, 13, 17, and 18 of
33 this act are each added to chapter 48.43 RCW.

NEW SECTION. **Sec. 22.** 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. 23.** 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. 24.** APPLICATION. (1) 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 public employee health benefits provided under chapter 41.05 RCW.

(2) Except as provided in section 17 of this act, this act applies to contracts renewing after June 30, 2001.

NEW SECTION. **Sec. 25.** Section 17 of this act takes effect July 1, 2001.

NEW SECTION. **Sec. 26.** 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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