S-4075.1

SUBSTITUTE SENATE BILL 6199

State of Washington 56th Legislature 2000 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored by Senators Wojahn, Winsley, Thibaudeau, Snyder, Goings, Kohl-Welles, Jacobsen, Fraser, Prentice, Costa, Rasmussen, Bauer, Spanel, McAuliffe, Gardner, Franklin and Kline)

Read first time 01/24/2000.

AN ACT Relating to health care patient protection; amending RCW 51.04.020, 74.09.050, and 70.47.130; adding new sections to chapter 48.43 RCW; adding a new section to chapter 43.70 RCW; adding new sections to chapter 41.05 RCW; adding a new section to chapter 7.70 RCW; creating new sections; repealing RCW 48.43.075, 48.43.095, and 48.43.105; and providing an effective date.

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

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 improved access to information regarding their health plans;

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

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

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

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

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

NEW SECTION. **Sec. 2.** HEALTH INFORMATION PRIVACY. (1) Each carrier that offers a health plan 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, and for which there is no reasonable basis to believe that the information could be used to identify an 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 (1968) and 45 C.F.R. Sec. 46 (1972).

(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. 3.** INFORMATION DISCLOSURE. (1) A carrier that offers a health plan may not offer to sell a health plan to an enrollee or to any group representative, agent, employer, or enrollee representative without providing 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 taken off the formulary, and how enrollees 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;

(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. 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 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 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) The criteria used by the carrier to make utilization review and medical necessity determinations.

(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 or provider to divulge proprietary information to an enrollee including the specific contractual terms and conditions between a carrier and a provider.

(5) No carrier may advertise, 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. The state department of health shall recommend appropriate standardized measures for this purpose, after consideration of national standardized measurement systems adopted by national managed care accreditation organizations and state agencies that purchase managed health care services;

(c) Demonstrates a partnership with the state department of health or a local health jurisdiction, by means of a letter from the secretary of the state department of health or the local health jurisdiction verifying the plan's current 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 an enrollee of the care he or she requires, including various treatment options, and whether in the providers' view such care is consistent with the plan's health coverage criteria, or otherwise covered by the enrollee's 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 an enrollee with a carrier. Nothing in this section shall be construed to authorize a provider to bind a carrier to pay for any service.

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

NEW SECTION. **Sec. 4.** ACCESS TO APPROPRIATE HEALTH SERVICES. (1) Each enrollee in a health plan must have adequate choice among qualified 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.

(3) Each carrier must have a process whereby an enrollee whose medical condition so warrants is authorized to use a medical specialist

as a primary care provider, or to receive a standing referral to a specialist for an extended period of time. This may include enrollees suffering from chronic diseases and those with other special needs.

(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 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 consumer is responsible for payment of any charges in excess of the amount paid to the nonparticipating provider by the carrier.

(6) Each 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 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.

(7) 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.

(8) 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. 5.** 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 reviewing relevant standards adopted by national managed care accreditation organizations and the state agencies that purchase managed health care services.

NEW SECTION. **Sec. 6.** 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.

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

NEW SECTION. **Sec. 7.** 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 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 in rules; 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 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.

NEW SECTION. **Sec. 8.** INDEPENDENT REVIEW OF HEALTH CARE DISPUTES. (1) There is a need for a process for the fair consideration of enrollee complaints relating to decisions by carriers that offer a health plan to modify, discontinue, or deny coverage of or payment for health care. The commissioner shall adopt rules that:

(a) Permit an enrollee 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;

(d) Authorize reviewers to make determinations regarding the medical necessity or appropriateness of, or the application of health plan coverage provisions to, health care services for an enrollee. Independent review is not intended to override health plan contract provisions that clearly exclude coverage of particular types of medical services or procedures, or treatment of particular health conditions. In reviewing disputes related to coverage, reviewers should consider any and all contract provisions related to the health service that is the subject of the dispute. The medical reviewers' determinations must

be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence; and

(e) Require carriers to comply with the independent review organization's determination, 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. 9.** 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 for contracting with one or more organizations to perform independent review of health care disputes described in section 8 of this act. The organization shall:

(i) Assign expert reviewers who are licensed physicians or other licensed health care providers with substantial current clinical experience dealing with the same health condition under review;

(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 department directly related to the functions the organization is to perform under section 8 of this act;

(b) Designate every two years one or more organizations selected in accordance with this subsection to perform the functions listed in section 8 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 contract it has with the department and this act.

(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. 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 with respect to the carrier whose decision is being reviewed, any health care provider or facility who has made a treatment recommendation or determination prior to the appeal being initiated by the consumer, or the consumer;

(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) The rules adopted under subsection (1)(a) of this section must require that the independent review organization proceed to a final determination once a request for determination has been made, unless requested otherwise by both the carrier and the enrollee, or the enrollee's representative.

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

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

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

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

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

(i) A carrier;

(ii) A utilization review agent;

(iii) A nonprofit 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 8 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 8 of this act.

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

(7) 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.

(8) 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.

(9) In adopting rules for this section, the department shall take into consideration standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

NEW SECTION. **Sec. 10.** 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. 11. 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. 12. 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. 13.** 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. 14.** 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 carrier" means the same as defined in RCW 48.43.005.

(d) "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.

(e) "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.

(2)(a) A health carrier or a managed care entity for a health plan shall adhere to the accepted standard of care for health care providers under this chapter when arranging for the provision of medically necessary health care services to its enrollees. A health carrier or managed care entity for a health plan 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 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) The health care service in question is not a benefit provided under the plan;

(b) 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

(c) 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, an employer group purchasing organization that purchases coverage or assumes risk on behalf of its employers, or a governmental agency that purchases coverage on behalf of individuals and families. The governmental entity established to offer and provide health insurance to public employees and their covered dependents under RCW 41.05.140 is subject to liability under this section.

(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) An enrollee or an enrollee’s representative 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 8

of this act to seek independent review of the health care treatment decision.

(b) This subsection (6) 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 care 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 under section 8 of this act.

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

NEW SECTION. **Sec. 15.** DELEGATION OF DUTIES. Each carrier is accountable for and must oversee any activities required by this section that it delegates to any subcontractor. 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. 16.** APPLICATION. This act applies to: Health plans offered, renewed, or issued by a carrier; medical assistance provided under chapter 74.09 RCW; the basic health plan offered under chapter 70.47 RCW; and public employee health benefits provided under chapter 41.05 RCW.

NEW SECTION. **Sec. 17.** A new section is added to chapter 41.05 RCW to read as follows:

Each health plan that provides medical insurance offered to public employees and their covered dependents under this chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, are subject to the provisions of sections 1 through 8, 14, and 15 of this act.

Sec. 18. RCW 70.47.130 and 1997 c 337 s 8 are each amended to read as follows:

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

(a) Benefits as provided in RCW 70.47.070;

(b) Managed health care systems are subject to the provisions of sections 1 through 8, 14, and 15 of this act;

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

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

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

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

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

NEW SECTION. **Sec. 21.** Sections 1 through 8, 10, and 15 of 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.** EFFECTIVE DATE. (1) Except as provided in subsection (2) of this section, this act applies to contracts renewing after June 30, 2001.

(2) Sections 10 through 13 of this act take effect January 1, 2001.

NEW SECTION. **Sec. 25.** 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.

--- END ---