Z-0450.2

SENATE BILL 5607

State of Washington 59th Legislature 2005 Regular Session

By Senators Deccio and Keiser; by request of Insurance Commissioner

Read first time 01/31/2005. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to health care grievance and appeal processes; amending RCW 41.05.017, 48.43.005, 48.43.055, 48.43.510, 48.43.530, 48.43.535, 48.43.545, 48.46.020, 48.46.030, 48.46.040, and 70.47.130; amending 2000 c 5 s 19 (uncodified); adding new sections to chapter 48.43 RCW; creating new sections; and repealing RCW 48.46.100.

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

Sec. 1. 2000 c 5 s 19 (uncodified) is amended to read as follows:

((~~This act applies~~)) RCW 48.43.500 through 48.43.550 apply to:

(1) Health plans as defined in RCW 48.43.005 offered, renewed, or issued by a carrier;

(2) Medical assistance provided under RCW 74.09.522, excluding requirements set forth in RCW 48.43.530, 48.43.535, and sections 7, 8, and 10 of this act; ((~~the basic health plan offered under~~))

(3) Managed health care systems as defined in chapter 70.47 RCW, except eligibility determinations; and ((~~health benefits provided under~~))

(4)(a) Insuring entities as defined in chapter 41.05 RCW and self-insured or self-funded benefit plans authorized under chapter 41.05 RCW, except eligibility determinations.

(b) For purposes of this section only, "eligibility determinations" does not include determinations relating to coverage of disabled dependent children under RCW 48.20.420, 48.21.150, 48.44.210, and 48.46.320.

Sec. 2. RCW 41.05.017 and 2000 c 5 s 20 are each amended to read as follows:

Each health plan that provides medical insurance offered under this chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, are subject to the provisions of RCW 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 43.70.235, 48.43.545, 48.43.550, 70.02.110, ((~~and~~)) 70.02.900, and sections 7, 8, and 10 of this act.

Sec. 3. RCW 48.43.005 and 2004 c 244 s 2 are each amended to read as follows:

Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Adjusted community rate" means the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities.

(2) "Adverse determination" means:

(a) A denial, reduction, termination of, or failure to provide or make payment, in whole or in part, for a benefit, including:

(i) A denial, reduction, termination, or failure to provide or make payment that is based on a determination of a covered person's eligibility to participate in a plan; and

(ii) A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review; or

(b) A failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(3) "Authorized representative" means:

(a) A person to whom a covered person has given express written consent to represent the covered person for purposes of grievances and appeals;

(b) A person authorized by law to provide substituted consent for a covered person; or

(c) A family member of the covered person, or the covered person's treating health care professional when the covered person is unable to provide consent.

(4) "Basic health plan" means the plan described under chapter 70.47 RCW, as revised from time to time.

((~~(3)~~)) (5) "Basic health plan model plan" means a health plan as required in RCW 70.47.060(2)((~~(d)~~)) (e).

((~~(4)~~)) (6) "Basic health plan services" means that schedule of covered health services, including the description of how those benefits are to be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

((~~(5)~~)) (7) "Catastrophic health plan" means:

(a) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand dollars; and

(b) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least five thousand five hundred dollars; or

(c) Any health benefit plan that provides benefits for hospital inpatient and outpatient services, professional and prescription drugs provided in conjunction with such hospital inpatient and outpatient services, and excludes or substantially limits outpatient physician services and those services usually provided in an office setting.

((~~(6)~~)) (8) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

((~~(7)~~)) (9) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

((~~(8)~~)) (10) "Covered person" or "enrollee" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

((~~(9)~~)) (11) "Dependent" means, at a minimum, the enrollee's legal spouse and unmarried dependent children who qualify for coverage under the enrollee's health benefit plan.

((~~(10)~~)) (12) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty or more hours. The term includes a self-employed individual, including a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not work less than thirty hours per week and derives at least seventy-five percent of his or her income from a trade or business through which he or she has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form. Persons covered under a health benefit plan pursuant to the consolidated omnibus budget reconciliation act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements of chapter 265, Laws of 1995.

((~~(11)~~)) (13) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

((~~(12)~~)) (14) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

((~~(13)~~)) (15) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

((~~(14)~~)) (16) "Grievance" means a written ((~~complaint submitted by or on behalf of a covered person regarding: (a) Denial of payment for medical services or nonprovision of medical services included in the covered person's health benefit plan, or (b) service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier~~)) or oral complaint submitted by or on behalf of an enrollee regarding an issue other than an adverse determination, including, but not limited to, dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or providers, and dissatisfaction with carrier practices or actions unrelated to health care services.

((~~(15)~~)) (17) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

((~~(16)~~)) (18) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

((~~(17)~~)) (19) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

((~~(18)~~)) (20) "Health carrier" or "carrier" means a disability

insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020.

((~~(19)~~)) (21) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care services offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

((~~(20)~~)) (22) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

((~~(21)~~)) (23) "Member materials" means the document provided to the enrollee that describes the essential features of coverage under the plan, such as the individual policy and contract, group certificate of coverage, and member handbook.

(24) "Postservice claim" means any claim for a benefit under a health plan that is not a preservice claim.

(25) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(22)~~)) (26) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

((~~(23)~~)) (27) "Preservice claim" means any claim for a benefit under a health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(28) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

((~~(24)~~)) (29) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least two but no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor must derive at least seventy-five percent of his or

her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year except for a self-employed individual or sole proprietor in an agricultural trade or business, who must derive at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year. A self-employed individual or sole proprietor who is covered as a group of one on the day prior to June 10, 2004, shall also be considered a "small employer" to the extent that individual or group of one is entitled to have his or her coverage renewed as provided in RCW 48.43.035(6).

((~~(25)~~)) (30) "Urgent care claim" means a claim for medical care or treatment with respect to which the application of the time periods for making nonurgent care determinations could, in the reasonable opinion of the enrollee's health care provider or the carrier's medical director:

(a) Seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

(b) Subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(31) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

((~~(26)~~)) (32) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

Sec. 4. RCW 48.43.055 and 2002 c 300 s 6 are each amended to read as follows:

Each health carrier as defined under RCW 48.43.005 shall file with the commissioner its procedures for review and adjudication of complaints initiated by health care providers. Procedures filed under this section ((~~shall~~)) must provide a fair review for consideration of complaints. Every health carrier ((~~shall~~)) must provide reasonable means allowing any health care provider aggrieved by actions of the health carrier to be heard after submitting a written request for review. If the health carrier fails to grant or reject a request within thirty days after it is made, the complaining health care provider may proceed as if the complaint had been rejected. A complaint that has been rejected by the health carrier may be submitted to nonbinding mediation. Mediation shall be conducted under mediation rules similar to those of the American arbitration association, the center for public resources, the judicial arbitration and mediation service, RCW 7.70.100, or any other rules of mediation agreed to by the parties. This section is solely for resolution of provider complaints. Complaints by, or on behalf of, a covered person are subject to the grievance and appeal processes in RCW 48.43.530 and sections 7 and 8 of this act.

Sec. 5. RCW 48.43.510 and 2000 c 5 s 6 are each amended to read as follows:

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

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

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

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

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

(e) ((~~A summary~~)) An explanation of the carrier's grievance ((~~process~~)) and appeals processes;

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

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

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

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

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

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

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

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

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

(g) A copy of the carrier's grievance ((~~process~~)) and appeal

processes for claim or service denial and for dissatisfaction with care; and

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

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

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

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

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

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

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

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

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

(8) Each carrier must communicate enrollee information required in chapter 5, Laws of 2000 by means that ensure that a substantial portion of the enrollee population can make use of the information.

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

Sec. 6. RCW 48.43.530 and 2000 c 5 s 10 are each amended to read as follows:

(1) Each carrier that offers a health plan must have a fully operational, comprehensive ((~~grievance~~)) process ((~~that complies~~)) to address appeals of adverse determinations. The appeals process must be in writing and must comply 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~~)):

(a) Have an appeals process with either one or two levels of appeal;

(b) File with the commissioner a copy of its written appeals process. If a material change is made to the appeals process, the carrier must refile with the commissioner;

(c) Provide a clear explanation of the appeal process in the member materials and upon request;

(d) Ensure that the appeal process is accessible to enrollees who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file an appeal; and

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

(3) Each carrier must provide written or electronic notice of an adverse determination to an enrollee or the enrollee's ((~~designated~~)) authorized representative, and the enrollee's treating 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~~)). The notice must explain:

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

(b) Instructions for obtaining the clinical review criteria used to make the decision;

(c) Instructions for appealing the carrier's decision; and

(d) Information, as appropriate, about how to continue receiving services as provided in this section.

(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~~)) permit an enrollee or an enrollee's authorized representative to appeal an adverse determination in writing, orally, or electronically.

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

(a)(i) Provide written ((~~notice~~)) acknowledgement to the enrollee and the enrollee's authorized representative when the appeal is received;

((~~(b) Assist the enrollee with the appeal process;~~

~~(c)~~)) (ii) The acknowledgement required by (a)(i) of this

subsection must be provided within five working days of receipt of the appeal;

(b) Make its decision regarding the appeal ((~~within thirty days of the date the appeal is received. An appeal must be expedited if the enrollee's provider or the carrier's medical director reasonably determines that following the appeal process response timelines could seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours of the date the appeal is received~~)) and notify the enrollee or the enrollee's representative of the decision within the time frames set forth in section 7 of this act;

((~~(d)~~)) (c) Cooperate with ((~~a~~)) the enrollee's authorized representative ((~~authorized in writing by the enrollee~~)); and

((~~(e)~~)) (d) Consider all information submitted by the enrollee((~~;~~

~~(f) Investigate and resolve the appeal; and~~

~~(g) Provide written notice of its resolution of the appeal to the enrollee and, with the permission of the enrollee, to the enrollee's providers. The written notice must explain the carrier's decision and the supporting coverage or clinical reasons and the enrollee's right to request independent review of the carrier's decision under RCW 48.43.535~~)) and the enrollee's authorized representative.

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

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

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

~~(7)~~)) Each carrier must provide written or electronic notice of its decision on appeal to the enrollee and, with the permission of the enrollee, to the enrollee's providers. In the case of an adverse determination on review, the notice must explain:

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

(i) Any internal rule, guideline, or protocol relied upon in making the adverse determination; or a statement that the rule, guideline, or

protocol was relied upon and that a copy will be provided free of charge to the enrollee upon request;

(ii) An explanation of the scientific or clinical judgment for any adverse determination based on a medical necessity or experimental treatment or similar exclusion or limit, or a statement that such an explanation will be provided free of charge upon request;

(b) A statement of the enrollee's right to request independent review of the carrier's decision under RCW 48.43.535 and instructions for obtaining independent review; and

(c) A statement that the enrollee is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the enrollee's claim for benefits.

(7) Each carrier must provide an expedited review process for urgent care claims pursuant to which all necessary information, including the carrier's adverse determination on review, must be transmitted between the carrier and the enrollee by telephone, facsimile, or other available similarly expeditious method.

(8) When an enrollee ((~~requests that the carrier reconsider its decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving through the health plan and the carrier's decision~~)) appeals an adverse determination that is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier must continue to provide benefits for that health service until the appeal is resolved. If the resolution of the appeal or any review sought by the enrollee under RCW 48.43.535 affirms the carrier's decision, the enrollee may be responsible for the cost of this continued health service.

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

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

~~(10) Each carrier must: Track each appeal until final resolution;~~

~~maintain, and make accessible to the commissioner for a period of three years, a log of all appeals; and identify and evaluate trends in appeals.~~))

(9)(a) The commissioner shall adopt rules relating to appeals of adverse determinations, except that the administrator of the health care authority shall adopt rules for managed health care systems as defined in chapter 70.47 RCW and self-insured or self-funded benefit plans authorized under chapter 41.05 RCW.

(b) For the purpose of adopting rules, the commissioner and administrator must give primary consideration to the federal department of labor claims procedure regulations in 29 C.F.R. Sec. 2560.503-1, and must also consider appeals process standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

NEW SECTION. **Sec. 7.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Each carrier must provide enrollees:

(a) At least one hundred eighty days following receipt of a notification of an adverse determination within which to appeal the determination; and

(b) A reasonable period of time to file a second level of appeal following receipt of a notification denying the first level of appeal, when the carrier has a two-level appeals process.

(2) Each carrier must notify the enrollee or the enrollee's authorized representative of the carrier's decision on an appeal in accordance with this subsection.

(a) For urgent care claims, each carrier must notify the enrollee or the enrollee's authorized representative of the decision on appeal as soon as possible, taking into account the medical exigencies, but not later than seventy-two hours after receipt of the enrollee's request for appeal.

(b) For preservice claims, each carrier must notify the enrollee or the enrollee's authorized representative of the decision on appeal within a reasonable period of time appropriate to the medical circumstances. However:

(i) In the case of a health plan that provides for one level of

appeal of an adverse determination, notification must be provided not later than thirty days after receipt by the carrier of the enrollee's request for appeal; and

(ii) In the case of a health plan that provides for two levels of appeal of an adverse determination, notification must be provided, with respect to any one of the two appeals, not later than fifteen days after receipt by the carrier of the enrollee's request for appeal.

(c) For postservice claims, the carrier must notify the enrollee or the enrollee's authorized representative of the carrier's decision on appeal within a reasonable period of time. However:

(i) In the case of a health plan that provides for one level of appeal of an adverse determination, notification must be provided not later than sixty days after receipt by the carrier of the enrollee's request for appeal; and

(ii) In the case of a health plan that provides for two levels of appeal of an adverse determination, notification must be provided, with respect to any one of the two appeals, not later than thirty days after receipt by the carrier of the enrollee's request for appeal.

(3) For purposes of subsection (2) of this section, the period of time within which a carrier's decision on appeal must be made begins at the time the appeal is filed in accordance with the carrier's reasonable procedures, without regard to whether all the information necessary to make a decision on appeal accompanies the filing.

NEW SECTION. **Sec. 8.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Each carrier that offers a health plan must have a fully operational, comprehensive grievance process. The grievance process must be in writing and must comply with the requirements of this section and any rules adopted by the commissioner to implement this section.

(2) Each carrier must:

(a) File with the commissioner its written grievance process. If a material change is made to the grievance process, the carrier must refile with the commissioner;

(b) Provide a clear explanation of the grievance process to enrollees in the member materials and upon request;

(c) Ensure that the grievance process is accessible to enrollees who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance;

(d) Permit an enrollee or an enrollee's authorized representative to file a grievance in writing, orally, or electronically;

(e) Provide an enrollee at least one hundred eighty days following the event giving rise to a complaint within which to file a grievance;

(f) Cooperate with an enrollee's authorized representative; and

(g) Consider all information submitted by the enrollee and the enrollee's authorized representative.

(3)(a) Each carrier must provide written or electronic acknowledgement to the enrollee when a grievance is received in writing or electronically.

(b) The acknowledgement required by (a) of this subsection must be provided to the enrollee within five working days of receipt of the grievance.

(4)(a) Each carrier must make its decision regarding a grievance within ninety calendar days of receipt of the grievance.

(b) The ninety-day period may be extended by an additional fourteen days if:

(i) The enrollee requests the extension in writing or electronically; or

(ii) The carrier determines that additional information is necessary and the delay would be in the enrollee's interest. The carrier must provide the enrollee with written notice of the extension prior to the expiration of the initial ninety-day period. The extension notice must indicate the circumstances requiring an extension of time and the date by which the carrier expects to render the decision.

(5) Each carrier must notify an enrollee of the disposition of a grievance in writing, electronically, or orally.

(a) A carrier must provide written or electronic notice of disposition if the grievance was filed in writing or electronically.

(b) A carrier may provide written or electronic notice of disposition in the same document acknowledging receipt of the enrollee's grievance if the decision is within the time frame set forth in subsection (3) of this section.

(6)(a) The commissioner shall adopt rules to implement this section, except that the administrator of the health care authority shall adopt rules for managed health care systems as defined in chapter 70.47 RCW and self-insured or self-funded benefit plans authorized under chapter 41.05 RCW.

(b) For the purpose of adopting rules, the commissioner shall consider grievance process standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

Sec. 9. RCW 48.43.535 and 2000 c 5 s 11 are each amended to read as follows:

(1) There is a need for a process for the fair consideration of disputes relating to decisions by carriers that offer a health plan to deny, modify, reduce, or terminate coverage of or payment for health care services for an enrollee.

(2) An enrollee may seek review by a certified independent review organization of a carrier's ((~~decision to deny, modify, reduce, or terminate coverage of or payment for a health care service,~~)) adverse determination after exhausting the carrier's ((~~grievance~~)) appeal process and receiving a decision that is unfavorable to the enrollee, or after the carrier has exceeded the timelines for ((~~grievances~~)) appeals of adverse determinations provided in RCW 48.43.530, without good cause and without reaching a decision.

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

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

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

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

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

(d) A list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the ((~~appeal~~)) review. Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to rules adopted by the commissioner.

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

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

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

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

section. If the determination affirms the carrier's decision, the enrollee may be responsible for the cost of the continued health service.

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

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

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

NEW SECTION. **Sec. 10.** A new section is added to chapter 48.43 RCW to read as follows:

For purposes of this section and sections 7 and 8 of this act, any electronic notification must comply with the following standards:

(1) The carrier must take appropriate and necessary measures reasonably calculated to ensure that the system for furnishing documents:

(a) Protects the confidentiality of personal information relating to the enrollee's benefits; and

(b) Results in actual receipt of transmitted information, such as using return-receipt or notice of undelivered electronic mail features, conducting periodic reviews or surveys to confirm receipt of the transmitted information;

(2) Notice is provided to each enrollee or other individual, in electronic or nonelectronic form, at the time a document is furnished electronically, that apprises the individual of the significance of the document when it is not otherwise reasonably evident as transmitted and of the right to request and obtain a paper version of the document; and

(3) Upon request, the enrollee or other individual is provided a paper version of the electronically furnished documents.

Sec. 11. RCW 48.43.545 and 2000 c 5 s 17 are each amended to read as follows:

(1)(a) A health carrier shall adhere to the accepted standard of

care for health care providers under chapter 7.70 RCW when arranging for the provision of medically necessary health care services to its enrollees. A health carrier shall be liable for any and all harm proximately caused by its failure to follow that standard of care when the failure resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, an enrollee.

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

(i) Employees;

(ii) Agents; or

(iii) Ostensible agents who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control.

(2) The provisions of this section may not be waived, shifted, or modified by contract or agreement and responsibility for the provisions shall be a duty that cannot be delegated. Any effort to waive, modify, delegate, or shift liability for a breach of the duty established by this section, through a contract for indemnification or otherwise, is invalid.

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

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

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

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

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

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

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

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

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

(ii) The affected enrollee or the enrollee's authorized representative has exercised the opportunity established in RCW 48.43.535 to seek independent review of the health care treatment decision, or the opportunity for an adjudicative proceeding if the enrollee is receiving medical assistance under RCW 74.09.522.

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

(8) In an action against a health carrier, a finding that a health care provider is an employee, agent, or ostensible agent of such a health carrier shall not be based solely on proof that the person's name appears in a listing of approved physicians or health care providers made available to enrollees under a health plan.

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

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

Sec. 12. RCW 48.46.020 and 1990 c 119 s 1 are each amended to read as follows:

As used in this chapter, the terms defined in this section shall have the meanings indicated unless the context indicates otherwise.

(1) "Health maintenance organization" means any organization receiving a certificate of registration by the commissioner under this chapter which provides comprehensive health care services to enrolled participants of such organization on a group practice per capita prepayment basis or on a prepaid individual practice plan, except for an enrolled participant's responsibility for copayments and/or deductibles, either directly or through contractual or other arrangements with other institutions, entities, or persons, and which qualifies as a health maintenance organization pursuant to RCW 48.46.030 and 48.46.040.

(2) "Comprehensive health care services" means basic consultative, diagnostic, and therapeutic services rendered by licensed health professionals together with emergency and preventive care, inpatient hospital, outpatient and physician care, at a minimum, and any additional health care services offered by the health maintenance organization.

(3) "Enrolled participant" means a person who or group of persons which has entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health maintenance organization to receive health care services.

(4) "Health professionals" means health care practitioners who are regulated by the state of Washington.

(5) "Health maintenance agreement" means an agreement for services between a health maintenance organization which is registered pursuant to the provisions of this chapter and enrolled participants of such organization which provides enrolled participants with comprehensive health services rendered to enrolled participants by health professionals, groups, facilities, and other personnel associated with the health maintenance organization.

(6) "Consumer" means any member, subscriber, enrollee, beneficiary, or other person entitled to health care services under terms of a health maintenance agreement, but not including health professionals, employees of health maintenance organizations, partners, or

shareholders of stock corporations licensed as health maintenance organizations.

(7) "Meaningful role in policy making" means a procedure approved by the commissioner which provides consumers or elected representatives of consumers a means of submitting the views and recommendations of such consumers to the governing board of such organization coupled with reasonable assurance that the board will give regard to such views and recommendations.

(8) ((~~"Meaningful grievance procedure" means a procedure for investigation of consumer grievances in a timely manner aimed at mutual agreement for settlement according to procedures approved by the commissioner, and which may include arbitration procedures.~~

~~(9)~~)) "Provider" means any health professional, hospital, or other institution, organization, or person that furnishes any health care services and is licensed or otherwise authorized to furnish such services.

((~~(10)~~)) (9) "Department" means the state department of social and health services.

((~~(11)~~)) (10) "Commissioner" means the insurance commissioner.

((~~(12)~~)) (11) "Group practice" means a partnership, association, corporation, or other group of health professionals:

(a) The members of which may be individual health professionals, clinics, or both individuals and clinics who engage in the coordinated practice of their profession; and

(b) The members of which are compensated by a prearranged salary, or by capitation payment or drawing account that is based on the number of enrolled participants.

((~~(13)~~)) (12) "Individual practice health care plan" means an association of health professionals in private practice who associate for the purpose of providing prepaid comprehensive health care services on a fee-for-service or capitation basis.

((~~(14)~~)) (13) "Uncovered expenditures" means the costs to the health maintenance organization of health care services that are the obligation of the health maintenance organization for which an enrolled participant would also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made as provided herein. The term does not include expenditures for covered services when a provider has agreed not to

bill the enrolled participant even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured, or assumed by a person or organization other than the health maintenance organization.

((~~(15)~~)) (14) "Copayment" means an amount specified in a subscriber agreement which is an obligation of an enrolled participant for a specific service which is not fully prepaid.

((~~(16)~~)) (15) "Deductible" means the amount an enrolled participant is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.

((~~(17)~~)) (16) "Fully subordinated debt" means those debts that meet the requirements of RCW 48.46.235(3) and are recorded as equity.

((~~(18)~~)) (17) "Net worth" means the excess of total admitted assets as defined in RCW 48.12.010 over total liabilities but the liabilities shall not include fully subordinated debt.

((~~(19)~~)) (18) "Participating provider" means a provider as defined in subsection ((~~(9)~~)) (8) of this section who contracts with the health maintenance organization or with its contractor or subcontractor and has agreed to provide health care services to enrolled participants with an expectation of receiving payment, other than copayment or deductible, directly or indirectly, from the health maintenance organization.

((~~(20)~~)) (19) "Carrier" means a health maintenance organization, an insurer, a health care services contractor, or other entity responsible for the payment of benefits or provision of services under a group or individual agreement.

((~~(21)~~)) (20) "Replacement coverage" means the benefits provided by a succeeding carrier.

((~~(22)~~)) (21) "Insolvent" or "insolvency" means that the organization has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

Sec. 13. RCW 48.46.030 and 1990 c 119 s 2 are each amended to read as follows:

Any corporation, cooperative group, partnership, individual, association, or groups of health professionals licensed by the state of Washington, public hospital district, or public institutions of higher

education shall be entitled to a certificate of registration from the insurance commissioner as a health maintenance organization if it:

(1) Provides comprehensive health care services to enrolled participants on a group practice per capita prepayment basis or on a prepaid individual practice plan and provides such health services either directly or through arrangements with institutions, entities, and persons which its enrolled population might reasonably require as determined by the health maintenance organization in order to be maintained in good health; and

(2) Is governed by a board elected by enrolled participants, or otherwise provides its enrolled participants with a meaningful role in policy making procedures of such organization, as defined in RCW 48.46.020(7), and 48.46.070; and

(3) Affords enrolled participants with ((~~a meaningful~~)) grievance ((~~procedure~~)) and appeal processes aimed at settlement of disputes between such persons and such health maintenance organization, ((~~as defined in RCW 48.46.020(8) and 48.46.100~~)) in accordance with RCW 48.43.530 and sections 7 and 8 of this act; and

(4) Provides enrolled participants, or makes available for inspection at least annually, financial statements pertaining to health maintenance agreements, disclosing income and expenses, assets and liabilities, and the bases for proposed rate adjustments for health maintenance agreements relating to its activity as a health maintenance organization; and

(5) Demonstrates to the satisfaction of the commissioner that its facilities and personnel are reasonably adequate to provide comprehensive health care services to enrolled participants and that it is financially capable of providing such members with, or has made adequate contractual arrangements through insurance or otherwise to provide such members with, such health services; and

(6) Substantially complies with administrative rules and regulations of the commissioner for purposes of this chapter; and

(7) Submits an application for a certificate of registration which shall be verified by an officer or authorized representative of the applicant, being in form as the commissioner prescribes, and setting forth:

(a) A copy of the basic organizational document, if any, of the

applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(b) A copy of the bylaws, rules and regulations, or similar documents, if any, which regulate the conduct of the internal affairs of the applicant, and all amendments thereto;

(c) A list of the names, addresses, members of the board of directors, board of trustees, executive committee, or other governing board or committee and the principal officers, partners, or members;

(d) A full and complete disclosure of any financial interests held by any officer, or director in any provider associated with the applicant or any provider of the applicant;

(e) A description of the health maintenance organization, its facilities and its personnel, and the applicant's most recent financial statement showing such organization's assets, liabilities, income, and other sources of financial support;

(f) A description of the geographic areas and the population groups to be served and the size and composition of the anticipated enrollee population;

(g) A copy of each type of health maintenance agreement to be issued to enrolled participants;

(h) A schedule of all proposed rates of reimbursement to contracting health care facilities or providers, if any, and a schedule of the proposed charges for enrollee coverage for health care services, accompanied by data relevant to the formulation of such schedules;

(i) A description of the proposed method and schedule for soliciting enrollment in the applicant health maintenance organization and the basis of compensation for such solicitation services;

(j) A copy of the solicitation document to be distributed to all prospective enrolled participants in connection with any solicitation;

(k) A financial projection which sets forth the anticipated results during the initial two years of operation of such organization, accompanied by a summary of the assumptions and relevant data upon which the projection is based. The projection should include the projected expenses, enrollment trends, income, enrollee utilization patterns, and sources of working capital;

(l) A detailed description of the enrollee ((~~complaint system~~))

grievance and appeal processes as provided by RCW ((~~48.46.100~~)) 48.43.530 and sections 7 and 8 of this act;

(m) A detailed description of the procedures and programs to be implemented to assure that the health care services delivered to enrolled participants will be of professional quality;

(n) A detailed description of procedures to be implemented to meet the requirements to protect against insolvency in RCW 48.46.245;

(o) Documentation that the health maintenance organization has an initial net worth of one million dollars and shall thereafter maintain the minimum net worth required under RCW 48.46.235; and

(p) Such other information as the commissioner shall require by rule or regulation which is reasonably necessary to carry out the provisions of this section.

A health maintenance organization shall, unless otherwise provided for in this chapter, file a notice describing any modification of any of the information required by subsection (7) of this section. Such notice shall be filed with the commissioner.

Sec. 14. RCW 48.46.040 and 1990 c 119 s 3 are each amended to read as follows:

The commissioner shall issue a certificate of registration to the applicant within sixty days of such filing unless he notifies the applicant within such time that such application is not complete and the reasons therefor; or that he is not satisfied that:

(1) The basic organizational document of the applicant permits the applicant to conduct business as a health maintenance organization;

(2) The organization has demonstrated the intent and ability to assure that comprehensive health care services will be provided in a manner to assure both their availability and accessibility;

(3) The organization is financially responsible and may be reasonably expected to meet its obligations to its enrolled participants. In making this determination, the commissioner shall consider among other relevant factors:

(a) Any agreements with an insurer, a medical or hospital service bureau, a government agency or any other organization paying or insuring payment for health care services;

(b) Any agreements with providers for the provision of health care services;

(c) Any arrangements for liability and malpractice insurance coverage; and

(d) Adequate procedures to be implemented to meet the protection against insolvency requirements in RCW 48.46.245.

(4) The procedures for offering health care services and offering or terminating contracts with enrolled participants are reasonable and equitable in comparison with prevailing health insurance subscription practices and health maintenance organization enrollment procedures; and, that

(5) Procedures have been established to:

(a) Monitor the quality of care provided by such organization, including, as a minimum, procedures for internal peer review;

(b) Resolve ((~~complaints and~~)) grievances and appeals initiated by enrolled participants in accordance with RCW ((~~48.46.010 and 48.46.100~~)) 48.43.530 and sections 7 and 8 of this act;

(c) Offer enrolled participants an opportunity to participate in matters of policy and operation in accordance with RCW 48.46.020(7) and 48.46.070.

No person to whom a certificate of registration has not been issued, except a health maintenance organization certified by the secretary of the department of health and human services, pursuant to Public Law 93-222 or its successor, shall use the words "health maintenance organization" or the initials "HMO" in its name, contracts, or literature. Persons who are contracting with, operating in association with, recruiting enrolled participants for, or otherwise authorized by a health maintenance organization possessing a certificate of registration to act on its behalf may use the terms "health maintenance organization" or "HMO" for the limited purpose of denoting or explaining their relationship to such health maintenance organization.

The department of health, at the request of the insurance commissioner, shall inspect and review the facilities of every applicant health maintenance organization to determine that such facilities are reasonably adequate to provide the health care services offered in their contracts. If the commissioner has information to indicate that such facilities fail to continue to be adequate to provide the health care services offered, the department of health,

upon request of the insurance commissioner, shall reinspect and review the facilities and report to the insurance commissioner as to their adequacy or inadequacy.

Sec. 15. RCW 70.47.130 and 2004 c 115 s 2 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 RCW 48.43.022, 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 43.70.235, 48.43.545, 48.43.550, 70.02.110, ((~~and~~)) 70.02.900, and sections 7, 8, and 10 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)(c), "solicit" does not include distributing information and applications for the basic health plan and responding to questions; and

(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. 16.** RCW 48.46.100 (Grievance procedure) and 1975 1st ex.s. c 290 s 11 are each repealed.

NEW SECTION. **Sec. 17.** The purpose of this act is to create processes for grievance and appeals of adverse determinations that are

substantially consistent with the federal department of labor claims procedure regulations in 29 C.F.R. Sec. 2560.503-1.

NEW SECTION. **Sec. 18.** Section 1 of this act is added to chapter 48.43 RCW.

NEW SECTION. **Sec. 19.** This act applies to contracts issued or renewed on or after January 1, 2006.

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