H-0483.1

HOUSE BILL 1396

State of Washington 61st Legislature 2009 Regular Session

By Representatives Green, Ericksen, Cody, Hinkle, Morrell, Moeller, Bailey, Williams, and Nelson

Read first time 01/20/09. Referred to Committee on Health Care & Wellness.

AN ACT Relating to referral procedures for medical eye care; and amending RCW 48.43.515.

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

Sec. 1. RCW 48.43.515 and 2000 c 5 s 7 are each amended to read as follows:

(1) Each enrollee in a health plan must have adequate choice among health care providers.

(2) Each carrier must allow an enrollee to choose a primary care provider who is accepting new enrollees from a list of participating providers. Enrollees also must be permitted to change primary care providers at any time with the change becoming effective no later than the beginning of the month following the enrollee's request for the change.

(3) Each carrier must have a process whereby an enrollee with a complex or serious medical or psychiatric condition may receive a standing referral to a participating specialist for an extended period of time.

(4) Each carrier must provide for appropriate and timely referral of enrollees to a choice of specialists within the plan if specialty

care is warranted. If the type of medical specialist needed for a specific condition is not represented on the specialty panel, enrollees must have access to nonparticipating specialty health care providers.

(5) Each carrier shall provide enrollees with direct access to the participating chiropractor of the enrollee's choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection shall prevent carriers from restricting enrollees to seeing only providers who have signed participating provider agreements or from utilizing other managed care and cost containment techniques and processes. For purposes of this subsection, "covered chiropractic health care" means covered benefits and limitations related to chiropractic health services as stated in the plan's medical coverage agreement, with the exception of any provisions related to prior referral for services.

(6) Each carrier shall provide enrollees with direct access to the participating medical eye care provider of the enrollee's choice for covered medical eye care without the necessity of prior referral. Nothing in this subsection shall prevent carriers from restricting enrollees to seeing only providers who have signed participating provider agreements or from utilizing other managed care and cost containment techniques and processes. For purposes of this subsection, "covered medical eye care" means covered benefits and limitations related to all health care services within the scope of practice of optometry as defined in RCW 18.53.010, whether provided or performed by a provider licensed under chapter 18.53, 18.57, or 18.71 RCW, as stated in the plan's medical coverage agreement, with the exception of any provisions related to prior referral for services. For purposes of this subsection, "medical eye care provider" means all providers licensed to provide services within the scope of the practice of optometry as defined in RCW 18.53.010, whether provided or performed by a provider licensed under chapters 18.53, 18.57, and 18.71 RCW. A referral for specialty eye care services made by a medical eye care provider is equivalent to a referral by a primary care provider for all purposes, including enrollee point-of-service cost-sharing calculations. A carrier may require by contract that a medical eye care provider notify any primary care provider for a patient who is referred for specialty eye care services.

(7) 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 participating provider of the enrollee's choice.

((~~(7)~~)) (8) Each carrier must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract for at least sixty days following notice of termination to the enrollees or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. The provider's relationship with the carrier or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the carrier assign new enrollees to the terminated provider.

((~~(8)~~)) (9) Every carrier shall meet the standards set forth in this section and any rules adopted by the commissioner 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.

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