H-4947.2

SUBSTITUTE HOUSE BILL 2552

State of Washington 61st Legislature 2010 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Cody, Kenney, Morrell, and Moeller)

READ FIRST TIME 02/03/10.

1 AN ACT Relating to individual health coverage; amending RCW
2 48.43.510; adding a new section to chapter 48.43 RCW; and creating a
3 new section.

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

5 NEW SECTION. **Sec. 1.** It is the intent of the legislature to
6 clarify how the annual benefits and deductibles of individual health
7 plans are reconciled with the date an enrollee begins or changes
8 coverage through a health carrier. The legislature further intends to
9 provide an enrollee credit for his or her annual benefits and
10 deductibles when the enrollee changes his or her individual health
11 plan.

12 **Sec. 2.** RCW 48.43.510 and 2009 c 304 s 1 are each amended to read
13 as follows:
14 (1) A carrier that offers a health plan may not offer to sell a
15 health plan to an enrollee or to any group representative, agent,
16 employer, or enrollee representative without first offering to provide,
17 and providing upon request, the following information before purchase
18 or selection:

1 (a) A listing of covered benefits, including prescription drug
2 benefits, if any, a copy of the current formulary, if any is used,
3 definitions of terms such as generic versus brand name, and policies
4 regarding coverage of drugs, such as how they become approved or taken
5 off the formulary, and how consumers may be involved in decisions about
6 benefits;
7 (b) A listing of exclusions, reductions, and limitations to covered
8 benefits, and any definition of medical necessity or other coverage
9 criteria upon which they may be based;
10 (c) A statement of the carrier's policies for protecting the
11 confidentiality of health information;
12 (d) A statement of the cost of premiums and any enrollee cost-
13 sharing requirements;
14 (e) A summary explanation of the carrier's grievance process;
15 (f) A statement regarding the availability of a point-of-service
16 option, if any, and how the option operates; and
17 (g) A convenient means of obtaining lists of participating primary
18 care and specialty care providers, including disclosure of network
19 arrangements that restrict access to providers within any plan network.
20 The offer to provide the information referenced in this subsection (1)
21 must be clearly and prominently displayed on any information provided
22 to any prospective enrollee or to any prospective group representative,
23 agent, employer, or enrollee representative.
24 (2) Upon the request of any person, including a current enrollee,
25 prospective enrollee, or the insurance commissioner, a carrier must
26 provide written information regarding any health care plan it offers,
27 that includes the following written information:
28 (a) Any documents, instruments, or other information referred to in
29 the medical coverage agreement;
30 (b) A full description of the procedures to be followed by an
31 enrollee for consulting a provider other than the primary care provider
32 and whether the enrollee's primary care provider, the carrier's medical
33 director, or another entity must authorize the referral;
34 (c) Procedures, if any, that an enrollee must first follow for
35 obtaining prior authorization for health care services;
36 (d) A written description of any reimbursement or payment
37 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) A written description of benefits and deductibles that apply on a calendar year basis and how the carrier reconciles them with the member's plan year;

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

((~~(h)~~)) (i) 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. Carriers may implement alternative, efficient methods of communication to ensure enrollees have access to information including, but not limited to, web site alerts, postcard mailings, and electronic communication in lieu of printed materials.

(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, as well as opportunities to reduce administrative costs included in health plans.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43 RCW to read as follows:

The commissioner shall adopt rules providing for the reconciliation of annual deductibles and benefits for individual health benefit plans with a member's plan year, including an annual fourth quarter credit that carries over to the next calendar year. In developing rules to implement this section, the commissioner shall provide for

1 circumstances in which a member changes individual health benefit plans
2 on dates other than the member's plan year or the beginning of the
3 calendar year.

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