S-3670.1

SENATE BILL 6584

State of Washington 61st Legislature 2010 Regular Session

By Senators Fraser, Swecker, Keiser, Schoesler, Roach, McDermott, and Shin

Read first time 01/18/10. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to applying the prohibition against unfair practices by insurers and their remedies and penalties to the state health care authority; amending RCW 41.05.017, 41.05.017, and 48.43.530; providing an effective date; and providing an expiration date.

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

Sec. 1. RCW 41.05.017 and 2008 c 304 s 2 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, 70.02.900, 48.43.190, ((~~and~~)) 48.43.083<u>, and 48.30.010. The applicability of RCW 48.30.010 to health plans under this chapter does not create a private cause of action</u>.

Sec. 2. RCW 41.05.017 and 2007 c 502 s 2 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, 70.02.900, ((~~and~~)) 48.43.083, and 48.30.010. The applicability of RCW 48.30.010 to health plans under this chapter does not create a private cause of action.

Sec. 3. 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 with the requirements of this section and any rules adopted by the commissioner to implement this section. For the purposes of this section, the commissioner shall consider grievance process standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

(2) Each carrier must process as a complaint an enrollee's expression of dissatisfaction about customer service or the quality or availability of a health service. Each carrier must implement procedures for registering and responding to oral and written complaints in a timely and thorough manner.

(3) Each carrier must provide written notice to an enrollee or the enrollee's designated representative, and the enrollee's provider, of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility.

(4) Each carrier must process as an appeal an enrollee's written or oral request that the carrier reconsider: (a) Its resolution of a complaint made by an enrollee; or (b) its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility. A carrier must not require that an enrollee file a complaint prior to seeking appeal of a decision under (b) of this subsection.

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

(a) Provide written notice to the enrollee when the appeal is received;

(b) Assist the enrollee with the appeal process;

(c) Make its decision regarding the appeal within thirty days of the date the appeal is received. An appeal must be expedited if the enrollee's provider or the carrier's medical director reasonably determines that following the appeal process response timelines could seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours of the date the appeal is received;

(d) Cooperate with a representative authorized in writing by the enrollee;

(e) Consider information submitted by the enrollee;

(f) Investigate and resolve the appeal; and

(g) Provide written notice of its resolution of the appeal to the enrollee and, with the permission of the enrollee, to the enrollee's providers. 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.

(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) 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 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 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. The state health care authority must make accessible to the commissioner a log of all complaints processed under subsection (2) of this section.

(11) Beginning in 2011, the commissioner must prepare an annual report to the legislature of the complaints and appeals processed by the state health care authority in the preceding twelve months. The report must include an analysis of any trends identified. The commissioner must complete the report by September 30th, unless the commissioner notifies the legislative committees by September 1st that data necessary to complete the report are not available and informs the committee when the report will be completed.

NEW SECTION. **Sec. 4.** Section 1 of this act expires June 30, 2013.

NEW SECTION. **Sec. 5.** Section 2 of this act takes effect June 30, 2013.

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