S-3876.1

SENATE BILL 6470

State of Washington 65th Legislature 2018 Regular Session

By Senators Becker, Keiser, Rivers, Bailey, Brown, Cleveland, and Hasegawa

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

AN ACT Relating to health carrier provider networks; amending RCW 48.43.510; and adding a new section to chapter 48.43 RCW.

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

NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43 RCW to read as follows:

(1) In reviewing and approving a health plan, the commissioner must affirmatively approve the adequacy of the plan's proposed provider network. In determining the adequacy of the proposed provider network, the commissioner must consider whether the proposed network includes a sufficient number of contracted providers practicing at contracted facilities to reasonably ensure that enrollees have in-network access to covered health care services delivered at those facilities.

(2) A health plan must permit an enrollee to petition the plan to cover health care services delivered by an out-of-network provider if: (a) The health plan has an absence of or an insufficient number or type of in-network providers or facilities to provide a particular covered health care service; and (b) the health care services would be covered if provided by an in-network provider. If the enrollee has already received such services, the plan must provide retroactive coverage of the services.

(3) A health plan must ensure that any enrollee cost-sharing obligation is included in the enrollee's in-network deductible and maximum out-of-pocket expenses if the enrollee receives health care services provided by an out-of-network provider at an in-network facility and the services would have been covered if provided by an in-network provider.

Sec. 2. RCW 48.43.510 and 2012 c 211 s 26 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 explanation of the carrier's review of adverse benefit determinations and grievance 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)~~)) Information on how to access the health plan's provider directory or directories maintained on the health plan's web site, as required by subsection (3) of this section. This information 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 review of adverse benefit determinations grievance process for claim or service denial and its grievance process 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) A health plan issued or renewed after December 31, 2018, must publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the health plan's enrollees.

(a) A health plan's provider directory:

(i) Must be published on the health plan's web site and be available to enrollees, potential enrollees, providers, and the public without restriction or limitation;

(ii) Must indicate which providers are accepting new patients; and

(iii) May not include information on a provider that is not currently under contract with the health plan.

(b) A health plan must establish and maintain a process for enrollees, potential enrollees, providers, and the public to identify and report potentially inaccurate, incomplete, or misleading information provided in a provider directory. These processes must, at a minimum, include a telephone number and dedicated email address at which the plan will accept these reports, as well as a form on the plan's provider directory web site that allows the information to be reported to the plan directly through the web site.

(c)(i) Except as provided in (c)(ii) of this subsection, a health plan must update its provider directory or directories at least once a month.

(ii) A health plan must update a provider directory within seven calendar days of confirming that information in the directory is inaccurate if the plan is informed of or otherwise learns of an inaccuracy related to: Whether a provider is under contract with the plan; whether a contracted provider, or an individual provider in a contracted provider group, is accepting new patients; or a contracted provider's practice location or other contact information.

(d) Upon receipt of a complaint, the commissioner shall determine whether an enrollee obtained health care services from an out-of-network provider that would have been covered if provided by an in-network provider because the enrollee reasonably relied on materially inaccurate, incomplete, or misleading information in a health plan's provider directory. If the commissioner finds that these requirements are met, the commissioner shall require the health plan to: (i) Provide coverage for any health care services provided to the enrollee that would have been covered if provided by an in-network provider; and (ii) reimburse the enrollee for any amount in excess of what the enrollee would have paid had the services been delivered by an in-network provider.

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

((~~(4)~~)) (5) 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)~~)) (6) 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)~~)) (7) 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)~~)) (8) 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)~~)) (9) 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)~~)) (10) 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.

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