# FINAL BILL REPORT
# ESHB 2018

**PARTIAL VETO**
**C 231 L 97**
Synopsis as Enacted

**Brief Description:** Enacting health insurance reform.

**Sponsors:** By House Committee on Health Care (originally sponsored by Representatives Dyer, Grant, Backlund, Quall, Zellinsky, Sheldon, Sherstad, Morris, Parlette, Scott and Skinner).

**House Committee on Health Care**
**Senate Committee on Health & Long-Term Care**
**Senate Committee on Ways & Means**

**Background:** As managed care emerges as the prevalent method of delivering health care services, a number of issues have been missed about quality assurance standards of patient service utilization review, resolution of patient and provider grievances, and the adequacy of provider networks that contract with managed care organizations.

The Department of Social and Health Services contracts for managed care services in the state's Medical Assistance (Medicaid) program. These managed care services must comply with quality assurance standards and other standards in federal rules to receive federal matching funds.

Prior to 1994, health carriers typically reviewed each applicant for individual health coverage. This underwriting enabled carriers to predict costs and charge premiums to cover those costs. Preexisting condition limitations allowed carriers to provide coverage to some applicants who would otherwise be rejected because of health status, but the limitations also allowed carriers to make coverage decisions that reflected the need to evaluate risks and costs.

The Health Care Services Act of 1993, anticipating universal coverage under which everyone would have health coverage, authorized the Office of the Insurance Commissioner (OIC) to adopt rules restricting the use of preexisting conditions. In 1994, the OIC established a three-month open enrollment during which there was guaranteed issue of health policies in the individual market with no underwriting based on health status and no waiting period for coverage of preexisting medical conditions. The rules also require guaranteed issue without underwriting for health status outside the open enrollment period, although a three month preexisting condition waiting period was allowed; this rule was codified in 1995. Between 1993

and 1995, enrollment in the individual market expanded by 40 percent. At the end of this period, however, carriers began reporting significant losses in the individual market, and individual market rates, which were relatively flat initially, began increasing. Enrollment in the individual market leveled off and may be declining. The explanation for the market's behavior could include many complex factors, but it appears that new enrollees entering the market after the 1994 rules were adopted tended to use more health care services, and claims submitted to carriers increased. Generally, as rates increase without incentives for healthy people to maintain continuous coverage, the possibility exists that adverse selection will occur, where healthy people who least expect to need expensive care choose not to have health coverage, or choose to enter the market only when needing major medical care and dropping coverage after receiving medical treatment.

The Washington State Health Insurance Pool (WSHIP) was created in 1988 to provide a fee-for-service health insurance product at 150 percent of average rates for individuals who had been denied substantially equivalent– coverage by a carrier, usually because of serious medical conditions. The pool is administered by a private insurer according to state specifications and is partially subsidized through an assessment on insurers. The pool's board of directors has deemed the Basic Health Plan (BHP) as substantially equivalent– to the pool plan, which results in the denial of pool coverage when BHP coverage is available. However, the BHP drug benefit is not as comprehensive as the pool's and the BHP does not include rehabilitation services. The WSHIP does not offer a managed care product nor does it include maternity care service, which limits the scope and cost containment ability of the pool plan. The cost of WSHIP premiums is disparate for men and women. WSHIP rates must be approved by the OIC.

In 1995, a model plan, based on the BHP benefits, was created which all carriers must offer. As written, a change in the BHP would require a change in the model plan.

The adjusted community rate standard, which applies to all health insurance coverage for individuals and to coverage for groups under 50 enrollees, permits rate variation only for geographic area differences, family size, age and wellness activities. The granting a tenure discount for individuals who enroll for an extended period is not allowed.

Loss ratios are used by the OIC to review carrier rate modification requests. The OIC enabling statute grants explicit authority to adopt rules setting loss ratios. Under the OIC review process, if the benefits are deemed reasonable– to the premium then the loss ratio and rate are generally approved. Loss ratio rules have been adopted for individual and group disability coverage and for health care services contractors, although the contractor rules were repealed in October 1995. Loss ratio rules have never been adopted for health maintenance organizations.

Health insurance plans contain criteria that include or exclude coverage for certain conditions or treatments and these determine the extent of coverage for medical tests, treatments, procedures or care. Under these criteria, an insurer may decide that treatment recommended by a provider is not covered. If the patient does not get treatment and suffers harm because of the lack of the treatment, a question of liability arises. Both the insurer and the health care provider could be defendants in a lawsuit. Potential liability issues are sometimes addressed in contract clauses between the health carrier and the provider. These clauses, known as Wickline clauses– after a California case, are not addressed in Washington law.

There is no statute governing the appropriate coverage of emergency services by a health carrier.

**Summary:**

Utilization Review. An entity performing utilization review under contract with, or acting on behalf of, a health carrier must meet specified standards by January 1, 1998. 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.

The Office of the Insurance Commissioner (OIC) is required to periodically examine national accreditation standards for utilization review and report to the Legislature to ensure that such standards continue to be substantially equivalent to or exceed the act's requirements. Health carriers that continuously maintain such accreditation are deemed in compliance with the state requirements.

In performing a utilization review, a review organization is limited to access to the records of persons covered by the specific health carrier or lawful third party payer for which the review is performed.

Grievance Procedures. Standards for establishing and maintaining grievance procedures by health carriers are provided. A grievance– is defined as a written complaint submitted by or on behalf of a covered person regarding denial of payment for medical services, or service delivery issues, 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.

Every health carrier is required to: use written procedures for receiving and resolving grievances from covered persons; include, at each level of review of a grievance, a person or persons with sufficient background and authority to deliberate the merits of the grievance and establish appropriate terms of resolution; provide toll free or collect telephone access to covered persons for purposes of presenting a

complaint for review; provide the covered person, or authorized representative of the covered person, with a written determination of its review; provide a second level grievance review for those covered persons who are dissatisfied with the first level grievance review decision; process the grievance in a reasonable length of time, not to exceed 30 days from receipt of the request for a second level review; issue a written decision to the covered person or authorized representative of the covered person within five working days of completing the review meeting; file with the OIC its procedures for review and adjudication of grievances initiated by covered persons; include in the policy material a notice of the availability and the requirements of the grievance procedure process; make a decision and notify the covered person in no more than two business days after the request for expedited review is received.

The OIC is required to periodically examine national accreditation standards for grievance procedures and report to the Legislature to ensure that such standards continue to be substantially equivalent to or exceed the act's requirements. Health carriers that continuously maintain such accreditation are deemed in compliance with the state requirements.

The statutory grievance procedure requirement for health maintenance organizations is repealed. The grievance procedure for carriers is amended to apply to providers only.

Network Adequacy. The Department of Health, in consultation with the OIC, the Department of Social and Health services (DSHS), the Health Care Authority (HCA), the Health Care Policy Board, consumers, providers, and health carriers, must review the need for network adequacy requirements and submit its report and recommendations to the health care committees of the Legislature by January 1, 1998. No agency may engage in rulemaking relating to network adequacy until the Legislature has reviewed the findings and recommendations of the study and has passed related legislation.

Access Plan Requirements. As of July 1, 1997, each health carrier must develop and update annually an access plan that meets specified requirements. By August 1, 1997, each health carrier must submit its access plan to the DOH.

The OIC is required to periodically examine national accreditation standards for network adequacy and report to the Legislature to ensure that such standards continue to be substantially equivalent to or exceed the act's requirements. Health carriers that continuously maintain such accreditation are deemed in compliance with the state requirements.

Medical Assistance Waivers. To the extent required by federal Medicaid statutes, the state's utilization review, grievance procedures, and access plan standards do not apply to contracts with health carriers awarded by the DSHS.

Preexisting Condition Limitations. The time frame regulating a carrier's use of a three-month benefit waiting period for preexisting conditions is changed from all year to an open enrollment period of the months of July and August only.

Carriers may refuse enrollment if the applicant has not maintained continuous coverage and is not applying as a newly eligible dependent, and the carrier used uniform health evaluation criteria for all individual health plans it offers.

If a carrier refuses to enroll an applicant, it must offer to enroll the applicant in the Washington State Health Insurance Pool (WSHIP) in an expeditious manner as determined by the board of directors of the WSHIP. An applicant who declines enrollment must decline in written form.

Carriers may not refuse enrollment based on health evaluation criteria to otherwise eligible applicants who have been covered either continuously or for any part of the three-month period immediately preceding the date of application for the new individual health plan under a comparable group or individual health benefit plan with substantially similar benefits. Coverage of the Basic Health Plan (BHP) and the Medical Assistance Program are considered comparable health benefit plans, as is the WSHIP, as long as the person is continuously enrolled in the WSHIP until the next open enrollment period.

Carriers must accept for enrollment all newly eligible dependents within 63 days of eligibility.

At no time are carriers required to accept for enrollment any individual residing outside of Washington, except for qualifying dependents who reside outside the carrier service area.

Continuity of Coverage. Guaranteed renewability and product modification provisions are amended to permit carriers to discontinue offering a health plan, if the carrier: provides notice to each covered person at least 90 days prior to discontinuation; offers to each covered person the option to purchase any other health plan currently being offered by the health carrier to similar covered persons in the market category and geographic area; and acts uniformly without regard to any health-status related factor of covered persons or persons who may become eligible for coverage.

A health carrier may discontinue all health plan coverage in one or more of the established lines of business if it provides notice to the OIC and to each person covered by a plan within the line of business of the discontinuation at least 180 days prior to the expiration of coverage, and all plans issued are discontinued and not renewed. In such cases, the carrier may not issue any new health plan coverage in the line of business in the state for five years.

Model Basic Health Plan. The Model Basic Health Plan is defined as the BHP benefit package configured on January 1, 1996. Therefore, future adjustments in the BHP will not affect the model plan.

Reporting Requirements. Foreign (out-of-state) and alien (out-of-country) insurers are exempt from requirements to report the names and addresses of all carrier officers, directors, or trustees and their compensation in the insurer's supplemental compensation exhibit of its annual statement.

Tenure Discounts. Adjusted community rate provisions are modified to permit carriers to vary the adjusted community rate to offer tenure discounts for continuous enrollment in the health plan of two years or more, not to exceed 10 percent of the rate.

Washington State Health Insurance Pool. The WSHIP is authorized to offer managed care plans. Covered persons enrolled in the WSHIP on January 1, 1997, may continue coverage under the WSHIP fee-for-services plan in which they are enrolled on that date. The WSHIP may, however, incorporate managed care features into such existing plans. Maternity care service without waiting periods is added to the WSHIP benefits when provided in a managed care plan. The WSHIP must comply with the three-month preexisting condition limitation as required of private carriers. The WSHIP standard risk rate base is changed from 10 to 50 persons in the average standard group rate. The maximum rate for managed care coverage is set at 125 percent of the model group rate. WSHIP rates no longer require the approval of the OIC.

For the purposes of determining if an individual already has substantially equivalent coverage, coverage under the BHP is not deemed to be substantially equivalent to the WSHIP plans.

Loss Ratios. The benefits in a contract of a health maintenance organization and health care services contractor are deemed reasonable in relation to the amount charged as long as the anticipated loss ratios are, at least: 65 percent for individual subscriber contract forms; 75 percent for franchise plan contract forms; 80 percent for group contract forms other than small group contract forms; and 75 percent for small group contract forms.

Loss ratios are also set for individual, group, and blanket disability insurance, except for: additional indemnity and premium waiver forms for use only in conjunction with life insurance policies; Medicare supplement policies; and credit insurance policies.

Emergency Medical Services. Health carriers are required to cover emergency services necessary to screen and stabilize a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

An emergency medical condition– is defined as 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. Emergency service– is defined as otherwise covered health care items and services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

Study of Wickline Clauses. A Joint Task Force on Wickline Clauses is created to review the practice of contractually assigning or avoiding potential liability for decisions by health carriers or other third-party payers to not pay for health care services recommended by a health care provider. The task force, comprised of four representatives, four senators, and eight non-legislative persons, must report to the Legislature by December 1, 1997.

**Votes on Final Passage:**

House 66 32
Senate 30 19 (Senate amended)
House 61 30 (House concurred)

**Effective:** July 27, 1997
January 1, 1998 (Section 301)

**Partial Veto Summary:** The governor vetoed provisions relating to managed care rule making, preexisting condition limitations, continuation of existing coverage, and rate setting loss ratios.