# HOUSE BILL REPORT
# ESHB 2018

**As Passed Legislature**

**Title:** An act relating to health insurance reform.

**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).

**Brief History:**
**Committee Activity:**
Health Care: 2/25/97, 2/28/97 [DPS].
**Floor Activity:**
Passed House: 3/18/97, 66-32.
Senate Amended.
House Concurred.
Passed Legislature.

## HOUSE COMMITTEE ON HEALTH CARE

**Majority Report:** The substitute bill be substituted therefor and the substitute bill do pass. Signed by 6 members: Representatives Dyer, Chairman; Backlund, Vice Chairman; Skinner, Vice Chairman; Parlette; Sherstad and Zellinsky.

**Minority Report:** Do not pass. Signed by 5 members: Representatives Cody, Ranking Minority Member; Murray, Assistant Ranking Minority Member; Anderson; Conway and Wood.

**Staff:** Bill Hagens (786-7131).

**Background:** As managed care emerges as the prevalent method of delivering health care services greater concern has been expressed 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 state's Medical Assistance (Medicaid) Program must comply with federal rules in order to receive federal matching funds. These standards might conflict with the quality assurance standards set forth in this could jeopardize federal funding.

In anticipation of universal coverage, the Health Services Act of 1993 gave the Office of the Insurance Commissioner (OIC) authority to adopt rules restricting the use of pre-existing condition limitations. The OIC established a three-month open enrollment during which there was guaranteed issue in the individual market with no waiting period for coverage of preexisting medical conditions. As a result, enrollment in the individual market at first accelerated, expanding 40 percent between 1993 and 1995. With no health status underwriting, the new enrollees tended to use more health care services than the pre-reform years and claims submitted to carriers increased. Initially aggregate premiums were relatively flat, even declining. Regulatory action by the OIC delayed the immediate increase in premiums. Also there is evidence that some individuals changed carriers or products to reduce their premium and some new products were introduced with higher deductibles and/or less comprehensive benefits. The combined effect of increasing aggregate costs and declining premiums resulted in significant carrier losses in the individual market, estimated at $58 million for the top six carriers in 1995 representing 3 percent of their total premiums, and 8 percent of their combined net worth. Toward the end of 1995 and in 1996, most carriers were able to push through premium increases. There is evidence that individual market enrollment is now declining as a result. Disenrollment is expected to occur primarily among the healthier people who least expect to need expensive care. In short, as premiums increase, adverse selection is likely to occur. Carriers are concerned that some people are delaying buying insurance until they need health care and dropping coverage after they receive medical treatment. Incentives for healthy people to maintain continuous coverage may offset this potential problem.

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. Presently, 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. Further, the pool's board of directors 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. The BHP drug benefit is not as comprehensive as the Pool's and the BHP does not include rehabilitation services--a common reason for persons seeking pool coverage. Presently, WSHIP rates must be approved by 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 discount for an extended period (tenure) of enrollment is not allowed.

Loss ratios are used by the OIC to review carrier rate modification requests. Explicit in the OIC enabling statute is the authority to adopt rules setting loss ratios. Under the current review process, if the benefits are deemed reasonable– to the premium then the loss ratio and rate are generally approved. To date loss ratio standards have been adopted, by rule, 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.

Presently, there is no statute governing the appropriate use of emergency services.

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. For instance, when a decision is made by the insurer that treatment is not covered, the question still remains as to whether the patient should have the treatment. The patient and health care provider then must decide whether treatment will be provided, even if the insurer is not going to pay for it. If the patient does not get treatment and suffers harm because of the lack of the treatment, a lawsuit may result. Both the insurer and the health care provider could be defendants in the suit. This predicament is commonly referred to as "Wickline," named after a California court case. Presently state law does not provide a remedy to this conflict.

**Summary of Bill:**

UTILIZATION REVIEW

Review organization– is defined as an entity performing utilization review under contract with, or acting on behalf of a health carrier. Utilization review– is defined to mean 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. Every review organization shall meet the standards set forth in the bill by January 1, 1998.

The 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 requirements of this act. Health carriers that continuously maintain such accreditation are deemed in compliance with this act.

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

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; included 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 requirements of this act. Health carriers that continuously maintain such accreditation are deemed in compliance with this act.

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 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 rule making 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 the requirements of this bill. 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 requirements of this act. Health carriers that continuously maintain such accreditation are deemed in compliance with this act.

MEDICAL ASSISTANCE WAIVERS

To the extent required by federal Medicaid statutes, the DSHS is exempt from utilization review, grievance procedures, and access plan standards as required in this bill.

PREEXISTING CONDITION LIMITATIONS MODIFICATIONS

The current 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 nor is 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 WSHIP in an expeditious manner as determined by the board of directors of the WSHIP. Declination by the applicant to enroll must be done in written form.

Carriers may not refuse enrollment based upon 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 the state of Washington, except for qualifying dependents who reside outside the carrier service area.

CONTINUITY OF COVERAGE MODIFICATIONS

Current provisions of guaranteed renewability and product modification 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 such 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 MODIFICATIONS

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 as mandated in a 1995 law. Presently, this information is required by law to be reported in the insurer's supplemental compensation exhibit of its annual statement.

TENURE DISCOUNTS

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

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, however, the WSHIP may 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. The BHP is deemed to be not substantially equivalent to the WSHIP plans. WSHIP rates no longer require OIC approval.

LOSS RATIOS

Loss ratios are established in statute whereby benefits 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

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.

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.

WICKLINE STUDY

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, shall report to the Legislature by December 1, 1997.

**Appropriation:** None.

**Fiscal Note:** Requested on February 19, 1997.

**Effective Date:** Ninety days after adjournment of session in which bill is passed except for Sections 105 through 108 and Section 301 which take effect January 1, 1998 and Section 111 which contains an emergency clause and takes effect on July 1, 1997.

**Testimony For:** Pending quality assurance standards require the prudent review of the most prominent public purchasing agency in the state--the HCA. The current requirements of preexisting condition limitations and guaranteed renewability of coverage encourage gaming of the insurance market and hamstrings carriers in their efforts to provide a comprehensive affordable insurance product to individuals. The statutory changes will encourage individual responsibility and increase access through the addition of maternity care services in the Health Insurance Pool and the reductions of the maximum premium rate for pool coverage. The addition of the loss ratio statute will bring objective standards to the rate review process and limit the use of the rate review process for political purposes. The new emergency services standards will permit ingenuous patients to use such without the fear of excessive costs.

**Testimony Against:** The quality assurance standard process included is a blatant and reprehensible attack on the insurance commissioner who has been elected twice, overwhelmingly, to protect the peoples' rights to affordable and effective insurance coverage. Designating HCA, a large public purchaser, as the agency to oversee quality assurance standards poses a conflict of interests. The reductions in the preexisting condition limitations and guaranteed renewability is the effort of the highly profitable insurance industry to continue to erode what little power is left to the consumer by the 1993 Health Reform Act. The loss ratios put forth would, in some

cases, permit carriers to spend as much as 35 percent of every premium dollar on administrative costs at a time when the salaries of insurance executives are excessively high.

**Testified:** Gary Smith, Independent Business Association (pro); Lincoln Ferris, Services Group of America (pro); Carolyn Logue, National Federation of Independent Business (pro); Jim Halstrom, Health Care Purchasers Association (pro); Jane Seavecki and David Allen, American Cancer Society (con); Ed Denning, Group Health (pro); Mimi Fields, Department of Health; Jane Beyer, DSHS; Beth Berendt, Health Care Authority; Nancy Purcell and Mark Adams, Washington State Medical Association (pro); Nick Federici, Washington State Nurses Association; Melissa Kurtz, Washington Coalition of Citizens w/Disabilities (con); Mel Sorensen, Washington Physicians Service (pro); and Roger Mercer, Skagit Medical Bureau (pro).