SENATE BILL REPORT

ESHB 2018

As Reported By Senate Committee On:
Health & Long-Term Care, April 1, 1997
Ways & Means, April 3, 1997

Title: An act relating to health insurance reform.

Brief Description: Enacting health insurance reform.

Sponsors: 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 & Long-Term Care: 3/20/97, 4/1/97 [DPA-WM, DNPA-DNRef-WM].
Ways & Means: 4/3/97 [DPA (HEA)-DNP].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Deccio, Chair; Wood, Vice Chair; Benton and Strannigan.

Minority Report: Do not pass as amended and do not refer to Committee on Ways & Means.
Signed by Senators Fairley and Wojahn.

Staff: Don Sloma (786-7319)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass as amended by Committee on Health & Long-Term Care.
Signed by Senators West, Chair; Deccio, Vice Chair; Strannigan, Vice Chair; Hochstatter, Long, McDonald, Rossi, Schow, Swecker, Winsley and Zarelli.

Minority Report: Do not pass.
Signed by Senators Bauer, Brown, Fraser, Loveland, Snyder, Spanel and Thibaudeau.

Staff: Susan Lucas (786-7711)

Background: Many are concerned that as managed care emerges as the prevalent method of delivering health care services, its focus on cost control may be jeopardizing patient choice, health or safety. The concern stems, in part, from the belief that managed care organizations may be developing limited networks of overly cost conscious health providers who may not be paying adequate attention to staffing, clinical judgment and other issues to insure quality patient care.

Responding to these concerns, public and private groups have developed a variety of managed care standards to judge the adequacy of provider networks, the appropriateness of utilization review procedures, and the responsiveness of health plans to grievances. While most agree that some standards are needed, there is widespread debate regarding what role, if any, the government should play in establishing, monitoring or enforcing such standards.

A second major health care concern is the economic stability of the individual insurance market. In 1993, the Legislature authorized the Office of the Insurance Commissioner (OIC) to prohibit the practice of denying insurance because applicants had pre-existing medical conditions. In 1994, the OIC established a one month open enrollment during which anyone could get immediate health insurance coverage with no waiting period for coverage of pre-existing medical conditions. Subsequently, a three-month pre-existing condition limitation was established. As a result of this, and aggressive recruitment efforts by carriers to enroll individuals, enrollment in the individual market accelerated, expanding 40 percent between 1993 and 1995. With no health status underwriting, the new enrollees tended to use more health care services than those who enrolled during the pre reform years, and claims submitted to carriers increased.

Initially, aggregate premiums were relatively flat, even declining. This was due, in part, to regulatory intervention by the OIC which delayed any immediate increase in premiums. In addition, some new insurance benefits packages were offered with higher deductibles and/or less comprehensive benefits, and some people switched to these to avoid premium increases. The combined effect was significant carrier losses in the individual market, estimated at $58 million for the top six carriers in 1995. This represented 3 percent of their total premiums that year, and 8 percent of their combined net worth.

Toward the end of 1995 and in 1996, most carriers were able to obtain approval for premium increases. But now it seems individual insurance market enrollment may be declining as higher premiums dissuade potential customers. Some believe that this is occurring primarily among healthier people who least expect to need expensive care, leaving fewer, sicker people to share insurance costs in the individual market. Others believe that most are remaining in the market, although they may be opting for less comprehensive coverage to avoid premium increases.

Carriers are concerned that the relatively short (three months) waiting period now in effect allows people to avoid buying insurance until they need health care, and then dropping coverage after they receive medical treatment. They reason that incentives for healthy people to maintain continuous coverage may offset this potential problem.

Summary of Bill: Utilization Review. 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. Every health carrier's utilization review organization must meet the standards set forth in the bill by January 1, 1998.

The Washington State Health Care Authority (HCA) must periodically examine review organization accreditation standards of national accreditation organizations and, if appropriate, adopt rules exempting a review organization from the requirements of the bill,

if certified by a national credentialing entity approved by the authority. These powers are transferred to the OIC on January 1, 2001.

In performing a utilization review, a review organization may have access only to the records of persons covered by the specific health carrier 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, or provider or staff attitude or demeanor.

Every carrier must: 1) use written procedures to handle grievances; 2) include in the grievance procedure at least one individual with sufficient background and authority to deliberate on the grievance; 3) provide free telephone access to present a complaint; 4) provide a written response regarding a complaint; 5) provide a second level grievance review for those dissatisfied with the first; 6) process the grievance not more then 30 days from receipt of the request for a second level review; 7) issue a written decision within five working days of completing the review meeting; 8) file with the OIC its procedures for review and adjudication of grievances; 9) provide covered persons with a written notice of the availability and the requirements of the grievance procedure process; 10) notify the covered person of their decision on the grievance in no more than two business days after the request for expedited review is received.

HCA must periodically examine grievance procedure accreditation standards of national accreditation organizations and, if appropriate, must adopt rules exempting a carrier from the grievance procedure requirements of the bill, if certified by a national credentialing entity approved by the authority. These powers are transferred to OIC on January 1, 2001.

Separate statutory grievance procedures for health maintenance organizations are repealed. The grievance procedures for carriers in existing law are amended to apply to providers only.

Network Adequacy. The Department of Health (DOH), in consultation with other named agencies and groups, 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, update annually and make available an access plan that meets requirements contained in the bill. By August 1, 1997, each health carrier must submit its access plan to DOH.

HCA must periodically examine network adequacy accreditation standards of national accreditation organizations and, if appropriate, adopt rules exempting a review organization from the requirements of the bill, if certified by a national credentialing entity approved by the authority. These powers are transferred to the OIC on January 1, 2001.

Medical Assistance Waivers. To the extent required by federal Medicaid statutes, the Department of Social and Health Services (DSHS) is exempt from utilization review, grievance procedures, and access plan standards contained in the bill.

Pre-existing Condition Limitations Modifications. The current requirement that a carrier may not deny coverage because of pre-existing conditions for more than three-months is changed so that it applies only during the month of July. During each year, each carrier need only take new enrollees equal to 1 and one-half percent of that carrier's average enrollment in the individual market during January of that year. If all carriers meet this cap, the OIC may lift it such that enrollment opens to all in July or remains open for a 31-day period each year.

At other times, a carrier may refuse enrollment using uniform health evaluation criteria across all its individual market plans, if the applicant has not maintained continuous coverage, and is not applying as a newly eligible dependent.

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 pool. 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 for this purpose, as is WSHIP, as long as the person is continuously enrolled in 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.

Washington State Health Insurance Pool. WSHIP is authorized to offer managed care plans, and to include managed care features in its existing plans. The pool standard risk rate base is changed from ten 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 OIC's authority to approve WSHIP premiums is repealed.

BHP is deemed not to be substantially equivalent to WSHIP plans.

Maternity care service is added to managed care WSHIP benefits.

State-approved chemical dependency treatment programs are allowed to render chemical dependency treatment services within WSHIP.

Continuity of Coverage. Carriers are permitted to either modify or discontinue a health plan if the carrier: a) provides notice to each covered person at least 90 days in advance; b) offers each covered person the option to purchase another health plan currently being offered to similar persons; and c) acts uniformly without regard to any health-status related factor of either covered persons or person who may become eligible for coverage. A carrier may also withdraw from an entire market (e.g. the individual insurance market) by providing six months notice and agreeing not to reenter that market for at least five years.

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

Maternity Benefits. All health carriers must offer at least one plan, in addition to the model basic health plan, that contains maternity coverage substantially equivalent to that offered under the basic health plan.

Tenure Discounts. Carriers may offer tenure discounts– of up to 10 percent for continuous enrollment in the health plan of two years or more.

Loss Ratios. Loss ratios are established in statute, whereby benefits of a health maintenance organization or a health care service contractor are deemed reasonable in relation to the premium charged, so long as loss ratios specified in the bill are met. For example, the premium for a plan composed of individual subscribers is deemed reasonable if 65 percent of the premiums taken in by the carrier are paid out as claims. Similarly, a group contract covering more than 50 people is deemed to have a reasonable premium if 80 percent of the premiums taken in by the carrier are paid out as claims.

Emergency Medical Services. The terms emergency medical condition– and emergency service– are defined. Carriers must 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 is created to review the practice of contractually assigning or avoiding potential liability for decisions by health carriers or other third-party payers not to pay for health care services recommended by a health care provider. The task force reports to the Legislature by December 1, 1997.

Amended Bill Compared to Substitute Bill: The requirement that all carriers offer at least one plan in addition to the BHP model plan which contains maternity benefits is added to the amended bill. The amended bill clarifies that state certified chemical dependency programs may deliver services under the WSHIP. Finally, the 1 and one-half percent cap on enrollment in the individual market is added in the amended bill.

Appropriation: None.

Fiscal Note: Available.

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 (Health & Long-Term Care): Since the insurance reforms were adopted, many carriers have left the individual insurance market, some well respected carriers will not enter it for fear of financial disaster, coverage has declined, prices have risen and fewer people have obtained coverage. The Insurance Commissioner has denied needed rate increases arbitrarily and proposed rules regulating managed care that duplicate a nationwide effort and are therefore unneeded. The bill is needed to allow use of nationally recognized standards of quality for managed care; to rein in unnecessarily complex government regulatory efforts in managed care; to bring some predictability to rate making in the health insurance market; to stop the practice of individuals purchasing insurance, using benefits and then canceling coverage until they are sick again (i.e. "churning"); and to allow health carriers to cancel products that no longer meet consumers needs. If these changes are adopted, Washington will become a more attractive market for health insurers. Those not now in the individual market will enter. Those now in will stay. Rates will stabilize and free markets will control price and quality. Without the bill, no new carriers will enter the market. Some of those in it will leave, and rates for individual insurance will continue to skyrocket.

Testimony Against (Health & Long-Term Care): This bill was written by and for insurers. It is good for insurance company profits and bad for consumers. Insurers in the individual market have stipulated that losses have leveled off. Some are projecting profits in 1997. The worst financial impact of the insurance reforms has been absorbed. So-called "churning" has been studied by the University of Washington Medical School and found not to be a significant contributor to rate escalation in the individual market. So the changes to pre-existing condition and guaranteed issue rules are not needed. They will deny access unnecessarily. Proposed managed care rules which require the Health Care Authority to "deem" national standards are misplaced, duplicative, unenforceable and a blatant and arrogant attempt to undermine a popular and aggressive Insurance Commissioner. It is personal and highly inappropriate. Deeming certain loss ratios as reasonable without looking at reserves, administrative costs, capital and other factors guarantees huge insurance company profits, effectively repeals the OICs rate approval authority and will hurt consumers.

Testified (Health & Long-Term Care): Carol Horn, Generations United (con); Dr. Mark Adams, Dr. Peter Marsh, WSMA (pro); Ele Hamburger, Washington Citizen Action (con); Deana Knutsen (con); Janet Varon, Health Coalition for Children and Youth (con); David Allen; Linda Grant, Assn. of Alcoholism & Addiction Programs; Trent House, Association of Washington Business (pro); Robby Stern, WSLC - AFL/CIO (con); Frank Morrison, WA Podiatric Medical Association (concerns); Lucy Homans, WA State Psychological Assn. (concerns); Margaret Lane, King County Medical (pro); Karen Merrikin, Group Health (pro); Ed Denning, WA State Health Insurance Pool (pro); Scott DeNies, Pierce County Medical (pro); Mary Jo Wilcox, WA Assembly for Citizens with Disabilities (con); Molly Bordonaro, ARR (pro); Tanis Marsh, League of Women Voters of WA (con); Ann Simons, WA Association for Marriage and Family (concerns); Diane Stollenwerk, Providence Health System, Peace Health (pro); John Conniff, OIC (con); Gary Smith, Ind. Bus. Assn. (pro);

Carolyn Logue, NFIB (pro); Jim Halstrom, HCPA (pro); Pat Maddock, WA Assn. of Health Underwriters (pro); Nick Federici, WSNA, Lung Assn. (concerns).

Testimony For (Ways & Means): The bill is necessary to correct problems in the individual insurance market.

Testimony Against (Ways & Means): The bill will cause insurance rates in the individual markets to rise.

Testified (Ways & Means): Rachael Myers, Washington Citizen Action (con); Mel Sorensen, Washington Physicians Service (pro).