HOUSE BILL REPORT
2SSB 6199

As Reported By House Committee On:
Health Care

Title: An act relating to health care patient protection.

Brief Description: Adopting a patient bill of rights.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Wojahn, Winsley, Thibaudeau, Snyder, Goings, Kohl-Welles, Jacobsen, Fraser, Prentice, Costa, Rasmussen, Bauer, Spanel, McAuliffe, Gardner, Franklin and Kline).

Brief History:
Committee Activity:
Health Care: 2/17/00, 2/25/00 [DPA].

Brief Summary of Second Substitute Bill
(As Amended by House Committee)

- Carriers offering health plans (including disability insurers, health care service contractors, health maintenance organizations, and state health plans) must comply with requirements regarding the privacy of an enrollee's health records; the disclosure of information about health plans to enrollees; access of enrollees to participating health providers of their choice, including specialists; and timely review of health care disputes through a grievance process.

- The Insurance Commissioner is required to establish a system for the review through an independent review organization of carrier decisions that deny, modify, reduce or terminate an enrollee's benefit coverage or payment. The Department of Health is required to certify qualified and impartial independent review organizations.

- An enrollee may bring a civil action against a carrier for damages for substantial harm proximately caused by its health care treatment under accepted standards of medical care. No enrollee may sue a carrier without first seeking redress through independent review.

HOUSE COMMITTEE ON HEALTH CARE

Majority Report: Do pass as amended. Signed by 10 members: Representatives Cody, Democratic Co-Chair; Parlette, Republican Co-Chair; Pflug, Republican Vice Chair; Schual-Berke, Democratic Vice Chair; Campbell; Conway; Edmonds; Edwards; Pennington and Ruderman.

Minority Report: Without recommendation. Signed by 2 members: Representatives Alexander and Mulliken.

Staff: John Welsh (786-7133).

Background:

Health carriers include disability insurers, health care service contractors, and health maintenance organizations. Carriers are regulated by the Insurance Commissioner and must meet statutory requirements regarding benefits, information disclosure, and emergency care among other standards required by law.

Managed care has emerged as the most prevalent method of delivering health care services today, with an estimated 75 percent of insured individuals relying on some form of managed care. The growth of managed care plans is a response to the rising costs of health care, with health insurers offering employers a variety of health plans to control the delivery of health care services more prudently. Competition among plans in the health market place is intense. Increased pressures on carriers to contain rising costs is worsening brought on by a growing aging population, new expensive technology, higher prices for new prescription drugs, as well as general health inflation. The cost conscious practices of some managed care plans have prompted concerns about the ability of consumers to make informed decisions and receive appropriate health care services.

Summary of Amended Bill:

The bill addresses a number of subjects regarding the structure and operations of health carriers in providing protections for enrollees of health plans, and is known as the Health Care Patient Bill of Rights.

There is a declaration of legislative intent to assure that enrollees have improved access to information about their health care and sufficient and timely access to appropriate services; that decisions are made by appropriate medical personnel; that enrollees have a quick and impartial process for appealing plan decisions; and that enrollees are protected from unnecessary invasions of privacy.

HEALTH INFORMATION PRIVACY

Carriers as third-party payers cannot disclose an enrollee's health information except to the extent that health providers can under state law, and must adopt policies to protect an enrollee's right to privacy and confidentiality granted under federal and state law. The Insurance Commissioner is authorized to implement privacy requirements, considering any impact on a carrier's disease management activities.

INFORMATION DISCLOSURE

A carrier selling a plan must first provide to an enrollee the following information, though carriers and health providers need not disclose proprietary information:

- Covered benefits, including exclusions and limitations;
- Costs to consumer, i.e., premiums, copayments, and deductibles;
- Policy on confidentiality of patient health information;
- Grievance process;
- List of participating providers and network arrangements;
- Procedure for referral to specialists;
- Description of payments for health care providers;
- Any accreditation status.

Carriers which provide services that prevent illness and promote health must provide all clinical preventive health services provided by the Basic Health Plan and monitor and report annually to enrollees on standards of consumer satisfaction.

No carrier may preclude its providers from informing patients of the care required, whether or not the care is covered; nor preclude providers from advocating for the patient; nor preclude discussions with patients on the comparative merits of different carriers.

ACCESS TO APPROPRIATE HEALTH SERVICES

Enrollees must be assured of an adequate choice among qualified health care providers. Carriers must allow an enrollee to choose a primary health care provider from a list of participating providers and allow enrollees to change providers. Enrollees must also have direct access to covered chiropractic care, though carriers are not precluded from utilizing managed care and cost containment processes. Enrollees with complex or serious conditions may receive a standing referral to a specialist. Carriers must provide appropriate and timely referrals of enrollees to a choice of specialists within the plan, or otherwise nonparticipating specialists. Carriers must provide for second opinions on request.

HEALTH CARE DECISIONS

Carriers offering health plans must maintain a documented utilization review program description and criteria based on reasonable medical evidence, including a method for updating the criteria. However, carriers reviewing religious non-medical treatment are not required to use medical standards. Carriers must also make available to requesting providers clinical protocols, medical management standards, and other review criteria. The Insurance Commissioner must adopt standards by rule after considering relevant national and state agency standards.

Carriers offering health plans may not retrospectively deny coverage for emergency and nonemergency care previously authorized, and the commissioner shall adopt standards by rule.

GRIEVANCE PROCESS

Carriers offering health plans must have a fully operational, comprehensive grievance process that complies with rules adopted by the commissioner. The commissioner must consider relevant national and state standards in adopting rules. The grievance process shall include:

- Implementation of procedures for registering and responding to complaints in a timely manner; and

- Written notification to enrollees and their providers of a carrier's decision to deny, modify, reduce, or terminate payment or coverage of a health service. The carrier must process an enrollee's appeal to reconsider its decision; must assist an enrollee in the process; must make a decision within 30 days; and must provide notice of its resolution of the complaint, including supporting clinical reasons, and any appropriate alternative health services, as well as information on how to obtain a second opinion, and continue the denied service.

Carriers must continue to provide denied services pending the reconsideration process, but the enrollee may be responsible for the cost of the service if the decision is affirmed. Carriers must also provide an explanation of the grievance process upon the request of an enrollee, upon enrollment of new enrollees, and annually to all enrollees, as well as track complaints, and maintain a log of all grievances for three years, and identify trends.

INDEPENDENT REVIEW OF HEALTH CARE DISPUTES

There is a declared need for the fair consideration of consumer complaints relating to decisions to deny, modify, reduce, or terminate coverage or payment for health care.

The commissioner must adopt by rule a process by which a person may seek a review of a carrier's decision by an independent review organization, after the carrier has

completed its grievance procedures, or where the carrier has exceeded the timelines for grievance resolution without cause and without reaching a decision. The independent review organization can also review decisions affecting interpretations of the health plan contract. Contract language on medical standards can be overridden if it is unreasonable or inconsistent with good medical practice.

The Insurance Commissioner by rule must establish a rotational registry system for the assignment of independent review organizations, flexible enough to ensure the availability of medical expertise. Independent review is not intended to override health plan contract provisions. Determinations must be based on expert medical judgment. Determinations must be made at least 20 days after receiving the request for review, or no less than eight days if the enrollee's health is seriously jeopardized. Carriers must continue to provide a denied health service pending the review, and pay the costs of an independent review. The requirements for independent review are not applicable to programs with existing independent review requirements.

INDEPENDENT REVIEW ORGANIZATIONS

The Department of Health must provide for a procedure for certifying independent review organizations by rule. Such organizations must utilize providers with demonstrated expertise and experience and meet reasonable requirements of the Department of Health. The rules must ensure the confidentiality of medical records, the qualifications and independence of reviewers, and a quality assurance mechanism.

Decisions of independent review organizations must be made not later than 15 days after receipt of review information, or 20 days after receipt of the request for a determination, whichever is sooner. In cases of serious jeopardy to an enrollee's health or maximum function, the decision must be made within 72 hours after the receipt of review information, or within eight days of the request for determination, whichever is earlier.

Independent review organizations must be certified by the department by submitting required information on its ownership, relationships, and the procedure used for conducting reviews. The department may accept national or equivalent accreditation or certification in certifying the organization. The rules must provide for termination of certification for cause. Independent review organizations may not be owned or controlled by carriers and they are immune from civil liability, except for acts made in bad faith or involving gross negligence.

CARRIER MEDICAL DIRECTOR

A carrier offering health plans, including the state Department of Labor and Industries, the Secretary of Social and Health Services for the Medical Assistance

Program, and the state Health Care Authority, must designate a medical director who is licensed as a physician or osteopathic physician.

CARRIER LIABILITY

Carriers must adhere to accepted standards of care provided by health care providers when arranging for medically necessary health care services to its enrollees. A carrier for a health plan is liable for damages for harm to an enrollee proximately caused by its health care treatment decisions. However there is no liability imposed on health care providers or facilities liable for malpractice under other provisions of state law, nor employers who purchase health care coverage for their employees, nor governmental agencies that purchases coverage for individuals and families.

No person may sue a carrier until the enrollee has suffered substantial harm and first sought independent review of the health care decision. Substantial harm includes loss of life or significant impairment or disfigurement, and severe or chronic pain. However, an enrollee may pursue other appropriate remedies, including injunctive relief or a declaratory judgment, if the enrollee's health is in serious jeopardy. Actions must be commenced within three years of the completion of the independent review process.

Carriers are accountable to their enrollees for activities delegated to their subcontractors, and such contracts may not relieve carriers of liability.

APPLICATION TO STATE PROGRAMS

The requirements of this law apply to carriers offering health plans, the managed care portion of the state Medical Assistance Program, the Basic Health Plan offered by the state Health Care Authority, and to plans offered through the state Public Employees' Benefits Board, including the Uniform Medical Plan.

EFFECTIVE DATES

This act applies to health plans offered, renewed, or issued after June 30, 2001. However, the requirements for designating medical directors take effect July 1, 2001. The bill is null and void unless funding is provided in the budget by June 30, 2000.

REPEALERS

Duplicate statutory sections are repealed.

Amended Bill Compared to Second Substitute Bill: The language in the Senate bill is substituted for the language in SHB 2331 as it passed the House. The House language is generally similar. However there are new provisions relating to privacy;

direct access to chiropractic care; accommodations to Christian Science; new standards for the grievance process; and a change in the definition of substantial harm to exclude mental impairment. Other amendments were adopted that included the specific contract terms between health providers and carriers as protected proprietary information excluded from disclosure, and removed the duty of carriers to recommend alternative care. The carrier's obligation to continue health services pending a review is limited to covered services. Independent reviews once begun must be completed unless both parties agree otherwise. The department's role in certifying independent review organizations is clarified, and an effective date of a repealed disclosure law is made consistent with the new disclosure provisions.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill contains several effective dates. Please refer to the bill. However, the bill is null and void unless funded in the budget.

Testimony For: The language in the House version is preferable in regards to privacy, disclosure, access to care other than chiropractic, the grievance process, and independent review. The requirement for independent review solves 99.9 percent of the problems, and will contain the number of malpractice suits, as reported in Texas, reducing malpractice rates. Promptness of settling disputes over care through independent review will not place patients in jeopardy.

(Concerns) The Senate language on liability and the ability to sue is preferable, limited to when an enrollee prevails in independent review. The House version will increase premiums and health care costs more by encouraging lawsuits.

Testimony Against: None.

Testified: (In support) Senator Thibaudeau, prime sponsor; Susie Tracy, Washington State Medical Association; Larry Shannon, Washington State Trial Lawyers Association; Barbara Flye, Washington Citizen Action; Andrea Stephenson, The Empower Alliance; Steve Wehrly, Washington State Chiropractors; Cliff Armstrong, Christian Science Churches; and David Allen, American Cancer Society.

(Concerns) Trent House, Association of Washington Health Plans; Ken Bertrand, Group Health Cooperative; Basil Badley, Health Insurance Association of America; Nancee Wildermuth, Regence/Pacificare; Rick Wickman, Premera Blue Cross; and Ken Johnson, Association of Washington Business.