ANALYSIS OF HOUSE BILL 2331

Adopting a patient bill of rights.

SPONSORS: Representatives Campbell and Schual-Berke.

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 entities are organizations that deliver, administer and assume the risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization and costs of health services provided to an enrolled population.

Managed care has emerged as the most prevalent method of delivering health care services today, with an estimated 75% 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: The bill addresses a number of subjects regarding the structure and operations of health carriers.

There is a declaration of legislative intent to assure that patients 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, and patients have a quick and impartial process for appealing plan decisions; and that patients are protected from unnecessary invasions of privacy.

PRIVACY

Each carrier must develop and implement policies and procedures governing the collection, use and disclosure of health information, including methods for patients to access information about themselves and correct inaccurate information, carrier oversight and information policies. Carriers are prohibited from the unauthorized disclosure of a patient's health information, except for bona fide research purposes defined by federal law. The insurance commission is authorized to implement this section by rule and enforce existing

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state laws relating to privacy applicable to carriers.

INFORMATION DISCLOSURE

A carrier selling a plan must first provide to an enrollee the following 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;

Carriers which provide services that prevent illness and promote health must provide all clinical preventive health services provided by the Basis Health Plan; monitor and report annually to enrollees on standards of consumer satisfaction; have a partnership certificate with the Department of Health or local health jurisdiction; and make available an integrated illness prevention plan.

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 have a process for authorizing the use of a medical specialist as a primary care provider for enrollees with special needs. Carriers must provide appropriate and timely referrals of enrollees to 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. 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 shall consider relevant national and state standards in adopting rules. The grievance process shall include:

*Written notification to enrollees and their providers of a carrier's decision to modify, discontinue, or deny

a health service. The notice shall include the clinical reasons, any appropriate alternative health services, as well as information on how to obtain a second opinion, and continue the denied service;
*The requirement to process as a grievance an enrollee's complaint about the quality or availability of a health service, or other complaints unresolved within established response timelines, and any request to reconsider the decision.

Carriers must process a grievance upon receipt; assist enrollees in the process; expedite a grievance seriously jeopardizing an enrollee's health or ability to regain maximum function; investigate and resolve the grievance; and notify the enrollee of the resolution.

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 provide an explanation of the grievance process upon the request of an enrollee, upon enrollment of new enrollees, and annually to all enrollees.

Carriers must track complaints, and maintain a log of all grievances for three years, and identify trends.

No penalties may be imposed on a provider until a grievance has been adjudicated.

INDEPENDENT REVIEW OF HEALTH CARE DISPUTES

There is a declared need for the fair consideration of consumer complaints relating to decisions to modify, discontinue or deny 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 unfavorable 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. Reviewers must make determinations on health care items and services for an enrollee, and carriers must comply with independent review determinations and pay for the reviews.

INDEPENDENT REVIEW ORGANIZATIONS

The Commissioner must provide for a procedure for certifying with independent review organizations by rule, taking into consideration national and state agency standards. Such organizations must utilize providers with demonstrated expertise and experience; be advised by a consumer advisory board; and meet reasonable requirements of the Department of Health.

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 annually by the department by applying, and submitting required information on its ownership, relationships, and the procedure used for conducting reviews.

Independent review organizations may not be owned or controlled by carriers. They are immune from civil liability, except for acts made in bad faith or involving gross negligence.

CARRIER MEDICAL DIRECTOR

Carriers offering health plans, as well as health plans under state jurisdiction including the Department of Labor and Industries and the Health Care Authority, must designate a medical director who is licensed as a physician or osteopathic physician. Naturopathic plans may have a medical director who is a licensed naturopath.

CARRIER LIABILITY

Carriers and managed care entities 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 or managed care entity 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 employers who purchase health care coverage for their employees, nor a governmental agency that purchases coverage for individuals and families.

No person may sue a carrier or managed care entity until the enrollee has first sought independent review of the health care decision, except (1)where the harm has already occurred caused by their conduct, or for any act or omission caused by their agents or representatives, and (2) the review would not be beneficial to the enrollee. 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.

EFFECTIVE DATES

This act applies to health plans offered, renewed, or issued by carriers; Medical Assistance provided by the Department of Social and Health Services; services under the Basic Health Plan offered by the State Health Authority; and Public Employees Health Benefits. It also applies to contracts renewed after June 30, 2001.

The provisions of carrier liability take effect July 1, 2001.

REPEALERS

Duplicate statutory sections are repealed.