SENATE BILL REPORT

ESSB 5587

As Passed Senate, March 11, 1999

Title: An act relating to health care patient protection.

Brief Description: Adopting a patient bill of rights.

Sponsors: Senate Committee on Health & Long-Term Care (originally sponsored by Senators Wojahn, Snyder, Thibaudeau, Fairley, Costa, Winsley, Prentice, McAuliffe, Kohl-Welles, Brown, Shin, Rasmussen and Franklin).

Brief History:
Committee Activity: Health & Long-Term Care: 2/11/99, 3/1/99 [DPS, DNP-WM].
Ways & Means: 3/5/99, 3/8/99 [DPS (HEA), DNPS].
Passed Senate, 3/11/99, 29-17.
First Special Session: Failed Senate, 5/19/99, 24-19.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5587 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.
Signed by Senators Thibaudeau, Chair; Wojahn, Vice Chair; Costa, Franklin and Winsley.

Minority Report: Do not pass.
Signed by Senators Deccio and Johnson.

Staff: Jonathan Seib (786-7427)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Substitute Senate Bill No. 5587 as recommended by Committee on Health & Long-Term Care be substituted therefor, and the substitute bill do pass.
Signed by Senators Loveland, Chair; Bauer, Vice Chair; Brown, Vice Chair; Fairley, Fraser, Kline, Kohl-Welles, Rasmussen, B. Sheldon, Snyder, Spanel, Thibaudeau, Winsley and Wojahn.

Minority Report: Do not pass substitute.
Signed by Senators Honeyford and West.

Staff: Tim Yowell (786-7435)

Background: "Health carriers" include disability insurers, health care service contractors, and health maintenance organizations. Current law imposes obligations on carriers regarding, among other things, required benefits, information disclosure, emergency care,

and gag rules. As managed care emerges as the prevalent method of delivering health care services, concern exists that current requirements are insufficient to allow consumers to make informed decisions and to receive adequate health care treatment.

Summary of Bill: Several requirements are established regarding the structure and operation of health plans by health carriers:

Each health carrier must develop and implement policies and procedures as set forth in the bill governing the collection, use, and disclosure of health information. Except as otherwise required, a health carrier is prohibited from disclosing personally identifiable health information unless authorized in writing by the person who is the subject of the information. The Insurance Commissioner must adopt rules to implement these requirements.

A listing of covered benefits, including any prescription benefits must be disclosed prior to purchase of any health plan. This disclosure must include any exclusion, limitation, or reduction in coverage, as well as any coverage criteria which may be applied when determining what is a covered service. Other items which must be disclosed prior to purchase are the carrier's policies to protect confidentiality, premium and other enrollee costs, a summary of grievance procedures, an explanation of a point-of-service option, and a convenient means of obtaining a list of participating providers.

Additional enumerated information describing the plan and its operations must be made available upon the request of a prospective enrollee or a current enrollee.

No carrier may present a plan to the public as a plan that prevents illness and promotes health unless it regularly tracks and reports to enrollees and others regarding certain indicators of health status and patient satisfaction. In addition, such plans must provide the same set of clinical prevention services provided through the Basic Health Plan, have a certificate of partnership with a public health agency regarding community-wide health education, and make available its strategy for managing the most prevalent diseases within its enrolled population.

No health carrier may preclude or discourage its providers from informing patients of the care he or she requires, nor penalize a provider for advocating on behalf of a patient with a health carrier. No health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers.

Each health carrier must have a fully operational, comprehensive grievance process which meets standards established by the Insurance Commissioner after consideration of national standards. Among other issues, enrollees' complaints about the quality or availability of a health service must be processed as a grievance consistent with the rules of the Insurance Commissioner. The process must be prompt, fair and impartial, providing timely notice of its results to the enrollee together with notice of other options for alternative treatment, further appeal, or independent third party review.

Carriers must supply regular reports on enrollee grievances and their resolution to the Insurance Commissioner.

Each health carrier must develop a process under which an enrollee whose health coverage has been denied may seek an independent, third party review. The results of this review are binding on the carrier. The Insurance Commissioner must adopt rules for the certification, selection, and operation of independent organizations to perform these reviews. The commissioner must designate organizations meeting these standards, charge health carriers fees as needed to fund these organizations, and provide ongoing oversight of them. A rotational registry system must be used to assign an organization to each appeal.

Current statutes prohibiting carriers from precluding or discouraging providers from informing patients about their care, imposing disclosure requirements, and regarding the preparation of documents that compare health carriers are repealed.

The bill applies to all health plans issued or renewed after December 31, 1999.

Appropriation: None.

Fiscal Note: Requested on March 4, 1999.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Testimony For (Health & Long-Term Care): People are tired of being abused by health plans and outraged by a health care system that puts business ahead of patients. The pendulum has swung too far in favor of the companies. An independent review process is important to avoid conflict of interest. Insurance companies create red tape making it difficult to access needed health care. This is the issue that the Insurance Commissioner hears about more than any other « patients who have coverage but cannot get treatment. It is not fair that consumers pay for services and have the problems with health care coverage that they have.

Testimony Against (Health & Long-Term Care): This bill increases the regulation of health care where there is no clear problem demonstrated and where such regulation will serve only to increase costs and not appreciably improve the quality of health care or insurance. The bill addresses areas that are already addressed by insurers in a satisfactory fashion. Review will not be independent to the extent that the Insurance Commissioner is able to establish the panel and process. The bill is redundant, vague, and inconsistent and would substantially increase health care costs.

Testified (Health & Long-Term Care): PRO: Deanna Knulsen, Shelly Sundstrom, Washington Citizen Action; Bruce Reeves, Senior Citizens Lobby; James Ellison; Sara Flemming, Washington Association of Churches; Steve Rea; Faye Wilson; Deborah Senn, Insurance Commissioner; Victoria Doyle; Mary Lou Pearson; Randi Abrams, Jewish Federation; Melanie Stewart, Washington State Podiatric Association, Washington State Mental Health Counselors, American Massage Therapists, Washington Chapter; CON: Debbie Ward, Group Health; Jeff Robertson, Bonnie Suminski, Regence Blue Shield; Ken Johnson, Association of Washington Business; Cliff Webster, Pharmaceutical Research and Manufacturers of America.

Testimony For (Ways & Means): Consumers have the right to know what is covered and what is not. The Lewin Group consulting firm estimates that external, independent reviews would cost only 0.3 cents to 7 cents per person per month.

Testimony Against (Ways & Means): There are 17 counties in the state where no individual insurance plans are available for people to purchase, so a patient bill of rights would do them no good. The bill doesn't specifically apply to state-purchased plans, since they are exempt from the insurance code. This legislation would further increase insurance premiums, which are already increasing dramatically.

Testified (Ways & Means): PRO: Sherry Appleton, Washington Citizen Action; Betty Jankus, WA Senior Citizens Lobby; CON: Mel Sorensen, Washington Physician Service; Gary Smith, Independent Business Association; Basil Badley, Health Insurance Association of America; Ken Johnson, Association of Washington Business; Carolyn Logue, National Federation of Independent Business.