FINAL BILL REPORT

2SSB 6199

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Synopsis as Enacted

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).

Senate Committee on Health & Long-Term Care
Senate Committee on Ways & Means
House Committee on Health Care

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: Numerous requirements are established regarding the structure and operation of health plans by health carriers.

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.

Upon request prior to selling any health plan, a carrier must provide the potential purchaser certain enumerated information. Among other things, this must include a listing of covered benefits, any coverage exclusions or limitations, and any coverage criteria which may be applied when determining what is a covered service.

Additional enumerated information describing the plan and its operations must be provided upon the request of any person at any time.

No carrier may advertise or market a plan to the public as a plan that prevents illness and promotes health unless it meets certain criteria set forth in the bill, including providing the same set of clinical prevention services provided through the Basic Health Plan. It must also make available its strategy for managing the most prevalent diseases within its enrolled population.

A carrier may not prevent its providers from informing a patient of the care he or she requires, nor penalize a provider for advocating on behalf of a patient with a carrier. No carrier may preclude or discourage patients from discussing the comparative merits of different health carriers with their providers.

A carrier must provide enrollees with an adequate choice among qualified providers, must have a process under which an enrollee whose medical condition warrants it can have a standing referral to a medical specialist, and must allow enrollees to obtain a second opinion on diagnosis or treatment.

Enrollees must also have direct access to covered chiropractic care, although carriers are not precluded from utilizing managed care and cost containment techniques and processes.

If a carrier terminates a provider contract without cause, a patient may continue seeing that provider for the longer of 60 days or, in group plans with an open enrollment period, until the end of the next open enrollment.

Carriers 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.

A carrier must have a fully operational, comprehensive grievance process which meets standards established by the Insurance Commissioner. Among other issues, enrollees' complaints about the quality or availability of a health service must be processed as a grievance. The process must be prompt, fair and impartial, providing timely notice of its results to the enrollee together with notice of the right to independent third party review.

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

An enrollee may seek review by a certified independent review organization of a carrier's decision to deny, reduce or terminate payment for a health care service. The results of this review are binding on the carrier. The Department of Health must adopt rules for the certification of independent organizations to perform these reviews. A rotational registry system must be used to assign an organization to each review.

Each carrier must designate a medical director who is a licensed physician in Washington State.

A health carrier is liable for any harm caused by its negligent denial or delay of a medically necessary health care service to an enrollee. However, an enrollee may not sue a carrier unless he or she has suffered substantial harm, and first sought review of the carrier's decision to deny or delay coverage from an independent review organization.

The act applies to health plans of carriers, the managed care portion of the state's medical assistance programs, the Basic Health Plan, and state employee health benefits, including the Uniform Medical Plan. It applies to all health plans offered or renewed after June 30, 2001.

Duplicate statutory sections are repealed.

Votes on Final Passage:

Senate	48	1	
House	98	0	(House amended)
Senate	45	1	(Senate concurred)

Effective: June 8, 2000
January 1, 2001 (Sections 13-16)
July 1, 2001 (Section 29)