SENATE BILL REPORT

2SSB 6199

As Passed Senate, January 26, 2000

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 & Long-Term Care: 1/12/2000, 1/19/2000 [DPS-WM].
Ways & Means: 1/24/2000, 1/25/2000 [DP2S].
Passed Senate, 1/26/2000, 48-1.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 6199 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, Deccio, Franklin, Johnson and Winsley.

Staff: Jonathan Seib (786-7427)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 6199 be substituted therefor, and the second 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.

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 implement policies and procedures 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.

Prior to selling any health plan, a carrier must provide the potential purchaser certain enumerated information upon request. 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 present 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 have a 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.

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 medical specialist as a primary care provider, and must allow enrollees to obtain a second opinion on diagnosis or treatment.

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.

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 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 claim has been denied may seek an independent, third party review. The results of this review are binding on the carrier. The Department of Health must adopt rules for the certification and operation 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 or appropriate covered service, as determined by the independent review.

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 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.

The bill applies to all health plans renewed after June 30, 2001.

Appropriation: None.

Fiscal Note: Available.

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. Medical necessity decisions should be made by doctors. 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): While there is support for a patient bill of rights, the provisions of this bill are too broad and vague. It is important to balance the obligations imposed by the bill against the costs that they will generate. Any increase in costs means a corresponding decrease in those who can afford coverage. The bill should be written to accomplish its purpose in the least costly way.

Testified (Health & Long-Term Care): PRO: Deborah Senn, Insurance Commissioner; Kenneth Gutman; Kathy Ferguson, WA Citizen Action; Glen Stream, M.A., WA Academy of Family Physicians; Barbara Flye, Citizen Action; Tanis Marsh, League of Women Voters; Andrea Stephenson, The Empower Alliance; Jim Hoye; Debbie Ward, Group Health Cooperative; Margaret Hernandez; Mike Fleming; Larry Shannon, WSTLA; Trent House, Margaret Stanley, Yori Milo, Nancy Fisher, Assn. of WA Healthcare Plans and Member Plans; Lisa Thatcher, WSHA.

Testimony For (Ways & Means): Some national groups, such as the Kaiser Family Foundation and the Lewin Group, have estimated that relatively small increases will result from such legislation. Texas enacted a right to sue law three years ago and only five lawsuits have been filed, so the concerns about high liability costs are unfounded.

Testimony With Concerns (Ways & Means): Some highly reputable actuarial firms have estimated cost impacts of 2 to 8 percent, far higher than reflected in the state agency fiscal rates. Based on actuarial studies, each 1 percent increase in premiums results in 8,400 more Washingtonians becoming uninsured; in $55 million of increased premium costs for Washington employers; and in $7.1 million of increased premium-sharing for Washington workers. Some of the provisions, particularly carrier liability, don't add enough value to warrant the cost. Group Health believes that the requirement to mail the prescribed information to all prospective enrollees will increase its costs by $1 million per year.

Testified (Ways & Means): Sherry Appleton; WA Citizen Action; Trent Howe, Association of WA Health Plans; Karen Merrikin, Group Health Cooperative; Irene Robbins, WA Senior Lobby; Bob First, AARP.

House Amendment(s): The House adopted a striking amendment containing the following provisions:

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.

The bill is null and void unless funding is provided in the budget by June 30, 2000.