SENATE BILL REPORT

SB 6199

As Reported By Senate Committee On:
Health & Long-Term Care, January 19, 2000
Ways & Means, January 25, 2000

Title: An act relating to health care patient protection.

Brief Description: Adopting a patient bill of rights.

Sponsors: 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].

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 Second Substitute 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.

Second Substitute Bill Compared to Substitute Bill: Like the original bill, but unlike the substitute bill, the second substitute bill applies to Medicaid managed care, rather than to all Medicaid services.

Like the original bill, but unlike the substitute bill, the second substitute requires carriers to provide information only upon request.

The second substitute bill makes carriers liable for damages only in those cases in which the independent review determines that the carrier has delayed or denied a medically necessary or appropriate, covered service.

Substitute Bill Compared to Original Bill: Unlike the original, the substitute bill applies to all Medicaid enrollees, not just those enrolled in Medicaid managed care.

The substitute bill requires carriers to automatically disclose certain information to potential enrollees, removing the requirement that the information be explicitly requested before it is provided. It also requires a carrier to disclose information regarding its utilization review criteria to persons upon request, and protects provider's proprietary information from disclosure.

The substitute bill removes the requirement that a carrier's provider network "substantially share the varied characteristics of the enrolled population."

In the substitute bill, the requirement that the independent review organization base its determination, among other things, on "standards of practice in the relevant community" is removed. It is also clarified that the independent review process is not intended to override health plan contracts.

The original bill generally requires that a person utilize the independent third party review process prior to pursuing their right to sue, with certain specified exceptions. The substitute bill removes some of these exceptions, and requires that once requested, the independent review process be completed.

Various clarifying and technical changes are made.

Appropriation: None.

Fiscal Note: Available on bill as introduced. Requested on substitute bill January 21, 2000.

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.