SENATE BILL REPORT
SB 5607

As Reported By Senate Committee On:
Health & Long-Term Care, February 28, 2005

Title: An act relating to health care grievance and appeal processes.

Brief Description: Regulating health care grievance and appeal processes.

Sponsors: Senators Deccio and Keiser; by request of Insurance Commissioner.

Brief History:
Committee Activity: Health & Long-Term Care: 2/16/05, 2/28/05 [DPS, w/oRec].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5607 be substituted therefor, and the substitute bill do pass.
Signed by Senators Keiser, Chair; Thibaudeau, Vice Chair; Benson, Franklin, Kastama, Kline and Poulsen.

Minority Report: That it be referred without recommendation.
Signed by Senators Brandland, Johnson and Parlette.

Staff: Jonathan Seib (786-7427)

Background: The state "Patient Bill of Rights" (PBOR) passed in 2000 requires each carrier that offers a health plan to have a fully operational, comprehensive grievance process that allows an enrollee to appeal decisions regarding customer service complaints or benefit denials. The statute and its accompanying administrative rules set forth the process and time lines governing such appeals. The PBOR applies to state regulated individual and group plans, Medicaid managed care plans, the Basic Health Plan, and plans of the Public Employees Benefits Board.

Many of the plans to which the PBOR applies are also subject to federal laws and private accreditation standards. In particular, federal regulations adopted by the Department of Labor pursuant to the Employee Retirement Income Security Act (ERISA), and effective in 2002, set forth requirements regarding claims and appeal procedures applicable to most employer-based health plans, both fully insured and self-insured. The Federal Balanced Budget Act also addresses these issues with regard to Medicaid managed care plans.

There is concern that the different standards governing the claims and appeal process may be confusing to consumers, and present an undue administrative burden on health carriers.

Summary of Substitute Bill: The grievance and appeals process for state purchased and state regulated health plans is clarified and made more consistent with the standards established under ERISA. Among other things, the bill:

- makes a distinction between an "adverse determination," which relates to a benefit denial, and a "grievance," which relates to a customer service concern, and establishes a separate appeal process and time line for each;
- establishes distinct time lines for appeal of different types of claims, based on the nature of the claim, its urgency, and the extent to which receipt of services is dependent on resolution of the claim;
- maintains and clarifies the provisions of current law which require a carrier to provide notice and explanation of the appeal process to its enrollees, and explanation of its decisions with regard to any particular appeal;
- maintains and clarifies the provisions of current law with regard to the mechanics of the appeal process, including enrollee assistance, and access to information considered by the carrier in making its determination;
- maintains the right of an enrollee to request an independent review of a carrier's decisions regarding an adverse determination; the independent review process is not applied to a grievance;
- establishes standards for the electronic communication of information between an enrollee and a carrier regarding the appeal of an adverse determination or grievance; and
- clarifies that for purposes of the Basic Health Plan and the Uniform Benefit Plan, the administrator of the Health Care Authority, rather than the Insurance Commissioner, must adopt administrative rules implementing appeal process.

The bill applies to contracts issues or renewed on or after January 1, 2006.

Substitute Bill Compared to Original Bill: The substitute bill: removes the exemption of Medicaid managed care plans from appeal process; adds "modification" of benefits as an item which may be appealed as an adverse determination and clarifies that the examples given of an adverse determination are not exclusive; requires a carrier to include in its notice of an adverse determination information regarding an enrollee's right to a second opinion; and explicitly requires a carrier to assist an enrollee in the appeal process.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

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

Testimony For: This bill is the product of a discussion initiated by the Commissioner regarding how the state can reduce administrative burdens in the health care system. It will simplify the grievance process for consumers, state agencies and carriers, while maintaining and even strengthening the protections included in the patient bill of rights. The bill was a year in development and is the result of many hours of work. It will free up precious health care dollars by removing duplications and differences between various regulatory systems that do not matter. The bill will lay the foundation for future cooperative efforts. It is especially important to any carrier that continues work in multiple lines of business that are currently regulated differently.

Testimony Against: This bill would be a diminution of consumer rights. The purpose of the patient bill of rights was to strengthen the process available to a consumer to question

decisions his or her health plan. The bill would eliminate the independent review process for medicaid managed care clients, leaving these people with a fair hearing process that is not geared to quick medical decision-making. The independent review process has a medical reviewer component which would also would be lost. The bill would permit health plans to add another layer of internal review which could reduce access to the independent review process. It would also eliminate some notice requirements. Consumers were not represented at the table when the bill was developed. The legislature also should not ignore administrative cost imposed on the health care system by others, including health carriers.

Who Testified: PRO: Mary Clogston, Office of the Insurance Commissioner; Sydney Zvara, Association of Washington Healthcare Plans; Ken Bertrand, Group Health.

CON: Janet Varon, Northwest Health Law Advocates; Bill Daley, Washington Citizen Action. OTHER: Dennis Martin, Washington Health Care Authority.