

SENATE BILL REPORT

SSB 6584

As Passed Senate, February 16, 2010

Title: An act relating to monitoring customer complaints and appeals and reporting them to the legislature.

Brief Description: Monitoring and reporting customer complaints and appeals to the state health care authority.

Sponsors: Senate Committee on Health & Long-Term Care (originally sponsored by Senators Fraser, Swecker, Keiser, Schoesler, Roach, McDermott and Shin).

Brief History:

Committee Activity: Health & Long-Term Care: 1/28/10, 2/01/10 [DPS].

Passed Senate: 2/16/10, 46-0.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 6584 be substituted therefor, and the substitute bill do pass.

Signed by Senators Keiser, Chair; Franklin, Vice Chair; Pflug, Ranking Minority Member; Becker, Fairley, Marr, Murray and Parlette.

Staff: Mich'l Needham (786-7442)

Background: The Office of the Insurance Commissioner (OIC) licenses and regulates insurance carriers offering products in Washington. Insurance laws govern these licensed carriers or health plans, but do not govern self-insured plans offered by employers, consistent with federal ERISA law. The state Health Care Authority (HCA) and Public Employees Benefits Board (PEBB) program contract with licensed health plans and self-insure. Special provisions have been provided that subject the state's self-insured plans to many of the insurance laws for licensed health plans.

All health plans offered to state employees and retirees through the PEBB program are required in current law to follow the insurance laws known as the Patient Bill of Rights. This includes such areas as privacy rights, requirements for carriers to disclose information, access to health services, utilization review, prohibition of the retrospective denial of coverage, a grievance process, and independent review of disputes. Each health plan is required to establish and manage a grievance and appeals process. In addition, each health plan is

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required to track appeals and keep a log for three years that must be made available to the Insurance Commissioner, and each plan must identify and evaluate any trends in appeals.

Other licensed insurance providers are subject to the insurance fair conduct act which sets up standards for unfair competition, advertising, denial of claims, and access to the superior court for review of an unreasonable denial of claim to recover actual damages. This does not apply to licensed health plans.

Summary of Substitute Bill: Beginning in 2011, the HCA must capture customer service complaints and require each health plan that provides PEBB medical coverage to submit a summary of customer service complaints and appeals to the agency. The HCA must summarize the complaints and appeals processed in the preceding 12 months and report to the Legislature with an analysis of any trends by September 30 of each year.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

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

Staff Summary of Public Testimony on Original Bill: PRO: A lot of PEBB retirees are dissatisfied with the resolution of complaints about their coverage. It is unclear if their complaints about health plans ever get shared with the HCA. It is difficult to get clear information and it is difficult to register complaints. The appeal process is too difficult for retirees. Having OIC review customer service complaints gathered by HCA would improve the accountability and visibility so we know how large a problem there is, and what the specific issues are. The retirees would really like an ombudsman to help them navigate their concerns, but they are not pursuing that approach during this budget crisis.

Persons Testifying: PRO: Senator Fraser, prime sponsor; Cassandra de la Rosa, Retired Public Employees Council; Leslie Main, Washington State School Retirees.