FINAL BILL REPORT
SSB 6584

C 293 L 10
Synopsis as Enacted

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).

Senate Committee on Health & Long-Term Care
House Committee on Health Care & Wellness

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 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: 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.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Votes on Final Passage:

Senate	46	0
House	87	9

Effective: June 10, 2010