Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

SSB 6584

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 Summary of Substitute Bill

- Requires each health plan that provides Public Employees Benefits Board medical coverage to submit a summary of customer service complaints and appeals to the agency.
- Requires the Health Care Authority to summarize the complaints and appeals processed in the preceding 12 months and report to the Legislature by September 30 of each year.

Hearing Date: 2/19/10

Staff: Dave Knutson (786-7146).

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 does not govern self-insured plans offered by employers, consistent with federal Employee Retirement Income Security Act 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. These laws include such areas as privacy rights, requirements for carriers to disclose information, access to

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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 appellate trends.

Summary of Bill:

Beginning in 2011, the HCA must capture customer service complaints and require each health plan providing 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: Not requested.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.