HOUSE BILL REPORT
ESSB 6392

As Passed House - Amended:
March 1, 1996

Title: An act relating to disclosure by managed care entities.

Brief Description: Requiring disclosures by managed care entities.

Sponsors: Senate Committee on Health & Long-Term Care (originally sponsored by Senators Wood, Quigley, Roach, Cantu, Deccio, Prince and Moyer).

Brief History:
Committee Activity:
Health Care: 2/20/96, 2/23/96 [DPA].
Floor Activity:
Passed House - Amended: 3/1/96, 97-0.

HOUSE COMMITTEE ON HEALTH CARE

Majority Report: Do pass as amended. Signed by 7 members: Representatives Dyer, Chairman; Backlund, Vice Chairman; Hymes, Vice Chairman; Casada; Crouse; Sherstad and Skinner.

Minority Report: Do not pass. Signed by 3 members: Representatives Cody, Ranking Minority Member; Conway and Morris.

Staff: Bill Hagens (786-7131).

Background: The health care delivery system is changing rapidly. There is great interest among consumers to know which options for patient care exist when selecting health plans. Research has indicated that enrollees frequently lack information necessary to make informed choices about the health plans they select. Concern exists that many consumers are unaware of which health care services are covered in their plans and which benefits are excluded until the time that services are needed.

Summary of Bill: A health carrier is prohibited from precluding or discouraging providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service

agreement with the health carrier. This item is commonly called the "anti-gag" provision.

A health carrier may not prohibit its enrollees from freely contracting at any time to obtain any health care services outside the health care plan on any terms or conditions the enrollees choose. This item is commonly called the "opt-out" provision.

Health carriers and the Washington Health Care Authority, upon request, must provide the following information: the availability of a point-of-service plan and how the plan operates within the coverage; documents, instruments, or other information referred to in the enrollment agreement; a full description of the procedures to be followed by an enrollee for consulting a provider other than the primary care provider and whether the enrollee's primary care provider, the carrier's medical director, or another entity must authorize the referral; whether a plan provider is restricted to prescribing drugs from a plan list or plan formulary; reimbursement arrangements with providers; incentive or disincentive programs intended to encourage providers to withhold services; what drugs are on the plan list or formulary, and the extent to which enrollees will be reimbursed for drugs that are not on the plan's list or formulary; procedures, if any, which an enrollee must first follow for obtaining prior authorization for health care services; circumstances under which the plan may retrospectively deny coverage for emergency and non-emergency care that had prior authorization under the plan's written policies; a copy of all grievance procedures for claim or service denial and for dissatisfaction with care; and a list of all available disclosure items, in addition to the above.

Immunity from civil liability is granted to public or private entities that exercise due diligence in preparing a document of any kind that compares health carriers when other conditions are met.

The Office of the Insurance Commissioner (OIC) is prohibited from promulgating rules regarding the provisions of this act.

Appropriation: None.

Fiscal Note: Not requested.

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

Testimony For: Health care policies are difficult to understand. They don't disclose plan restrictions or the procedures patients need to follow to obtain care. Information on health plans is not provided prior to enrollment. It is difficult for consumers to make informed choices about the health coverage they purchase. The required disclosure should apply to all providers.

Testimony Against: Insurers are currently required to provide benefits booklets, which provide a great deal of information. Consumers can also get information about the coverage provided by health plans from employer human resources departments, insurance agents, or directly from the health plans.

Testified: Senator Jeannette Wood, prime sponsor; Diane Stollenwerk, Sisters of Providence; Linda Daley and Kathleen Slater, private citizens; Susie Tracey, Washington State Medical Association; Nick Federici, Washington State Nurses Association; David Allen, American Cancer Society; Barry Anton, clinical psychologist; Gail McGaffick, American Diabetes Association; Tim Shelberg, Association of American Physicians and Surgeons; Bruce Bishop, Kaiser Permanente; and Scott DeNies, Pierce County Medical.