SENATE BILL REPORT

SB 5803

As of February 20, 1995

Title: An act relating to patient care.

Brief Description: Enacting the quality patient care preservation act.

Sponsors: Senators Quigley and Moyer.

Brief History:

Committee Activity: Health & Long-Term Care: 2/21/95.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Rhoda Jones (786-7198)

Background: Principles in the practice of good clinical medicine have evolved over time as a result of the accumulation of scientific knowledge, training, and experience. There are concerns by some providers that with the introduction of new types of health care systems, business arrangements will change the ability of providers to make medical decisions according to these principles.

There are further concerns that as the health care marketplace changes, there may be unforeseen consequences for consumers affecting access to health care, quality of service, and choice of provider.

Summary of Bill: Physician Decision-making. Physicians are permitted, under certain circumstances, to refer patients to care outside the managed care plan in which the patient is enrolled. Whistle-blower protections are stated for physicians who criticize the practices, or standards of the plan or supervising organization.

Hospitals who hire physicians must grant them the same due process in discipline actions as are granted to physicians who are not employed by the hospital.

Hospitals can only have physicians, osteopathic physicians and dentists on the medical staff. Physicians who are required to provide emergency back-up to non-physicians with hospital privileges are not held to the same malpractice standards as they are when these back-up situations have been prearranged and entered into voluntarily.

Consumer Choice. The act requires health plans to fully disclose to consumers the terms of their arrangements in clear language including services covered, services excluded, professional qualifications of the providers in their network, and if the plan does not offer a point of service plan.

Consumers are permitted to opt out of a plan in which they are enrolled, and obtain care elsewhere at their own expense, without the plan being obligated to pay for such care.

Utilization Review and Managed Care Standards. The Insurance Commissioner is required to set up procedures for certifying managed care plans and utilization review programs. Certification requirements must include information to prospective enrollees, adequate provider panels, and provider input on all aspects of the plans' medical policies.

Plan applicants are subject to specific criteria outlined in statute.

Utilization review programs must have a medical director.

Minimum requirements for the medical review or utilization practices employed by the program are outlined.

Health Care Plans. Purchasers are required to offer all plans within their catchment area.

Any provider who is willing and able to abide by the terms and conditions of the contracts may participate in the plan when it has a market penetration level of 30 percent or more.

Any plan may provide a point of service option.

Appropriation: None.

Fiscal Note: Requested on February 8, 1995.

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