SENATE BILL REPORT

ESSB 6392

As Passed Senate, February 7, 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 & Long-Term Care: 1/26/96, 2/2/96 [DPS].
Passed Senate, 2/7/96, 47-2.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 6392 be substituted therefor, and the substitute bill do pass.

Signed by Senators Quigley, Chair; Wojahn, Vice Chair; Deccio, Fairley, Franklin, Moyer, Thibaudeau, Winsley and Wood.

Staff: Wendy Saunders (786-7439)

Background: The health care delivery system is changing rapidly. Consumers need to know which options for patient care exist when selecting health plans. Patients 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.

It has been suggested that consumers have difficulty obtaining detailed information and understanding the language used in their health care policies.

Summary of Bill: All health maintenance organizations and health care service contractors must disclose information about their health plans. The disclosure must be in concise and specific terms and must include any costs associated with the plan and information on covered benefits. The information about covered benefits must include any restrictions or limitations on coverage and services, including prescription drugs and services obtained outside the plan.

Plans must disclose whether they require providers to comply with any specified numbers or targets and whether they use incentives or penalties to encourage providers to withhold services or specialty referrals.

The disclosure must contain information on any procedures, such as prior authorization, that an enrollee must follow to obtain care. The disclosure must also state whether a point of

service option is available, the grievance procedures available to enrollees, and a roster of all primary care providers.

The required information must be provided to employers and employees prior to enrolling in the plan.

No private right or cause of action is created in this legislation.

Appropriation: None.

Fiscal Note: Requested on January 17, 1996.

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 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 form the health plans.

Testified: PRO: Dr. Michael Schlitt, Kathleen Serkes, Association of American Physicians and Surgeons; David Allen, American Cancer Society; Tracy Lin, AARP; Nick Federici, WSNA; Melanie Stewart, WA State Podiatic Medical Association, Diane Stollenwerk, Providence Health System and Peace Health; CON: Mel Sorenson, Blue Cross; Rick Wickman, BCWA.

House Amendment(s): The amended bill requires all health insurers to provide a list of available disclosure items to all enrollees or potential enrollees and to provide those disclosure items if requested. The original bill required plans to provide all disclosure items to employers for their employees, without an initial list. The amended bill exempts plans from disclosing proprietary information.

The disclosure must contain any documents referred to in the enrollment agreement and information on procedures enrollees must follow for prior authorization of health care and referrals to specialists. The disclosure must also state whether a point of service option is available, the grievance procedures available to enrollees and the use of drug lists or formularies.

Plans must disclose whether they require providers to comply with any specified numbers or targets and whether they use incentives or penalties to encourage providers to withhold services or specialty referrals. Circumstances in which a plan may make a retroactive denial of coverage for prior approved treatment must also be disclosed.

The disclosure of a roster of providers, a list of benefits and restrictions, the cost of the plan and procedures to select or change providers are no longer required.

The amended bill prohibits contracts that prevent the exchange of information between providers and enrollees or that prohibit enrollees from purchasing health care outside of the plan. It also provides immunity for authors of comparison documents based on information provided in the disclosure.

The Insurance Commissioner is prohibited from promulgating any rules in the amended bill.