HOUSE BILL REPORT
HB 2331

As Reported By House Committee On:
Health Care
Appropriations

Title: An act relating to health care patient protection.

Brief Description: Adopting a patient bill of rights.

Sponsors: Representatives Campbell, Schual-Berke, H. Sommers, Linville, Doumit, Cody, Wolfe, Conway, Quall, Eickmeyer, Morris, Gombosky, Ruderman, Edmonds, Poulsen, Dunshee, Fisher, Scott, Regala, McIntire, Kastama, Kessler, Wood, Lantz, Ogden, Santos, Edwards, O'Brien, Romero, Stensen, Cooper, Reardon, Tokuda, Veloria, Rockefeller, Lovick, Kenney, Kagi, Haigh, Miloscia, Anderson, Constantine, Dickerson, Keiser, Hurst, Murray, McDonald and D. Sommers.

Brief History:
Committee Activity:
Health Care: 1/11/00, 1/20/00, 1/28/00 [DPS];
Appropriations: 2/5/00, 2/8/00 [DP2S(w/o sub HC)].

Brief Summary of Second Substitute Bill

- Carriers offering health plans (including disability insurers, health care service contractors, health maintenance organization, and state health plans) must comply with requirements regarding the privacy of an enrollee's health records; the disclosure of information about health plans to enrollees; access of enrollees to participating health providers of their choice, including specialists; and timely review of health care disputes through a grievance process.

- The Insurance Commissioner is required to establish a system for the review through an independent review organization of carrier decisions that deny, modify, reduce, or terminate an enrollee's benefit coverage or payment. The Department of Health is required to certify qualified and impartial independent review organizations.

- Civil action may be brought against a carrier for damages for harm proximately caused by its failure to follow accepted standards of medical care when that failure results in the denial, delay or modifications of health care services provided to an enrollee. No enrollee may sue a carrier without first seeking redress through independent review, and without having suffered substantial harm.

- The provisions of the bill apply to health plans provided by the following state agencies: Department of Social and Health Services Healthy Options, the Basic Health Plan, The Public Employees' Benefits Board, and the state's self-funded Uniform Medical Plan.

HOUSE COMMITTEE ON HEALTH CARE

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 12 members: Representatives Cody, Democratic Co-Chair; Parlette, Republican Co-Chair; Pflug, Republican Vice Chair; Schual-Berke, Democratic Vice Chair; Alexander; Campbell; Conway; Edmonds; Edwards; Mulliken; Pennington and Ruderman.

Staff: John Welsh (786-7133).

Background:

Health carriers include disability insurers, health care service contractors, and health maintenance organizations. Carriers are regulated by the Insurance Commissioner

and must meet statutory requirements regarding benefits, information disclosure, and emergency care among other standards required by law.

Managed care has emerged as the most prevalent method of delivering health care services today, with an estimated 75 percent of insured individuals relying on some form of managed care. The growth of managed care plans is a response to the rising costs of health care, with health insurers offering employers a variety of health plans to control the delivery of health care services more prudently. Competition among plans in the health market place is intense. Increased pressures on carriers to contain rising costs is worsening brought on by a growing aging population, new expensive technology, higher prices for new prescription drugs, as well as general health inflation. The cost conscious practices of some managed care plans have prompted concerns about the ability of consumers to make informed decisions and receive appropriate health care services.

Summary of Substitute Bill:

The bill addresses a number of subjects regarding the structure and operations of health carriers in providing protections for enrollees of health plans, and is known as the Health Care Patient Bill of Rights.

There is a declaration of legislative intent to assure that enrollees have improved access to information about their health care and sufficient and timely access to appropriate services; that decisions are made by appropriate medical personnel, and enrollees have a quick and impartial process for appealing plan decisions; and that enrollees are protected from unnecessary invasions of privacy.

Health Information Privacy:

Carriers as third-party payers cannot disclose an enrollee's health information except to the extent that health providers can under state law, and must adopt policies to protect an enrollee's right to privacy and confidentiality granted under federal and state law.

Information Disclosure:

A carrier selling a plan must first provide to an enrollee the following information, though carriers and health providers need not disclose proprietary information:

- covered benefits, including exclusions and limitations;
- costs to consumer, i.e., premiums, copayments, and deductibles;
- policy on confidentiality of patient health information;
- grievance process;

- list of participating providers and network arrangements;
- procedure for referral to specialists;
- description of payments for health care providers; and
- any accreditation status.

Carriers which provide services that prevent illness and promote health must provide all clinical preventive health services provided by the Basic Health Plan and monitor and report annually to enrollees on standards of consumer satisfaction.

No carrier may preclude its providers from informing patients of the care required, whether or not the care is covered; nor preclude providers from advocating for the patient; nor preclude discussions with patients on the comparative merits of different carriers.

Access to Appropriate Health Services:

Enrollees must be assured of an adequate choice among qualified health care providers. Carriers must allow an enrollee to choose a primary health care provider from a list of participating providers and allow enrollees to change providers. Enrollees must also have direct access to chiropractic care. Enrollees with complex or serious conditions may receive a standing referral to a specialist. Carriers must provide appropriate and timely referrals of enrollees to a choice of specialists within the plan, or otherwise nonparticipating specialists. Carriers must provide for second opinions on request.

Health Care Decisions:

Carriers offering health plans must maintain a documented utilization review program description and criteria based on reasonable medical evidence, including a method for updating the criteria. Carriers must also make available to requesting providers clinical protocols, medical management standards, and other review criteria. The Insurance Commissioner must adopt standards by rule after considering relevant national and state agency standards.

Carriers offering health plans may not retrospectively deny coverage for emergency and nonemergency care previously authorized, and the commissioner shall adopt standards by rule.

Grievance Process:

Carriers offering health plans must have a fully operational, comprehensive grievance process that complies with rules adopted by the commissioner. The commissioner must consider relevant national and state standards in adopting rules. The grievance process shall include:

- Implementation of procedures for registering and responding to complaints in a timely manner; and

- Written notification to enrollees and their providers of a carrier's decision to deny, modify, reduce, or terminate payment or coverage of a health service. The carrier must process an enrollee's appeal to reconsider it's decision; must assist an enrollee in the process; must make a decision within 30 days; and must provide notice of its resolution of the complaint, including supporting clinical reasons, and any appropriate alternative health services, as well as information on how to obtain a second opinion, and continue the denied service.

Carriers must continue to provide denied services pending the reconsideration process, but the enrollee may be responsible for the cost of the service if the decision is affirmed. Carriers must also provide an explanation of the grievance process upon the request of an enrollee, upon enrollment of new enrollees, and annually to all enrollees, as well as track complaints, and maintain a log of all grievances for three years, and identify trends.

Independent Review of Health Care Disputes:

There is a declared need for the fair consideration of consumer complaints relating to decisions to deny, modify, reduce, or terminate coverage or payment for health care.

The commissioner must adopt by rule a process by which a person may seek a review of a carrier's decision by an independent review organization, after the carrier has completed its grievance procedures, or where the carrier has exceeded the timelines for grievance resolution without cause and without reaching a decision. When a decision depends exclusively on an interpretation of the health plan contract, the dispute must be determined by the Insurance Commissioner.

The Insurance Commissioner by rule must establish a rotational registry system for the assignment of independent review organizations, flexible enough to ensure the availability of medical expertise. Independent review is not intended to override health plan contract provisions. Determinations must be based on expert medical judgment. Determinations must be made at least 20 days after receiving the request for review, or no less than eight days if the enrollee's health is seriously jeopardized. Carriers must continue to provide a denied health service pending the review, and pay the costs of an independent review. The requirements for independent review are not applicable to programs with existing independent review requirements.

Independent Review Organizations:

The Department of Health must provide for a procedure for certifying independent review organizations by rule. Such organizations must utilize providers with

demonstrated expertise and experience and meet reasonable requirements of the Department of Health. The rules must ensure the confidentiality of medical records, the qualifications and independence of reviewers, and a quality assurance mechanism.

Decisions of independent review organizations must be made not later than 15 days after receipt of review information, or 20 days after receipt of the request for a determination, whichever is sooner. In cases of serious jeopardy to an enrollee's health or maximum function, the decision must be made within 72 hours after the receipt of review information, or within eight days of the request for determination, whichever is earlier.

Independent review organizations must be certified by the department by submitting required information on its ownership, relationships, and the procedure used for conducting reviews. The department may accept national or equivalent accreditation or certification in certifying the organization. The rules must provide for termination of certification for cause. Independent review organizations may not be owned or controlled by carriers and they are immune from civil liability, except for acts made in bad faith or involving gross negligence.

Carrier Medical Director:

Carriers offering health plans must designate a medical director who is licensed as a physician or osteopathic physician. Naturopathic plans may have a medical director who is a licensed naturopath.

Carrier Liability:

Carriers must adhere to accepted standards of care provided by health care providers when arranging for medically necessary health care services to its enrollees. A carrier for a health plan is liable for damages for harm to an enrollee proximately caused by its health care treatment decisions. However, there is no liability imposed on health care providers or facilities liable for malpractice under other provisions of state law, nor employers who purchase health care coverage for their employees, nor governmental agencies that purchases coverage for individuals and families.

No person may sue a carrier until the enrollee has first sought independent review of the health care decision, except where substantial harm has already occurred caused by its conduct. Substantial harm includes loss of life or significant impairment or disfigurement, and severe or chronic pain. However, an enrollee may pursue other appropriate remedies, including injunctive relief or a declaratory judgment, if the enrollee's health is in serious jeopardy. Actions must be commenced within three years of the completion of the independent review process.

Carriers are accountable to their enrollees for activities delegated to their subcontractors, and such contracts may not relieve carriers of liability.

Effective Dates:

This act applies to health plans offered, renewed, or issued by carriers renewed after June 30, 2001, and to recipients of Medical Assistance provided by the Department of Social and Health Services, enrollees under the Basic Health Plan offered by the State Health Care Authority, and beneficiaries under the Public Employees Health Benefits. The liability provisions take effect July 1, 2001.

Repealers:

Duplicate statutory sections are repealed.

Substitute Bill Compared to Original Bill: The confidentiality of an enrollee's health information is governed by current state law, and is extended to carriers. Matters to be disclosed to enrollees are clarified. Direct access to chiropractic care is required. The grievance process is made consistent with national standards. Health care disputes are reviewed by independent review organizations in accordance with medical standards of practice in the state. Disputes involving the interpretation of contracts are resolved by the Insurance Commissioner. Health care providers are exempted from liability for carrier decisions. Enrollees suffering substantial harm may sue carriers for damages, bypassing preliminary independent review.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: Ninety days after adjournment of session in which bill is passed, except for section 17 which takes effect July 1, 2001.

Testimony For: Patients expressed concerns about abuses of managed care plans that affected their ability to make informed decisions and receive appropriate health care services. Treatments are arbitrarily denied, and no independent dispute mechanism exists to fairly consider these issues, short of maintaining expensive legal actions.

Testimony Against: Health plans are under increasing pressure to contain costs and stay efficient as a result of rising health care and prescription drug costs, expensive new technology, and sicker patients in a growing aging population. The requirements imposed by this legislation will only increase costs, result in rising premiums and threaten the economic viability of health carriers which are already pulling out of the health insurance market.

Testified: (In support) Representative Schual-Berke, prime sponsor; Deborah Senn, Insurance Commissioner; Susie Tracy and Dr. Maureen Callaghan, Washington State Medical Association; Dr. Glen Stream, Washington Academy of Family Physicians; Tanis Marsh, League of Women Voters; Barbara Flye; Washington Citizen Action; Dylan and Christine Malone; Larry Shannon, Washington State Trial Lawyers Association; Bruce Reeves, Senior Citizens' Lobby; Margaret Hernandez; Evalyn Poff, American Association of Retired Persons; Andrea Stephenson, The Empower Alliance; and Cathy and James Ellison.

(Support with amendment) Steve Wehrly, Chiropractors Association.

(Opposition) Ken Johnson, Association of Washington Business.

(Concerns) Trent House, Association of Washington Healthcare Plans; Margaret Stanley and Dr. Nancy Fisher, Regence Blue Shield; and Yori Milo, Premera Blue Cross.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Health Care. Signed by 23 members: Representatives H. Sommers, Democratic Co-Chair; Barlean, Republican Vice Chair; Doumit, Democratic Vice Chair; D. Schmidt, Republican Vice Chair; Alexander; Clements; Cody; Gombosky; Grant; Kagi; Keiser; Kenney; Kessler; Lambert; Linville; Lisk; Mastin; McIntire; Regala; Rockefeller; Ruderman; Sullivan and Tokuda.

Minority Report: Do not pass. Signed by 9 members: Representatives Huff, Republican Co-Chair; Benson; Boldt; Crouse; McMorris; Mulliken; Parlette; Sump and Wensman.

Staff: Denise Graham (786-7137).

Summary of Recommendation of Committee on Appropriations Compared to Recommendation of Committee on Health Care:

Health Information Privacy

The second substitute bill adds language that requires the Office of the Insurance Commissioner, in developing rules to implement the health information privacy

requirements of the bill, to consider the impact of potential rules on the ability of carriers to undertake enrollee care management or disease management activities.

Access to Appropriate Health Services

The second substitute bill adds language clarifying that a carrier cannot require enrollees to receive prior referral for chiropractic services, but a carrier can limit the scope of chiropractic care covered under the plan.

Health Care Decisions

Under the second substitute bill, carriers are not required to use medical evidence or standards when reviewing care provided through religious non-medical treatment.

Independent Review of Health Care Disputes

Under the second substitute bill, all disputes would go to an independent review organization. In contrast, the substitute bill provides that disputes requiring the use of medical judgment be sent to an independent review organization and disputes requiring interpretation of the health plan contract be sent to the Office of the Insurance Commissioner.

The second substitute requires that medical reviewers' decisions be consistent with the scope of covered benefits included in the enrollee's health plan contract. However, the reviewers can override the contract language if they find that the standards of "medical necessity" or "appropriateness" in the contract are unreasonable or inconsistent with good medical practice.

Carrier Liability

The second substitute requires that, in order to file a suit against a carrier, an enrollee must have suffered substantial harm and must have sought a determination from an independent review organization. The substitute bill however, would allow an enrollee who suffers substantial harm to file suit without first going through the independent review process.

Application to State Programs

The second substitute bill adds language to Chapter 41.05 (the Health Care Authority) and 70.47.130 RCW (the Basic Health Plan) to clarify that the bill applies to plans offered through the Public Employees' Benefits Board, including the state's self-funded Uniform Medical Plan, and to the Basic Health Plan.

Effective Date

The effective date of the carrier liability section is changed is the second substitute from July 1, 2001, to contracts entered into or renewed after June 30, 2001. This removes any state fiscal impact from premium rate increases during the current biennium. Also, the bill is null and void unless funding is provided in the budget by June 30, 2000.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Second Substitute Bill: The bill contains several effective dates. Please refer to the bill. However, the bill is null and void unless funded in the budget.

Testimony For: People want control of their health care and want to know that their doctors have control over and are making appropriate decisions. When that trust is there, the costs will reflect that. The bill will not increase costs as much as the fiscal notes indicate.

(Concerns) This bill will cost more than the fiscal notes indicate. Most of the bill is not needed to achieve the goals stated in the intent section; there are already rules and efforts underway to address issues of privacy, disclosure, grievance procedures and independent review. It is not cost effective to duplicate these efforts.

Testimony Against: None.

Testified: (In support) Larry Shannon, Washington State Trial Lawyers Association; and Sherry Appleton, Washington Citizen Action.

(Concerns) Trent House, Association of Washington Healthcare Plans; Ken Bertrand, Group Health; Rick Wickerman, Premera Blue Cross; Basil Badley, Health Insurance Association of America; Nancee Wildermuth, Regence Blue Shield; Ken Johnson, Association of Washington Business; and Steve Wehrly, Chiropractors Association.