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Technical Advisory

Update: Patient's Bill Of Rights

The most recent version of a Patient's Bill of Rights was introduced during the first week of February. Republican Senator John McCain of Arizona and Democratic Senator Edward Kennedy are co-sponsors of the bill.

Under the legislation, health plans could be held liable for medical decisions that result in injury or death to their patients. Sponsors also say the legislation would establish an independent appeals system to keep most cases out of the courts.

The driving force behind the legislation has been some highly publicized cases of HMOs denying or restricting patients access to health care. The legislation has stalled over the last few years over partisan arguments of whether or not patients should have the right to sue their health plans.

It appears both Republicans and Democrats now agree over the right to sue, but are still at odds on how much patients should be able to collect. The proposed legislation would set a cap on punitive damages at \$5,000,000 for federal cases with an unlimited cap for each state case.

Proponents of the legislation say giving patients the right to sue HMOs for punitive damages would assure quality care. In addition, the current review boards in place

do not compensate patients for substandard care or wrongly denied benefits.

Opponents of the legislation warn of lawsuits tying up the courts, with trial lawyers reaping the benefits. Also, expanding the grounds to sue HMOs would drive up costs, which in turn would be passed on to consumers in the form of higher premiums. Higher premiums could then lead businesses to drop coverage, leaving an increasing number of Americans without medical insurance.

For the time being the legislation appears be stalled on the issue of punitive damages and external review boards. Some lawmakers, and the President, agree that a \$5,000,000 cap is set too high; others feel the cap is appropriate. The same lawmakers believe an expedited review prior to the case going to trial could eliminate frivolous lawsuits.

Legislators are drafting compromise language in an attempt to satisfy both sides. The President has suggested that similar legislation he helped enact in Texas would be an appropriate starting point. Texas law currently limits punitive damages to \$750,000.



Domestic Partner Issue Heats Up

While Gov. Gary Locke signed off on allowing domestic partner coverage in 2000, that all could change in November. At the center of the controversy are concerns over increasing healthcare costs and possible discrimination.

Representative Joyce Mulliken, a Republican from Ephrata (Eastern Washington), is sponsoring measure (#HB1970) that would have the domestic partner directive decided on by voters this fall. Mulliken's goal is to eliminate the domestic partner benefits made available last year to unmarried partners of state employees.

Access to full health benefits was given to domestic partners to the employees of Washington State back in May of 2000. Following the lead of some major local businesses, as well as the city of Seattle, the Public Employee Benefits Board (PEBB) approved the action, feeling the move should have been made long before.

It is Mulliken's position, with the support of other Republicans in the House of Representatives, that this is just another unwanted healthcare cost.

Domestic partner coverage comes along the same year when the 'Every Category of Provider' mandates took effect. Mandated benefits like chiropractic and alternative care, along with the skyrocketing costs of prescription drugs, have already taken a toll on the market.

"The public employee benefits board is giving domestic partner

benefits and I don't want to pay for that," said Mulliken. (1)

The PEBB, however estimates the cost to add domestic partner coverage to the state medical package would be \$2.9 million in 2001 or about .5% of the total medical benefit. The board goes on to estimate that costs for each employee plan would rise \$2.43.

There is also the issue of what allowing domestic partner coverage does to the idea of traditional marriage in our state. Supporters of the measure believe that allowing coverage for domestic partners diminishes the traditional view of marriage.

Opponents see Rep. Mulliken's bill as further discrimination against people who are in non-traditional relationships; they fear the line separating Church and state is becoming blurred. Some Democrats feel that Mulliken's bill could cause lawmakers to choose sides and cause a halt to progress made on some of the State's other important issues.

"If we start dealing in morality, the things we agree are important for Eastern Washington could start falling off the table," says Walla Walla Representative Bill Grant. (2)

Both sides believe there is a chance that a vote could go in their favor. However, it is key for supporters of Mulliken's the bill that the issue be decided by the voters, because if it reaches Gov. Locke's desk in any other way as, "We know the governor will veto it." Mulliken says.

(1) and (2); Tom Roeder-Yakima Herald, 2/14/2001

Regence Settles Alternative Care Dispute

Regence Blue Shield has agreed to a \$30.4 million settlement of two class action lawsuits involving alternative healthcare in the State of Washington. The lawsuits, filed on behalf of Regence subscribers, claim that Regence had applied different standards to traditional and alternative treatments and failed to cover the cost of alternative treatments for the majority of its subscribers.

The victory adds strength to the "Every Category of Provider" law that took effect in January of 1996. The law requires Washington State health insurers to cover alternative care services.

Under the terms of the settlement, Regence subscribers who paid for treatments from chiropractors, massage therapists, naturopaths, acupuncturists or nutritionists from January 1, 1996 to February 29, 2000, may be eligible for reimbursement. All subscribers should receive a claim form from Regence within the next 90 days.

It is unknown, at this point, what impact the settlement will have on future premiums or the use of alternative care providers. The settlement does state that if Regence seeks approval from the state to raise rates over the next five years, Regence must show it is not trying to recover costs from the settlement.

Although the two sides have agreed on the terms of a settlement, they must wait for approval from the King County Superior Court before it becomes official.

FMLA and Sick Leave

A recent Federal District Court decision affirmed that the Family Medical Leave Act (FMLA) does not require employees to take sick leave before claiming the right to unpaid medical leave.

FMLA provides employees of larger employers with time off work to attend to serious family illnesses, childbirth and adoption without losing their jobs. To be eligible, an employee must meet the following conditions: must work for an employer with 50 or more employees in the current or preceding year; must have been employed at least 12 months and who worked in excess of 1,250 hours in the previous 12 month period.

If the conditions are met, an employee may get up to 12 weeks of leave during any 12-month period. Leave may be taken for the following:

- The birth of a child, whether the employee is the mother or father.
- Placement of a child for adoption or foster care.
- To care for a spouse, child, or parent with a serious health condition.
- To care for their own serious health condition.

According to FMLA, employers may allow employees to use accrued time off benefits to supplement family medical leave, but it is not a requirement.

Employees are not required to specifically ask for FMLA leave since employers are required to know when the act applies. However, employees are expected to provide notice that they intend to take FMLA leave. If an employee does not give advance

notice or a reasonable excuse for medical leave, then an employer may delay the start of leave.

The most common reasons for FMLA leaves are employee's own serious health conditions, followed by leaves for mothers to care for newborn infants.

Premera Agrees to Contract with Valley Medical Center

Valley Medical Center in Renton has announced they have signed a contract to once again be a part of the Premera Blue Cross provider network. The new contract became effective April 1, 2001.

The agreement applies to all eligible Premera Blue Cross members who are referred or directed to Valley Medical Center by their physician or provider for covered services. Covered services and care received on or after April 1st will be covered at the highest level of reimbursement. Service and care received prior to April 1st does not apply to this contract. Specifically, the agreement applies to covered services for eligible members in the following plans:

- Premera Blue Cross Participating - Group and Individual
- Premera Blue Cross Preferred (Prudent Buyer) - Group and Individual
- Premera HealthPlus
- Blue Choices
- Individual Managed Care
- Basic Health Plan
- Healthy Options

Premera Blue Cross has entered into a separate agreement for

physician and provider services at Valley Medical Center's primary and specialty clinics. This agreement also became effective April 1, 2001. The Valley Medical Center clinics or services covered are:

- Auburn North Primary Care
- Covington Primary Care
- Newcastle Primary Care
- Valley Family Primary Care
- Occupational Health
- Cascade Primary Care
- Fairwood Primary Care
- Kent Primary Care
- Behavioral Health

For further information, please contact Premera Blue Cross at 1-800-345-6784 or (425) 670-5900.

