HOUSE BILL REPORT
2SSB 5596

As Passed House - Amended:
March 12, 2008

Title: An act relating to fair payment for chiropractic services.

Brief Description: Requiring fair payment for chiropractic services.

Sponsors: By Senate Committee on Ways & Means (originally sponsored by Senators Franklin, Benton, Kline, Poulsen, Keiser and Roach).

Brief History:
Committee Activity:
Health Care & Wellness: 2/21/08, 2/27/08 [DPA];
Appropriations: 3/3/08 [DPA(APP w/o HCW)].
Floor Activity:
Passed House - Amended: 3/6/08, 79-15.
Senate Refused to Concur.
Passed House - Amended: 3/12/08, 81-16.

Brief Summary of Second Substitute Bill
(As Amended by House)

- Beginning January 1, 2009, prohibits health carriers and public employee health plans provided through the Health Care Authority from paying a chiropractor less for a service under certain billing codes than it pays to another type of provider under the same billing code, unless specified criteria are met.
- Requires the Insurance Commissioner to report by January 1, 2012, on an evaluation of the utilization and health care costs associated with these billing codes.
- Expires the payment requirements on June 30, 2013.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Majority Report: Do pass as amended. Signed by 10 members: Representatives Cody, Chair; Morrell, Vice Chair; Barlow, Campbell, DeBolt, Green, Moeller, Pedersen, Schual-Berke and Seaquist.

Minority Report: Do not pass. Signed by 3 members: Representatives Hinkle, Ranking Minority Member; Alexander, Assistant Ranking Minority Member; Condotta.

Staff: Chris Cordes (786-7103).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended by Committee on Appropriations and without amendment by Committee on Health Care & Wellness. Signed by 28 members: Representatives Sommers, Chair; Dunshee, Vice Chair; Anderson, Cody, Conway, Darneille, Ericks, Fromhold, Grant, Green, Haigh, Hunt, Hunter, Kagi, Kenney, Kessler, Kretz, Linville, McDonald, McIntire, Morrell, Pettigrew, Priest, Ross, Schual-Berke, Seaquist, Sullivan and Walsh.

Minority Report: Do not pass. Signed by 6 members: Representatives Alexander, Ranking Minority Member; Bailey, Assistant Ranking Minority Member; Haler, Assistant Ranking Minority Member; Chandler, Hinkle and Schmick.

Staff: Charlie Gavigan (786-7340).

Background:

Health carriers, including disability insurers, health care service contractors, and health maintenance organizations, must include every category of provider to provide services for conditions covered by the plan. Under Insurance Commissioner rules, health carriers may place reasonable limits on individual services rendered by specific categories of providers, but may not exclude an entire category of provider if providing a covered service is within the provider's scope of practice.

By state law, health carriers must offer health plan enrollees an adequate choice among health care providers. Insurance Commissioner rules require a health carrier to maintain plan networks that are sufficient in number and types of providers to assure that all health plan services are accessible to enrollees without unreasonable delay. This network adequacy must also include arrangements that ensure the reasonable proximity of network providers.

Insurance Commissioner's rules require health carriers to file sample contract forms proposed for use with their participating providers and facilities. However, the health carrier does not need to submit information about payment rates or amounts or other similar proprietary information. These rules also require health carriers to include schedules for prompt payment of providers, but do not regulate the payment methodologies that health carriers use to reimburse for health care services. Rates paid by health carriers may differ depending on the type of provider that provides the covered service.

Summary of Amended Bill:

A health carrier, including the public employee health insurance plans provided through the Health Care Authority, may not pay a chiropractor less for a service identified in a physical medicine and rehabilitation code or evaluation and management code, as listed in a nationally recognized code book, than it pays to another type of provider for a service under the same code. This requirement does not affect a health carrier's:
implementation of a health care quality improvement program, including pay-for-performance payment methods and other programs fairly applied to all health care providers to promote evidence-based practice;contracting to comply with network adequacy standards; differential pay to in-network and out-of-network providers; anddifferential pay based on geographic differences in practice costs.

These provisions do not require the payment of billings that do not meet the Insurance Commissioner's definition of a clean claim, do not require a health plan to cover any condition, and do not expand the scope of practice for any provider.

On or after January 1, 2010, the Insurance Commissioner must contract for an evaluation of the impact of the chiropractor payment requirement on utilization and cost of health care services associated with physical medicine and rehabilitation and evaluation and management billing codes. Data collected from health carriers for the evaluation are exempt from public disclosure. The Insurance Commissioner must submit the evaluation to the Legislature by January 1, 2012.

These payment provisions apply only to payments made on or after January 1, 2009, and expire on June 30, 2013.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: (Health Care & Wellness)

(In support) This bill presents a matter of fairness. Providers other than chiropractors are receiving 30 percent more for providing the same services, as defined by billing codes. Chiropractors do not get information about payment schedules when they agree to join a provider network. Where there is an overlap in scope of practice, the same billing codes should apply. Anti-trust laws limit how much negotiation is possible between the chiropractors and health carriers. Payment schedules do not seem to be based on skills or training since a chiropractor is paid the same without regard to his or her skills or training. Other state agencies and the federal government have studied how to devise payments schedules and generally have implemented the same payment rates when providers use the same billing codes. The level of compensation for a provider should depend on the provider's efficiency and skillful treatment of patients, not what type of provider is providing the

service. The bill does not dictate that chiropractic payment rates must be raised to implement the same payment schedule as other providers.

(Opposed) The bill will result in increased cost to the health care system without any benefit to patients. The cost is a particular concern to small employers. The money could be better spent on more Basic Health Plan slots. Sometimes carriers must pay more to selected providers in order to obtain the right mix of services, particularly specialty services. There may also be a differential between providers based on the cost of liability and overhead. An example of higher payment for higher skills and training within the same scope of practice is treatment of a facial laceration by a family practitioner compared to a plastic surgeon. Health carriers are looking toward payment based on high performing providers, but this bill might prevent that. This bill should apply to the state's self-insured plan, so that all plans are kept parallel. The bill will not apply to private sector self-insured plans or Taft-Hartley plans. Some provisions of the bill are not clear, such as what is meant by "substantially similar services." If this bill passes, it will be a disincentive for carriers to come into Washington.

Staff Summary of Public Testimony: (Appropriations)

(In support) Chiropractors recently learned that some carriers are paying them 30 percent less than they are paying other providers who are using the same billing code. Chiropractor provider contracts do not reveal the reimbursement rates until after the agreement is entered into. The biggest problem is physical therapy, where the pay to other providers is higher than for chiropractors who have more training. One option carriers have to comply with the bill is to lower fees, not raise them, to match. The payment should be based on the cost of delivery, not on the services. The cost to public employees health insurance is less than 0.1 percent.

(Opposed) The bill increases health care costs without increasing services or access to care. The bill does not apply to the Uniform Medical Plan. The state should be trying to control health care costs, not increasing them. Carriers must be able to use different reimbursement rates to account for medical malpractice costs and office expenses and to make sure networks are adequate. As a general matter, chiropractors are reimbursed more only in New York City and San Francisco. Carriers may have to reduce reimbursement to other providers because of the pressure to control health care costs. It is not in the best interest of patients to have provider reimbursement rates reduced. It is not advisable for the Legislature to get into the issue of billing codes. The cost for one carrier to implement the bill could be as much as $15 million per year.

Persons Testifying: (Health Care & Wellness) (In support) Senator Franklin, prime sponsor; and Lori Bielinski and Austin McMillan, Washington State Chiropractic Association.

(Opposed) Sydney Zvara, Association of Health Care Plans; Nancee Wildermuth, Regence-Blue Shield and PacifiCare; Steve Gano, Primera-Blue Cross; Mel Sorenson, American Health Insurance Plans and Washington Association of Underwriters; and Gary Smith, Independent Business Association.

Persons Testifying: (Appropriations) (In support) Lori Bielinski, Washington State Chiropractic Association.

(Opposed) Cliff Webster, Washington State Medical Association; Mel Sorensen, America's Health Insurance Plans; Donna Steward, Association of Washington Business; Nancee Wildermuth, Regence-Blue Shield, PacifiCare/United, and Aetna; and Steve Gano, Premera-Blue Cross.

Persons Signed In To Testify But Not Testifying: (Health Care & Wellness) None.

Persons Signed In To Testify But Not Testifying: (Appropriations) None.