Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

2SSB 5346

Brief Description: Concerning administrative procedures for payors and providers of health care services.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Keiser, Franklin, Marr, Parlette, Murray and Kohl-Welles).

Brief Summary of Second Substitute Bill

- Directs the Insurance Commissioner to designate an entity to establish streamlined and uniform procedures for payors and providers of health care.

Hearing Date: 3/19/09

Staff: Dave Knutson (786-7146)

Background:

At the request of the Blue Ribbon Commission on Health Care Costs and Access, the Office of the Insurance Commissioner (OIC) initiated some efforts to identify the administrative costs associated with health care. Legislation that passed in 2007 directed the OIC to formally report on opportunities to lower administrative expenses. The 2008 Legislature directed the OIC to convene a work group of health care providers, carriers, and payors, and to identify the five highest priority goals for achieving significant efficiencies and reducing health care administrative costs.

The five highest priority goals for achieving efficiencies and reducing health care administrative costs have been identified in a report submitted to the Legislature to:

- establish a standardized process and central data source for provider credentialing and other provider demographic data needs;
- amend state regulations regarding coordination-of-benefits claims processing to eliminate estimated payment requirements;

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- expand electronic sharing of patient eligibility and benefits information and efficient patient cost-share collection processes;
- standardize use of pre-authorization requirements and introduce transparency where standardization is not reasonable; and
- standardize code edits and payment policies, and introduce transparency of variations where standardization is not reasonable.

The report recommends that the state establish a formal public-private partnership to develop and promote standards for simplifying these top priority administrative processes.

Summary of Bill:

The Insurance Commissioner must designate a lead organization to identify and convene work groups to define key processes, guidelines, and standards by December 31, 2010. The Insurance Commissioner is directed to participate in and review the work of the lead organization, adopt rules and draft any necessary legislation, form an executive-level work group, and consult with the Office of the Attorney General to determine whether an antitrust safe harbor is necessary to enable carriers and providers to develop common rules and standards.

The lead organization must develop a uniform electronic process for collecting and transmitting provider data to support credentialing, admitting privileges, and other related processes that will serve as the source of credentialing information. The work must assure that data used in the uniform electronic process can be electronically exchanged with the Department of Health's professional licensing process. The lead organization must establish a uniform standard companion document and data set for electronic eligibility and coverage verification. Patient information must provide detailed information on the eligibility and the benefit coverage and cost-sharing requirements that assist the provider with collection of the patient cost-sharing. The lead organization must develop implementation guidelines for the use of code edits, including use of the National Correct Coding Initiative code edit policy, publication of any variations in codes, and use of the Health Insurance Portability and Accountability Act standard group codes, reason codes, and remark codes. The lead organization must develop a proposed set of goals and a work plan for additional code standardization efforts by October 31, 2010.

The lead organization must develop guidelines to ensure payors do not automatically deny claims for services when extenuating circumstances interfere with a provider obtaining preauthorization before services are performed, or delayed provider notification to the payor of a patient's admission. The guidelines should require payors use common and consistent timeframes for reviewing requests for medical management, consistent where possible with standards established by the National Committee for Quality Assurance. The lead organization must develop a single, common website for providers to obtain payors' preauthorization, benefits advisory, and preadmission requirements. By October 31, 2010, the lead organization must develop a set of goals and a work plan for the development of medical management protocols.

The Department of Social and Health Services, the Health Care Authority, and the Department of Labor and Industries, to the extent possible under their laws in Title 51, must adopt the processes and guidelines recommended by the lead organization.

Payors are allowed to develop and implement temporary code edits to detect and deter aberrant billing patterns that could expose fraudulent billings. Implementation of administrative simplification guidelines by state agencies is contingent upon funding provided in the budget.

Appropriation: None.

Fiscal Note: Not requested.

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