SENATE BILL REPORT
SB 5346

As Reported by Senate Committee On:
Health & Long-Term Care, February 09, 2009

Title: An act relating to establishing streamlined and uniform administrative procedures for payors and providers of health care services.

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

Sponsors: Senators Keiser, Franklin, Marr, Parlette, Murray and Kohl-Welles.

Brief History:
Committee Activity: Health & Long-Term Care: 1/26/09, 2/09/09 [DPS-WM].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5346 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Keiser, Chair; Franklin, Vice Chair; Pflug, Ranking Minority Member; Becker, Fairley, Marr, Murray and Parlette.

Staff: Mich'l Needham (786-7442)

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, and legislation 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 payers, and 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:

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

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.

3. expand electronic sharing of patient eligibility and benefits information and efficient patient cost share collection processes;
4. standardize use of pre-authorization requirements and introduce transparency where standardization is not reasonable;
5. 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 (Recommended Substitute): 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 time frames 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.

EFFECT OF CHANGES MADE BY HEALTH & LONG-TERM CARE COMMITTEE (Recommended Substitute): The definition of provider is added for clarification. The Department of Labor and Industries will participate in the implementation of the guidelines to the extent permissible under Title 51. Provider credentialing information is clarified. The requirement for electronic identification cards is removed. The language to clarify responsibility for eligibility information is modified. The goals for additional code standardization are delayed to October 31, 2010. The development of a common website is modified to include preauthorization, benefits advisory, and preadmission requirements. The information on medical management information is no longer required on the website. The additional set of goals and consideration of medical management protocols is delayed to October 31, 2010.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Original Bill: PRO: Administrative expenses in health care are out of control and this provides some concrete steps to move forward. All the parties have been working collaboratively on this proposal and it represents logical, feasible steps that will streamline the processes and administrative impacts on providers. Each area has been carefully evaluated with respect to timelines and resources available, and this approach is both feasible and meaningful. It is important to move forward collaboratively with a public-private partnership. It is critical that state agencies participate in the standards and guidelines to achieve the greatest simplicity and savings.

There are some concerns with the eligibility burdens placed on carriers and with the medical management guidelines. The administrative complexity with multiple insurance payors is a tremendous burden on providers. Centralized credentialing would be helpful. The safety net trigger for the OIC to move forward if the products are not completed by 2010 is appropriate. The Forum has made good efforts to standardize and eliminate processes, and it is time now for a new phase focusing on electronic processes.

The consumer voice needs to be added to the discussion with participation in the work group. Consumers are outraged when they hear 30-40 percent of health care dollars are wasted on administration and they support streamlining efforts.

Addressing variation is important but we need to ensure there is not a disconnect with a focus on quality. Streamlined credentialing efforts are important but be cautious about reducing standards to the lowest common denominator. We may need separate standards that address

flexibility for carriers to deal with experimental procedures, and we need to be cautious about creating any state specific standards that may keep new carriers from coming in the state.

Persons Testifying: PRO: Senator Keiser, prime sponsor; Commissioner Kreidler; Abbi Kaplan, Washington Healthcare Forum (Forum); Cynthia Markus, Bob Perna, Washington State Medical Association and Forum; Sydney Zvara, Association of Washington Health Plans and Forum; Rick Ruben, One Health Port; Lisa Thatcher, Washington State Hospital Association and Forum; Mel Sorensen, America's Health Insurance Plans; Bill Daley, Washington Community Action Network; Ingrid McDonald, AARP; Donna Steward, Association of Washington Businesses.