FINAL BILL REPORT
2SSB 5346

C 298 L 09
Synopsis as Enacted

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).

Senate Committee on Health & Long-Term Care
Senate Committee on Ways & Means
House Committee on Health Care & Wellness
House Committee on Ways & Means

Background: At the request of the Blue Ribbon Commission on Health Care Costs and Access, the Office of the Insurance Commissioner (OIC) initiated steps 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. These goals:

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;
3. expand electronic sharing of patient eligibility and benefits information and efficient patient cost share collection processes;
4. standardize use of preauthorization requirements and introduce transparency where standardization is not reasonable; and
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.

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.

Summary: 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, and is interoperable with other relevant systems.

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. Payors are allowed to develop and implement temporary code edits to detect and deter aberrant billing patterns that could expose fraudulent billings. If a payor uses temporary code edits to detect fraudulent billing, the payor must disclose to the provider its adjudication decision on a claim and allow the provider to access the payor's review and appeal process to challenge the decision.

The lead organization must develop guidelines by December 31, 2010, 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, and to be consistent where possible with standards established by leading national organizations. 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 within funds appropriated for the purpose. The Department of Health must implement standards that enable the sharing of professional licensing information for the uniform credentialing process within funds appropriated for the purpose.

Votes on Final Passage:

Senate	48	0	
House	97	0	(House amended)
Senate	43	0	(Senate concurred)

Effective: July 26, 2009