Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Ways & Means Committee

ESSB 5927

Brief Description: Limiting payments for health care services provided to low-income enrollees in state purchased health care programs.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Keiser and Pflug; by request of Health Care Authority and Department of Social and Health Services).

Brief Summary of Engrossed Substitute Bill

- Requires managed care plans in state medical assistance programs and the Basic Health Plan to negotiate and maintain networks of providers sufficient to provide adequate access to all covered services within their service areas and within each contracted facility.
- Requires managed care plans to provide documentation to the Department of Social and Health Services (DSHS) and the Health Care Authority (Authority) indicating that the plans attempted to contract with nonparticipating providers or provider groups on similar terms to participating providers.
- Requires the DSHS or the Authority to resolve disputes over whether the plans are meeting these requirements.
- Allows the managed care plans to reimburse nonparticipating providers at their mode reimbursement rates for the same services in the same service areas if these conditions are met.
- Requires managed care plans to explain the basis for utilizing nonparticipating providers' services to the DSHS or the Authority.

Hearing Date: 5/5/11

Staff: Erik Cornellier (786-7116).

Background:

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.

The Health Care Authority (Authority) administers the Basic Health Plan (BHP), which is a health care insurance program that assists enrollees by providing a state subsidy to offset the costs of premiums.

Medicaid is a federal-state partnership with programs established in the federal Social Security Act, and implemented at the state level with federal matching funds. Federal law provides a framework for coverage of children, pregnant women, some families, and elderly and disabled adults, with varying income requirements.

Managed care is a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty, and ancillary health services through a network of providers. The BHP provides coverage through managed care plans. Healthy Options (HO) is the Department of Social and Health Services' (DSHS) Medicaid managed care program for low-income people in Washington. Healthy Options offers eligible families, children under 19, and pregnant women a complete medical benefits package.

Disputes have arisen when HO or BHP enrollees receive covered services at in-network hospitals from nonparticipating health care providers. The nonparticipating providers maintain that they should receive their billed charges for the services provided, while the HO and BHP contracted carriers hold that the payments should be consistent with rates paid to network providers.

In the 2009-11 State Omnibus Operating Appropriations Act (2009-11 Operating Budget), the Legislature addressed this issue by requiring HO carriers to limit reimbursements made to non-network providers to no more than the Medicaid fee-for-service rates for comparable services. The Snohomish County Superior Court ruled that a contracted HO and BHP carrier must pay nonparticipating providers their billed charges despite the restriction in the 2009-11 Operating Budget. The Washington State Supreme Court declined a request for an expedited review and sent the case to the Court of Appeals for consideration. Other nonparticipating providers have filed similar lawsuits since then.

Summary of Bill:

Managed care plans in HO and the BHP must maintain networks of appropriate providers supported by written agreements sufficient to provide adequate access to all covered services, including hospital-based physician services. The plans must negotiate with providers to assure that adequate networks of health care providers are available within their service areas and within each contracted facility. Managed care plans must provide documentation to the DSHS and the Authority indicating that the plans attempted to contract with nonparticipating providers or provider groups on similar terms to other participating providers delivering the same care in the same service areas. Disagreements between the managed care plans and providers regarding whether the systems satisfied these requirement will be decided by the DSHS or the Authority.

If these conditions are met, the managed care plans are only obligated to reimburse nonparticipating providers at their mode reimbursement rates for the same services in the same service areas.

If managed care plans must send enrollees to nonparticipating providers, they must explain the basis for utilizing the nonparticipating providers' services to the DSHS or the Authority.

These provisions expire January 1, 2014, except that the definition of the term "nonparticipating provider" remains in effect.

Appropriation: None.

Fiscal Note: Requested on May 3, 2011.

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