HOUSE BILL REPORT
ESSB 5927

As Reported by House Committee On:
Ways & Means

Title: An act relating to limiting payments for health care services provided to low-income enrollees in state purchased health care programs.

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 History:
Committee Activity:
Ways & Means: 5/5/11 [DPA].

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

- Requires managed care systems to maintain networks of appropriate providers sufficient to provide adequate access to all services covered under contracts with the state, including hospital-based services.
- Requires the Department of Social and Health Services and the Health Care Authority to monitor and periodically report to the Legislature on the proportion of services provided by contracted providers and nonparticipating providers for each of their managed care systems.
- Requires managed care systems serving Basic Health Plan (BHP) and Healthy Options (HO) enrollees to pay nonparticipating providers the lowest amount that the systems pay for the same services under the systems' contracts with similar providers in the state.
- Requires nonparticipating providers to accept those rates as payment in full in addition to any deductibles, coinsurance, or copayments due from the patients.
- Limits liability of BHP and HO enrollees to nonparticipating providers to required deductibles, coinsurances, and copayments.

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.

HOUSE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass as amended. Signed by 26 members: Representatives Hunter, Chair; Darneille, Vice Chair; Hasegawa, Vice Chair; Alexander, Ranking Minority Member; Bailey, Assistant Ranking Minority Member; Dammeier, Assistant Ranking Minority Member; Orcutt, Assistant Ranking Minority Member; Carlyle, Cody, Dickerson, Haigh, Haler, Hinkle, Hudgins, Hunt, Kagi, Kenney, Ormsby, Parker, Pettigrew, Ross, Schmick, Seaquist, Springer, Sullivan and Wilcox.

Minority Report: Do not pass. Signed by 1 member: Representative Chandler.

Staff: Erik Cornellier (786-7116).

Background:

The Health Care 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' 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 nonparticipating 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 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 Amended Bill:

Managed care systems serving the Basic Health Plan and Healthy Options are required to pay nonparticipating providers the lowest amounts the systems pay for the same services under the systems' contracts with similar providers in the state. Nonparticipating providers must accept those rates as payment in full in addition to any deductibles, coinsurance, or copayments due from the patients. Enrollees are not liable to nonparticipating providers for covered services, except for amounts due for any deductibles, coinsurances, or copayments.

Managed care systems must maintain networks of appropriate providers sufficient to provide adequate access to all services covered under their contracts with the state, including hospital-based services. The Department of Social and Health Services and the Health Care Authority will monitor and periodically report to the Legislature on the proportion of services provided by contracted providers and nonparticipating providers for each of their managed care systems.

These provisions expire July 1, 2016, except that the definition of the term "nonparticipating provider" remains in effect.

Amended Bill Compared to Engrossed Substitute Bill:

The Ways and Means Committee recommendation removes the requirement that managed care systems 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. The DSHS and the Authority are not required to resolve disputes over whether the managed care systems are attempting to contract with nonparticipating providers, and the systems are not required to explain the basis for utilizing nonparticipating providers' services.

Instead, managed care systems must maintain networks of appropriate providers sufficient to provide adequate access to all services covered under their contracts with the state, including hospital-based services. The DSHS and the Authority will monitor and periodically report to the Legislature on the proportion of services provided by contracted providers and nonparticipating providers for each of their managed care systems.

Managed care systems must reimburse nonparticipating providers at the lowest amount paid for the same services under the systems' contracts with similar providers in the state instead of at their mode reimbursement rates for the same services in the same service areas. Nonparticipating providers are required to accept those rates as payment in full in addition to any deductibles, coinsurances, or copayments due from the patients. Enrollees in the Basic Health Plan and Healthy Options are not liable to nonparticipating providers for covered services except for required deductibles, coinsurances, or copayments.

These provisions expire July 1, 2016, instead of January 1, 2014.

Appropriation: None.

Fiscal Note: Requested on May 3, 2011.

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

Staff Summary of Public Testimony:

(In support) None.

(With concerns) The agencies proposed the underlying bill, but the Senate's amendment would have unintended consequences. In its current form, it would raise a number of legal issues and create a great deal of administrative responsibility that will increase costs. The original bill was a cost avoidance proposal, and now the bill would require funding for implementation.

(Opposed) The original bill was a common sense solution to a growing problem that could drive up costs in public programs. The Senate's amendment would add costs and administrative burdens with no additional value, and it increases the likelihood of disputes. The Senate amendments would establish a parallel but higher rate structure for providers that choose not to contract. This would require the state to pay millions more than it does today, and the state would not be able to achieve savings in managed care programs.

The intent of the underlying bill was to avoid future costs to the state for Healthy Options (HO) managed care and the Basic Health Plan (BHP), and it would have codified the 2009-11 budget proviso for Medicaid and the BHP. The current budget proviso states that if a provider does not have a contract with a plan, the highest the plan can pay is the fee-for-service rate. A court in Snohomish County ruled that if providers do not have contracts they can charge their billable rates and do not have to accept the fee-for-service rates. The judge held that the proviso was not law and disregarded it. Now there is no incentive for providers to contract with carriers, because the providers can receive their billable charges which are 200 to 250 percent higher than the fee-for-service rates. The underlying bill supports the fiscal integrity of HO and the BHP. Without it, the state will pay more to insure less people.

There could potentially be $100 million in unanticipated costs for paying providers billed charges in the BHP and Medicaid, and it would put $200 million of federal dollars at risk. Actuarially sound managed care rates provide certainty and are the bedrock of the Medicaid program. Maintaining solvency of these programs is a critical bridge to 2014 when more low-income individuals will be covered. Fewer and fewer people are able to get coverage through employers. The state should pursue smart purchasing strategies in a time of recession.

Most of these clients are low-income women and children and a majority of hospital services are related to maternity and women's health care. Under state law women can self-refer to any provider and participating hospital facility. The plans cannot redirect those women to participating providers.

The underlying bill was perceived as anti-provider. Thousands of providers should be commended for contracting to provide services to patients in public programs. The court

case pertains to a handful of providers statewide that maintain they have the right to bill anything they want. Thousands of providers were willing to enter into contracts, such as Group Health, which loses money.

References to existing network adequacy standards could allay the concerns of providers.

This bill could have unintended impacts on current and future contract negotiations. All hospitals are participating providers, but hospitals are still concerned about what might happen. The bill should be amended to ensure that it does not adversely affect existing agreements, require monitoring to track termination of agreements between plans and participating providers, and enhance network adequacy provisions.

The underlying bill took away the ability for providers to negotiate with the plans and put default rates in statute. The Senate attempted to put some borders around the negotiations relating to network adequacy. The Senate's amendment removes important balance billing provisions that protect low-income clients from unnecessarily high medical bills that could drive patients into bankruptcy and poverty. Consumers should not be caught in the middle of conflicts between plans and providers. Patients think they are playing by the rules and seeing providers that will accept their insurance. Members could be billed for the balance of their charges, which would ruin their credit or interfere with their other financial requirements. Patients pay the bills when they are charged out of fear and confusion. The underlying bill's protections prohibiting balance billing are critical to helping individuals in the community manage and pay health care costs.

Persons Testifying: (With concerns) Dennis Martin, Health Care Authority.

(Opposed) Rebecca Kavoussi, Community Health Plan and Network of Washington; Lisa Thatcher and Carl Nelson, Washington State Hospital Association; Ingrid McDonald, AARP of Washington; Teresa Mosqueda, Washington State Labor Council; Lonnie Johns Brown, National Organization of Women; Davor Gjurasic and Laurel Lee, Molina Healthcare of Washington; and Joe King, Group Health.

Persons Signed In To Testify But Not Testifying: None.