# SENATE BILL REPORT
# ESSB 5927

As Amended by House, May 9, 2011

**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: 4/13/11, 4/14/11, 4/15/11 [DPS].
**First Special Session:** Passed Senate: 5/03/11, 34-9.
Passed House: 5/09/11, 94-2.

## SENATE COMMITTEE ON WAYS & MEANS

**Majority Report**: That Substitute Senate Bill No. 5927 be substituted therefor, and the substitute bill do pass.

Signed by Senators Murray, Chair; Kilmer, Vice Chair, Capital Budget Chair; Zarelli, Ranking Minority Member; Parlette, Ranking Minority Member Capital; Baumgartner, Baxter, Brown, Conway, Fraser, Hatfield, Hewitt, Holmquist Newbry, Honeyford, Kastama, Keiser, Pflug, Pridemore, Regala, Rockefeller, Schoesler and Tom.

**Staff**: Tim Yowell (786-7435)

**Background**: The state contracts with health insurance systems to deliver medical care services under the state Medicaid, Disability Lifeline, and Basic Health Plan programs. These systems contract with individual health care practitioners, group practices, clinics, hospitals, pharmacies, and other entities to participate in their network of providers. Persons enrolled in the managed care plan must typically obtain their medical care services from providers who participate in their plan's network in order for the service to be covered.

When they receive services at an in-network facility, managed care enrollees sometimes receive services from health care providers who have not contracted to participate in their managed care plan's network. For example, an enrollee may have surgery at a hospital that

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has contracted to participate in their managed care plans' network but receive anesthesia from a practitioner who has not.

Disputes have arisen about how much the managed care plan should pay the health care practitioner in such instances. A Snohomish County Superior Court judge has ruled that in such instances the managed care organizations should pay the non-contracted practitioner the full amount billed by the practitioner. Managed care organizations, the Department of Social and Health Services, and the Health Care Authority have expressed concern this will increase the cost of services delivered under state-purchased plans.

**Summary of Engrossed Substitute Bill**: State-contracted managed care plans must negotiate with health care providers to assure an adequate network of health care providers within the plan's service delivery area and within each facility with which the managed care plan contracts. Disagreements between the managed care plan and providers regarding whether negotiations have been conducted in accordance with community standards for industry are to be decided by the department.

A nonparticipating provider is defined as a health care practitioner or facility that does not have a written contract to participate in a managed health care system's provider network. When a nonparticipating provider provides services to an enrollee covered by a state-contracted managed care plan, the plan must pay the nonparticipating provider the mode rate that the managed care plan pays participating providers for the same service in the same area. The plan must notify the department and the provider as to the basis for utilizing the nonparticipating provider's services.

These provisions expire January 1, 2014.

**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: The bill addresses what is a growing problem not only for state-purchased managed care programs, but commercial insurance programs as well. The problem arises when professionals working at a hospital that accepts a managed care plan's payment rates refuse to do so for their services. Billed charges are often as much as five times higher than Medicaid fee-for-service rates upon which state managed care payments are based. The bill provides a common sense solution to a growing problem that could result in major cost increases that the state simply can't afford.

CON: Hospitals are concerned that including the term "facilities" in the bill could weaken their ability to negotiate favorable rates with state-contracted managed care plans. The state agencies' concerns about the cost impact of the court case are over-stated. Nothing in the superior court ruling mandates that billed charges be paid to all providers. For other providers to be entitled to the payments at issue in the case in question, their situation would

need to match the very specific fact pattern in the case. The situation can be resolved without a legislative solution.

**Persons Testifying**: PRO: Senator Keiser, prime sponsor; Preston Cody, Health Care Authority, Department of Social and Health Services; Rebecca Kavoussi, Community Health Plan of Washington; Davor Gjurassic, Laurel Lee, Molina Healthcare; Joe King, Group Health Cooperative.

CON: Lisa Thatcher, Washington State Hospital Association; Tim Layton, Washington State Medical Association.

**House Amendment(s)**: The definition of nonparticipating provider is modified to include facilities and references to hospitals are removed. The managed care system contracting for Medicaid and Basic Health programs shall pay nonparticipating providers no more than the lowest amount paid for that service under the managed health care system's contracts with similar providers in the state. The nonparticipating provider must accept the payment as payment in full and may not balance bill the patient except for any deductible, copayment or coinsurance. The department must monitor and periodically report on the proportion of services provided by contracted providers and nonparticipating providers, by county, for each managed are health system to ensure that managed health care systems are meeting network adequacy requirements. No later than January 1st of each year, the department will review and reports its findings to the Legislature for the preceding state fiscal year. The new requirements expire July 1, 2016.