SENATE BILL REPORT
SB 5434

As of February 15, 2013

Title: An act relating to the filing and public disclosure of health care provider compensation.

Brief Description: Addressing the filing and public disclosure of health care provider compensation.

Sponsors: Senators Becker, Dammeier, Keiser, Harper and Conway.

Brief History:
Committee Activity: Health Care: 2/14/13.

SENATE COMMITTEE ON HEALTH CARE

Staff: Mich'l Needham (786-7442)

Background: The federal Affordable Care Act (ACA) established a number of new requirements for health insurance. Many requirements become effective for coverage offered on or after January 1, 2014. Among the requirements for the non-grandfathered individual and small-group markets are rating standards, enhanced rate review, standardized data submissions, and guaranteed availability. States with effective rate review programs will review the detailed information, and the Centers for Medicare and Medicaid Services (CMS) will review the information for states that do not have an effective rate review program.

Allowed rating factors include individual or family coverage, geographic rating area, age with a three to one variation for adults, and tobacco use with variation of one and one-half to one. The premiums for any plan may only vary from the rating index by actuarial value and cost-sharing of the plan, the plan's provider network and delivery system characteristics, and utilization management practices. Verification of the rating factors requires extensive rating detail to be submitted to the Office of the Insurance Commissioner (OIC).

Summary of Bill: Health insurance carriers must file all provider contracts and provider compensation agreements with OIC 30 calendar days before use. When a carrier and provider negotiate an agreement that deviates from a filed agreement, the specific contract must be filed 30 days prior to use. Any provider compensation agreements not affirmatively disapproved by OIC are deemed approved, except OIC may extend the approval date an additional 15 days with notice before the initial 30-day period expires. Changes to the previously filed agreements that modify the compensation or related terms must be filed and

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are deemed approved upon filing if no other changes are made to the previously approved agreement.

OIC may not base a disapproval of the agreement on the amount of the compensation or other financial arrangements between the carrier and provider, unless the compensation amount causes the underlying health benefit plan to be in violation of state or federal law. OIC is not granted authority to regulate provider reimbursement amounts. OIC may withdraw approval of a provider contract or compensation agreement at any time for cause.

Provider compensation agreements are confidential and not subject to public inspection or public disclosure if they are filed following the procedures for submitting confidential filings in the electronic rate and form filings. If the filing instructions are not followed and the carrier indicates the compensation agreement will be withheld from public inspection, OIC must reject the filing and notify the carrier to amend the filing in order to comply with the confidentiality instructions.

If a provider contract is disapproved or withdrawn from use by OIC, the insurance carrier has a right to demand and receive a hearing.

The requirement for Health Care Service Contractors and Health Maintenance Organizations (HMOs) to file forms of participating provider contracts 15 days before use is removed.

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: PRO: The Commissioner sends his strong support for this bill. Many provisions are already in place and we are requiring new filings to provide this detailed information now. This bill provides protection for the information that we have now. Provider contracts and agreements are currently filed but there will be an additional level of review required by the ACA. It is important that the competitive market maintain confidentiality with these trade secrets. The ACA builds on the competitive private insurance market and we need to ensure the tools that allow competitors to remain confidential. This bill is a great example of collaborative drafting with the industry and OIC. We worked together for months to ensure the language works for industry and regulators. Group Health is exploring an amendment that may help the language function for HMOs more appropriately.

OTHER: It is unclear how we bring transparency to consumers and empower consumers to choose their care wisely. This is an expansion of the practices within OIC and government should not collect more than is required to regulate. The language has no side boards for limiting what is withheld. The disclosure of all prices works very well in other insurance industries like the auto body repairs where you are told all the prices with and without insurance. The lack of disclosure in health care pricing has us by the throats.

Persons Testifying: PRO: Beth Berendt, OIC; Davor Gjurasic, Molina Healthcare; Mel Sorensen, America's Health Insurance Plans; Len Sorrin, Premera Blue Cross; Chris Bandoli, Regence Blue Shield; Syndey Zvara, Assn. of WA Healthcare Plans; Katie Kolan, WA State Medical Assn.; Amber Ulvenes, Group Health.

OTHER: Roland Thompson, Allied Daily Newspapers of WA, WA Newspaper Publishers.