FINAL BILL REPORT
SSB 5434

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Synopsis as Enacted

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

Sponsors: Senate Committee on Health Care (originally sponsored by Senators Becker, Dammeier, Keiser, Harper and Conway).

Senate Committee on Health Care
House Committee on Health Care & Wellness

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 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: 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 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

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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. The information is protected from disclosure in the Public Records Act. If the filing instructions are not followed and the carrier indicates that 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 act expires July 1, 2017.

Votes on Final Passage:

Senate	47	0	
House	96	0	(House amended)
Senate	47	0	(Senate concurred)

Effective: July 28, 2013.