SENATE BILL REPORT
SB 5631

As of February 21, 2013

Title: An act relating to modifying the expiration dates that limit payments for health care services provided to low-income enrollees in state purchased health care programs by aligning them with the start of medicaid expansion.

Brief Description: Modifying the expiration dates that limit payments for health care services provided to low-income enrollees in state purchased health care programs by aligning them with the start of medicaid expansion.

Sponsors: Senator Becker.

Brief History:
Committee Activity: Health Care: 2/19/13, 2/20/13.

SENATE COMMITTEE ON HEALTH CARE

Staff: Mich'l Needham (786-7442)

Background: The Health Care Authority (HCA) contracts with health insurance systems to deliver medical care services for Medicaid, Disability Lifeline, and Basic Health programs, among others. The managed care medical systems contract with individual health care providers, group practices, clinics, hospitals, pharmacies, and other entities to participate in their network. Persons enrolled in the managed care plan must typically obtain services from providers who participate in the plan's network in order for the service to be covered.

Enrollees received services from network facilities that included non-network providers, and disputes rose over the billing and payment requirements for the non-network providers who were demanding full-billed charges be paid by the managed care plans. Legislation passed in 2011 created a definition of non-participating providers for the HCA Medicaid-purchased programs, and placed limits on payments that can be made to non-participating providers. When a non-participating provider delivers services to an enrollee covered by a state-contracted managed care plan, the plan must pay the non-participating provider no more than the lowest amount paid for that service under the health care system's contracts with similar providers in the state. The payment must be accepted as payment in full and the provider may not balance bill the patient except for any deductible, copayment, or coinsurance.

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 2011 language also requires the HCA to monitor the network of providers to ensure adequate access to all services, and to report to the Legislature annually on the services provided by contracted providers and non-participating providers for each managed care system. The payment language and reporting requirements expire July 1, 2016.

Summary of Bill: The language limiting the state-contracted managed care plans' payment of non-participating providers, and the requirements to report the use of contracted providers and non-participating providers, expires July 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: PRO: The 2011 legislation was driven by the fear of litigation and the potential to be forced to pay billed charges, but the Court of Appeals did not support that argument. The 2011 language to pay the lowest possible rate was a policy over-reach in anticipation of court decisions that did not come. It has resulted in uneven contracting with Medicaid where there is no incentive for the managed care plans to reach a contract agreement if they can pay the lowest possible rate for services. Medicaid expansion should offer an opportunity to contract with providers with new negotiated rates. The default rate has undermined the contracting efforts and there are gaps in care.

CON: The managed care plans still need the protection offered by the 2011 legislation. Lawsuits are still pending for the request for full-billed charges. Removing the language allows providers to bill exorbitant rates in lieu of contracting with Medicaid-managed care plans. The cases that arose with services provided in contracted hospitals that included groups that refused to contract with Medicaid-managed care plans and then sued such plans for billed charges. The 2011 estimates for the state impact were in the $100 million range. The 2011 legislation also included requirements to monitor networks and access and that provides the incentive for managed care plans to negotiate a successful contract and maintain a network. As a newly participating Medicaid-managed care organization, we are committed to holistic solutions for Medicaid that help manage cost. This bill will increase cost for plans and the state.

Persons Testifying: PRO: Katie Kolan, WA State Medical Assn.; Brad Boswell, WA State Radiological Society; Lisa Thatcher, WA State Hospital Assn.

CON: Davor Gjurasic, Molina Healthcare; Pamela Crone, Community Health Plan of WA; Bill Stauffacher, Coordinated Care.