SENATE BILL REPORT
SB 6304

As of January 30, 2014

Title: An act relating to preserving patient and practitioner freedom to obtain and provide health care by prohibiting unfair and deceptive practices in contracting for and managing health care delivery under health plans.

Brief Description: Preserving patient and practitioner freedom to obtain and provide health care by prohibiting unfair and deceptive practices in contracting for and managing health care delivery under health plans.

Sponsors: Senators Parlette, Frockt, Benton, Rolfes, Keiser, Pearson, Angel, Bailey, Becker, Tom and Kohl-Welles.

Brief History:
Committee Activity: Health Care: 1/30/14.

SENATE COMMITTEE ON HEALTH CARE

Staff: Mich'l Needham (786-7442)

Background: Legislation passed in 2013 established contracting standards for health insurance carriers' contracts with health care providers. Health insurance carriers must provide health care providers with at least 60 days' notice of any proposed material amendments to their contract. Material amendments are those that require a provider to participate in a health plan or product line with a lower fee schedule in order to continue to participate in the health plan.

Some providers have expressed additional concerns with contracting practices and health plan benefit designs.

Summary of Bill: Health insurance plans are subject to requirements for benefit design management and additional contracting standards.

Health plans may not impose cost sharing that requires a covered person to pay more than 50 percent of the amount the health plan allows for coverage. Health plans may not require prior authorization for routine health care services for which a person may self-refer.

Health plans may not:

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- require health care providers to participate in one plan or arrangement as a condition for participating in any of the carrier's other arrangements;
- require a provider to provide a discount from usual and customary rates for services that are not covered under the plan; or
- terminate the network participation agreement based solely upon the provider's efforts to enforce the provider's rights or the rights of the patient.

Health plans must disclose:

- the criteria and methods for limits on access to network providers, including the method for determining that a network provider may render care to a covered person without prior authorization while imposing prior authorization on other network providers; and
- the methods and clinical protocols for authorizing coverage of services, including the carrier's method for determining initial visit limits for a particular service.

Health plans that use providers to consult on decisions to deny, limit, or terminate a covered service must hold a license, certification, or registration in Washington and must be actively practicing in the same field or specialty as the service under review. If the covered person is being treated by more than one provider, the review must be completed by a provider with a license, certification, or registration in Washington and must be actively practicing in the same field or specialty as the principal prescribing or diagnosing provider.

Appropriation: None.

Fiscal Note: Not requested.

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: This is about competition in the marketplace. Today providers are price takers with no negotiation room. We can accept the contract or reject it. Allowing plans to tie us to multiple products adds to their monopoly of the market. We would like to see the copay section modified to include the language discussed in SB 6123 with limits on copays tied to primary care. Plans should not be able to dictate standards on non-covered services. Let providers set their own prices on non-covered services. The right to self-refer is established for some services and patients should not have limitations on that. Providers want information on why they are in designated tiers, how did they get there and how do they move to different tiers. Prior authorization interferes with patients' access to care when they need it.

CON: This bill is very confusing. It is not clear to us what the specific issue is the bill seeks to resolve. It seeks to take away the plan's tools for managing cost with prior authorization, which allows us to ensure the care is safe and medically necessary. The disclosure requirements exist in WAC now with information available to providers. We do not need duplicative requirements. These changes will impact the carrier's ability to control costs and will increase premiums. The requirement to have every provider type that is licensed in

Washington on contract with carriers to complete reviews would create huge costs and administrative overhead with no added consumer benefit.

OTHER: Please add language on the prescription cost sharing. Some plans have very high cost sharing for specialty drugs and it is becoming a significant burden on patients and a barrier to care.

Persons Testifying: PRO: Senator Parlette, prime sponsor; Kate Tudor, WA Occupational Therapy Assn.; Melanie Stewart, American Massage Therapy Assn. WA Chapter, WA State Podiatric Medical Assn.; Brad Tower, Optometric Physicians of WA; Dale Tosland, Olympia Vision Clinic; Melissa Johnson, Physical Therapy Assn. of WA; Lori Grassi, Dave Butters, WA State Chiropractic Assn.

CON: Chris Bandoli, Regence BlueShield; Sydney Zvara, Assn. of W Healthcare Plans; Sheela Tallman, Premera Blue Cross; Joe King, Group Health; Mel Sorensen, America's Health Insurance Plans, Express Scripts.

OTHER: Jim Freeburg, National Multiple Sclerosis Society, Greater NW Chapter.