2SHB 1471 - H AMD **196**
By Representative Riccelli

ADOPTED 3/9/2015

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** A new section is added to chapter 41.05 RCW to read as follows:

(1) A health plan offered to public employees and their covered dependents under this chapter that imposes different prior authorization standards and criteria for a covered service among tiers of contracting providers of the same licensed profession in the same health plan shall inform an enrollee which tier an individual provider or group of providers is in. The health care authority shall post the information on its web site in a manner accessible to both enrollees and providers.

(2) The health plan may not require prior authorization for an evaluation and management visit or an initial treatment visit with a contracting provider in a new episode of habilitative, rehabilitative, East Asian medicine, or chiropractic care.

(3) Any prior authorization standards and criteria used by the health plan, or a subcontractor or third-party administrator administering all or part of the plan, must be based on the plan's medical necessity standards.

(4) The health care authority shall post on its web site and provide upon the request of a covered person or contracting provider any standards, criteria, or information the health plan uses for prior authorization decisions.

(5) A health care provider with whom the administrator of the health plan consults regarding a decision to deny, limit, or terminate a person's covered health care services must hold a license, certification, or registration, in good standing and must be in the same or related health field as the health care provider being reviewed or of a specialty whose practice entails the same or similar covered health care service.

(6) The health plan may not require a provider to provide a discount from usual and customary rates for health care services not

covered under the health plan, policy, or other agreement, to which the provider is a party.

(7) A health plan offered to employees and their covered dependents under this chapter may not require a covered person's cost sharing, including copayments, for habilitative, rehabilitative, East Asian medicine, or chiropractic care to exceed the cost-sharing amount the plan requires for primary care.

(8) For purposes of this section, "new episode of care" means treatment for a new condition that has not been presented to the provider:

(a) Less than sixty days prior to the first encounter for the condition; and

(b) Less than sixty days after the most recent encounter for the condition.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW to read as follows:

(1) A health carrier that imposes different prior authorization standards and criteria for a covered service among tiers of contracting providers of the same licensed profession in the same health plan shall inform an enrollee which tier an individual provider or group of providers is in. The carrier shall post the information on its web site in a manner accessible to both enrollees and providers.

(2) A health carrier may not require prior authorization for an evaluation and management visit or an initial treatment visit with a contracting provider in a new episode of habilitative, rehabilitative, East Asian medicine, or chiropractic care.

(3) Any prior authorization standards and criteria used by a health plan, or a subcontractor administering all or part of the health plan, must be based on the carrier's medical necessity standards on file with the commissioner.

(4) A health carrier shall post on its web site and provide upon the request of a covered person or contracting provider any standards, criteria, or information the carrier uses for prior authorization decisions.

(5) A health care provider with whom a health carrier consults regarding a decision to deny, limit, or terminate a person's covered health care services must hold a license, certification, or registration, in good standing and must be in the same or related

health field as the health care provider being reviewed or of a specialty whose practice entails the same or similar covered health care service.

(6) A health carrier may not require a provider to provide a discount from usual and customary rates for health care services not covered under a health plan, policy, or other agreement, to which the provider is a party.

(7) A health carrier may not require a covered person's cost sharing, including copayments, for habilitative, rehabilitative, East Asian medicine, or chiropractic care to exceed the cost-sharing amount the carrier requires for primary care.

(8) For purposes of this section, "new episode of care" means treatment for a new condition that has not been presented to the provider:

(a) Less than sixty days prior to the first encounter for the condition; and

(b) Less than sixty days after the most recent encounter for the condition.

NEW SECTION. **Sec. 3.** This act takes effect January 1, 2017."

Correct the title.

EFFECT: Removes the requirement that an enrollee be informed which tier his or her provider is in "on demand" and requires information about provider tiers to be posted on a web site accessible to both enrollees and providers. Applies the requirement that prior authorization standards be based on medical necessity standards to subcontractors and third-party administrators. Requires the medical necessity standards applicable to prior authorization decisions by a health carrier or its subcontractor to be on file with the Office of the Insurance Commissioner. Allows a provider with whom a carrier (or administrator of a health plan offered to public employees) consults when making coverage decisions to be in a specialty whose practice entails the same or similar covered health care service, instead of a "related health field." Changes the definition of "new episode of care" to include only conditions that have not been presented to the provider in the 60 days prior to the first encounter with the provider or the 60 days after the most recent encounter with the provider. Removes the provision requiring health plans to honor representations by subcontractors. Removes the provisions prohibiting "rental networks" from requiring providers to accept new products.

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