Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1471

Brief Description: Mitigating barriers to patient access to care resulting from health insurance contracting practices.

Sponsors: Representatives Cody, Schmick, Harris, Van De Wege, DeBolt, Hurst, Kretz, Moeller, Jinkins and Tharinger.

Brief Summary of Bill

- Imposes requirements on health carriers relating to prior authorization and the use of subcontractors.

Hearing Date: 2/4/15

Staff: Jim Morishima (786-7191).

Background:

Health carriers enter into contracts with health care providers under which the providers agree to accept a specified reimbursement rate for their services. Health carriers sometimes require prior authorization for certain health procedures. Prior authorization is the requirement that a health care provider seek approval of a drug, procedure, or test before seeking reimbursement from an insurer.

A health carrier may not require a provider to extend the carrier's Medicaid rates, or some percentage above the carrier's Medicaid rates, to a commercial plan or line of business, unless the provider has expressly agreed in writing to the extension. The requirement that the provider expressly agree to the extension does not prohibit the carrier from using its Medicaid rates, or some percentage above its Medicaid rates, as a base when negotiating payment rates with a provider.

Summary of Bill:

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.

A health carrier may not:

- impose different prior authorization standards and criteria for a covered person among contracting providers of the same licensed health profession;
- require prior authorization for the first encounter with a contracting provider in a new episode of care;
- require a health carrier to participate in one plan, program, or health care arrangement as a condition for participating in any of the carrier's other plans, programs, or arrangements;
- require a provider to provide a discount from his or her usual and customary rates for non-covered services; or
- impose a cost-sharing requirement for habilitative, rehabilitative, or chiropractic care that exceeds the carrier's requirements for primary care.

The health carrier must:

- disclose upon request its prior authorization standards, criteria, and information the carrier uses for prior authorization decisions; and
- respond to a prior authorization request within 24 hours—failure to do so results in the request being deemed granted.

A provider with whom the carrier consults regarding decisions to deny, limit, or terminate a person's coverage must hold a license, certification, or registration in Washington and must be actively practicing in the same field or specialty as the health care provider being reviewed. If the covered person is being treated by more than one provider, the reviewing provider must be actively practicing in the same field or specialty as the principal prescribing or diagnosing provider, unless the carrier and the covered person agree otherwise.

A health carrier is responsible for any activities it delegates to a subcontractor regarding coverage denials, limitations, or access. The carrier must ensure that the subcontractor uses the same standards and criteria applicable under a covered person's health plan. If a subcontractor informs a covered person that he or she is eligible for reimbursement for services that exceed the scope of his or her actual coverage, the carrier is bound by that information if it favors the covered person.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect on January 1, 2017.