FINAL BILL REPORT
E2SHB 1471

C 251 L 15
Synopsis as Enacted

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

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Cody, Schmick, Harris, Van De Wege, DeBolt, Hurst, Kretz, Moeller, Jinkins and Tharinger).

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

Background:

Health carriers may enter into contracts with health care providers under which the providers agree to accept a specified reimbursement rate for their services. Health carriers may 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 a health carrier. A health carrier may not retrospectively deny coverage for care that had prior authorization unless the prior authorization was based upon a material misrepresentation by the provider.

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.

A health carrier must provide at least 60 days' notice to a health care provider of any proposed material amendments to the provider's contract. A material amendment is an amendment to a contract that would result in requiring the provider to participate in a health plan, product, or line of business with a lower fee schedule in order to continue to participate in a health plan, product, or line of business with a higher fee schedule. During the 60-day period, the provider may reject the material amendment without affecting the terms of the existing contract. The material amendment must be clearly defined in a notice to the provider before the notice period begins. The notice must inform the provider that he or she

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may choose to reject the terms of the material amendment through written or electronic means at any time during the notice period and that such rejection will not affect the terms of the existing contract. The health carrier's failure to comply with the notice requirements voids the effectiveness of the material amendment.

Summary:

A health carrier or a health plan offered to public employees 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 chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapies. This prohibition does not affect the ability of a health plan to require a referral or prescription for these therapies. A "new episode of care" means treatment for a new or recurrent condition for which the enrollee has not been treated by the provider within the previous 90 days and is not currently undergoing any active treatment. A contracting provider does not include a provider employed within an integrated delivery system.

A health carrier or a health plan offered to public employees may not require a provider to provide a discount from his or her usual and customary rates for non-covered services.

The health carrier or health plan offered to public employees must post on its website (or the Health Care Authority's website for health plans offered to public employees), and disclose upon request, the prior authorization standards, criteria, and information used for medical necessity decisions.

A health carrier or health plan offered to public employees 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 must inform an enrollee which tier an individual provider or group of providers is in. The health carrier or health plan offered to public employees must make this disclosure by posting the information on its website in a manner accessible to both enrollees and providers.

A provider with whom the carrier or administrator of the health plan offered to public employees consults regarding decisions to deny, limit, or terminate a person's coverage must hold a license, certification, or registration in good standing and must be in the same or related field as the health care provider being reviewed or be a specialist whose practice entails the same or similar covered health care service.

Votes on Final Passage:

House	82	16	
Senate	47	2	(Senate amended)
House	95	0	(House concurred)

Effective: January 1, 2017