HOUSE BILL REPORT
E2SHB 1471

As Amended by the Senate

Title: An act relating to mitigating barriers to patient access to care resulting from health insurance contracting practices.

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).

Brief History:
Committee Activity:
Health Care & Wellness: 2/4/15, 2/20/15 [DPS];
Appropriations: 2/25/15, 2/27/15 [DP2S(w/o sub HCW)].
Floor Activity:
Passed House: 3/9/15, 82-16.
Senate Amended.
Passed Senate: 4/13/15, 47-2.

Brief Summary of Engrossed Second Substitute Bill

- Imposes requirements on health carriers and health plans offered to public employees relating to prior authorization, cost sharing, and the use of subcontractors.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 14 members: Representatives Cody, Chair; Riccelli, Vice Chair; Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Jinkins, Moeller, Robinson, Rodne, Short, Tharinger and Van De Wege.

Minority Report: Do not pass. Signed by 1 member: Representative Johnson.

Staff: Jim Morishima (786-7191).

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.

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Health Care & Wellness. Signed by 26 members: Representatives Hunter, Chair; Ormsby, Vice Chair; Chandler, Ranking Minority Member; Parker, Assistant Ranking Minority Member; Carlyle, Cody, Dent, Dunshee, Fagan, Haler, Hansen, Hudgins, S. Hunt, Jinkins, Kagi, Lytton, Magendanz, Pettigrew, Sawyer, Schmick, Senn, Springer, Stokesbary, Sullivan, Tharinger and Walkinshaw.

Minority Report: Do not pass. Signed by 7 members: Representatives Wilcox, Assistant Ranking Minority Member; Buys, Condotta, G. Hunt, MacEwen, Taylor and Van Werven.

Staff: Erik Cornellier (786-7116).

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 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 an insurer. 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 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 of Engrossed Second Substitute Bill:

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 habilitative, rehabilitative, East Asian medicine, or chiropractic care—a new episode of care means treatment for a new condition that has not been presented the provider in the 60 days prior to the first encounter with the provider or the 60 days after the most recent encounter;
- 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, East Asian medicine, or chiropractic care that exceeds the cost-sharing requirements for primary care.

The health carrier or health plan offered to public employees must:

- post on its website (or the Health Care Authority's web site for health plans offered to public employees) and disclose upon request the prior authorization standards, criteria, and information used for prior authorization decisions; and
- base its prior authorization standards and criteria on the plan's medical necessity standards, which, for private health carriers, must be on file with the Office of the Insurance Commissioner.

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. A health carrier must post the information on its web site in a manner accessible to both enrollees and providers. The Health Care Authority must post the information on its web site for a health plan offered to public employees.

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.

EFFECT OF SENATE AMENDMENT(S):

The Senate amendment: (1) removes the prohibition against a health plan imposing cost sharing for certain types of care that exceeds the cost sharing for primary care; (2) removes the requirement that prior authorization standards be based on medical necessity standards; (3) Clarifies that a health plan meets the requirement of disclosing which tier a provider is in by posting the information on its web site in a manner accessible to both enrollees and providers; (4) changes the information that a health plan must provide on its web site or upon request—the health plan must provide the prior authorization standards, criteria, or information used for medical necessity decisions, instead of the standards, criteria, or information used for prior authorization decisions; (5) changes the types of care for which prior authorization is prohibited for an evaluation and management or initial treatment visit—the prohibition applies to chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, and speech and hearing therapies, instead of to habilitative,

rehabilitative, East Asian medicine, or chiropractic care; (6) Clarifies that the health plan may require a referral or prescription for chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, and speech and hearing therapies; (7) Changes the definition of "new episode of care"—"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 undergoing any active treatment, instead of a new condition that has not been presented to the provider 60 days before the first encounter for the condition and 60 days after the most recent encounter; (8) Clarifies that "contracting provider" does not include providers employed within an integrated delivery system.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) Care should be based on patient needs. Prior authorization is not objectionable in and of itself, but it can be an administrative nightmare for providers, be stressful and confusing to patients, and cause treatment delays. The system is short-sighted and will increase patients' risk of injuries and hospitalizations. Carriers often place providers into tiers without their knowledge. Tiering is an administrative burden to providers, adversely affects patient care, and can be based on inaccurate data. Most patients are unaware of tiering; they have no idea that their benefits are limited based on the provider they choose. The number of visits that is authorized is often too few to adequately treat the patient. Copays for covered services are often excessive, exceeding the allowed amount of the service itself. The cost of copays is causing patients to delay needed care, which can result in disability, chronic pain, and the loss of work. If patients are unable to access their benefits because of copays, they are not getting the benefit for which they pay. Most providers are unable to negotiate their contracts with carriers. There should be a global fix to these problems. East Asian medicine practitioners should be included in this bill.

(Opposed) Requiring the carrier to consult with medical professionals licensed in every state when making coverage decisions would result in national carriers needing 50 different practitioners, one for each state. Much of this bill is already covered under current law; this bill will increase costs because of administrative burdens and will have no added value for enrollees. Providers are currently informed of tiering criteria and are given tools to measure themselves against their peers in order to improve themselves. Tiering is a way to reward efficiency and high quality. The reason copays are high for specialty services is to encourage the evaluation of care to be performed in primary care for better care coordination. Prior authorization timing is already specified in current law; a 24-hour turnaround is already required for emergency services. Many carriers are using evidence-based managed care; this bill would make it impossible for carriers to require prior authorization. It is unclear what this bill is trying to do about rental networks. This bill will conflict with current law.

Staff Summary of Public Testimony (Appropriations):

(In support) Two of the provisions that drove costs and administrative burdens in the fiscal note have been removed from the bill: the requirement to respond to a prior authorization request in 24 hours and the requirement that the person conducting the authorization have the same qualifications as the provider requesting it and must be practicing in the state.

The provision prohibiting prior authorization for the first visit was limited in response to concerns that the insurers brought forward. Now it only applies to habilitative, rehabilitative, East Asian medicine, and chiropractic visits. Most of those services require a referral from another provider, so there are already sidebars. Transparency and disclosure should not be cost prohibitive.

The fiscal note stated that there would be increased utilization and uncontrolled costs, but these provisions are managed under medical necessity requirements, benefit limits are set by carriers, and this is all done under managed care. Patients are not just using it to use. The copayment for chiropractic services currently exceeds the allowed amount in the fee schedule, so that is not a complete benefit since the client is already paying the premium anyway.

The application to Apple Health could be amended in the next renewal. The fiscal note mentioned possible savings.

(With concerns) The changes in the proposed substitute bill from the underlying committee were good. Significant issues remain. There are aspects of the proposed substitute bill that will have cost driving impacts. For example, if copays and out of pocket exposures are forced to go down, premiums must go up or there will be other adjustments in the program. There is no free money in the system. This is also the case for local governments.

(Opposed) A rough estimate of the cost to Regence Blue Shield (Regence) of the cost sharing provisions shows that they would require a $2.50 per member per month increase in premiums, a 0.5 percent premium increase. That is a large increase from one change. Regence's membership includes public sector employees in the Uniform Medical Plan.

This bill is aimed at severely weakening the ability of health carriers to use established tools to provide safe and efficient health care. Uncontrolled utilization would drive costs for Medicaid and commercial carriers. This would impact Washington residents' access to affordable coverage.

Persons Testifying (Health Care & Wellness): (In support) Lori Grassi and David Butters, Washington State Chiropractic Association; Melissa Johnson, Physical Therapy Association of Washington and Washington Speech and Hearing Association; Robin Schoenfeld and Emilie Jones, Physical Therapy Association of Washington; Leslie Emerick, Washington East Asian Medicine Association; Kim Wilson, Medical Massage and Acupuncture; and Jeff Gombosky, MultiCare Health System.

(Opposed) Mel Sorensen, America's Health Insurance Plans and CareCore National; Mark Tate and Todd Nakatsuka, CareCore-MedSolutions; Chris Bandoli, Regence Blue Shield; Len Sorrin, Premera Blue Cross; Sydney Smith Zvara, Association of Washington Healthcare Plans; and Chris Marr, Group Health Cooperative.

Persons Testifying (Appropriations): (In support) Melissa Johnson, Physical Therapists Association of Washington; and Lori Grassi, Washington State Chiropractic Association.

(With concerns) Mel Sorensen, America's Health Insurers and Care Core National.

(Opposed) Chris Bandoli, Regence Blue Shield; and Sydney Smith Zvara, Association of Washington Health Care Plans.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): None.

Persons Signed In To Testify But Not Testifying (Appropriations): None.