HOUSE BILL REPORT
ESHB 1762

As Passed House:
March 9, 2015

Title: An act relating to enhancing the relationship between a health insurer and a contracting health care provider.

Brief Description: Concerning the relationship between a health insurer and a contracting health care provider.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Riccelli, Schmick, Jinkins, Harris, Cody, Van De Wege, Robinson and Tharinger).

Brief History:
Committee Activity:
Health Care & Wellness: 2/4/15, 2/18/15 [DPS].
Floor Activity:
Passed House: 3/9/15, 82-16.

Brief Summary of Engrossed Substitute Bill

- Imposes requirements relating to insurance coverage for vision materials and vision services.
- Requires the Insurance Commissioner to respond to a complaint about coverage for vision materials or services in the same manner regardless of the identity of the person or entity making the complaint.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 12 members: Representatives Cody, Chair; Riccelli, Vice Chair; Schmick, Ranking Minority Member; Caldier, Clibborn, Jinkins, Johnson, Moeller, Robinson, Rodne, Tharinger and Van De Wege.

Minority Report: Do not pass. Signed by 2 members: Representatives Harris, Assistant Ranking Minority Member; Short.

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.

Minority Report: Without recommendation. Signed by 1 member: Representative DeBolt.

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. A health carrier must file all provider contracts and provider compensation agreements with the Insurance Commissioner 30 days before use.

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 Substitute Bill:

A health carrier may not:

- prohibit an enrollee from freely contracting at any time to obtain non-covered vision materials or services outside the health benefit plan on any terms or conditions agreed upon between the enrollee and the provider—this prohibition does not bind the carrier or provider for any non-covered vision materials or services or prohibit the provider from choosing to opt in to a materials discount program sponsored by a carrier or vision care plan;
- require an optometrist, ophthalmologist, or dispensing optician to participate with, or be credentialed by, another carrier or health benefit plan as a condition of joining one of the carrier's provider panels; or
- require an optometrist, ophthalmologist, or dispensing optician to purchase vision materials or services from suppliers, including optical labs, in which the carrier has a financial interest.

A health carrier must provide at least 60 days' notice to an optometrist, ophthalmologist, or dispensing optician of any proposed changes to the provider contract, which the provider may reject at any time within the notice period. Rejection of the changes may not affect the existing provider contract. If there is no response after 60 days, the health carrier may deem the amendments to be accepted as long as the notice was delivered via certified mail.

A carrier may require a vision care provider to notify the carrier of any changes to his or her provider practice status, including tax identification, address, phone number, hours of operations, and providers on staff.

The Insurance Commissioner must respond to a complaint regarding vision care coverage using the same standards, timelines, and procedures, regardless of the identity of the person or entity making the complaint.

"Vision materials" is defined as ophthalmic devices, including devices containing lenses, artificial intraocular lenses, ophthalmic frames and other lens mounting apparatuses, prisms, lens treatments and coating, contact lenses, or prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or adnexa. "Vision services" is defined as professional work performed by an optometrist or ophthalmologist within his or her scope of practice.

"Non-covered vision materials or services" is defined as vision materials or services that are ineligible for reimbursement or excluded from coverage under the terms and conditions of a health plan. Vision materials or services that are not reimbursable due to the operation of plan or contract limitations are not considered non-covered vision materials or services.

Appropriation: None.

Fiscal Note: Available.

Effective Date: This bill takes effect January 1, 2016.

Staff Summary of Public Testimony:

(In support) Health insurers are experimenting with different models for vision care services, which leads to patient confusion. Adequate networks are essential. Economic relationships between entities must be considered and limited. Accountability is critical. This bill improves transparency, prevents cross subsidization, prohibits insurers from funneling business to labs that they own, and prohibits an insurer from requiring acceptance of one product as a condition for accepting another product. Patients are often required to pay out-of-pocket expenses that exceed the usual and customary rates for the services. This bill does not prohibit these arrangements; it lets providers opt out of them and gives clear terms of engagement. Dispensing opticians should be included in this bill.

(Opposed) Many of the provisions of this bill are already covered under current law. This bill contradicts the existing provider notification practices, which will make it difficult to administer. This bill expands coverage for vision services. The requirement that vision care providers be reimbursed using usual and customary rates puts a fee-for-service system into law, emphasizes quantity over quality, and increases health care costs. Limiting the length of provider contracts will result in carriers having to renegotiate the contracts every year, which is contrary to industry practice and would be disruptive to provider networks. Any provider can currently opt out of a network with 60 days' notice. Negotiated discounts benefit both providers and patients, who expect these discounts. This bill will eliminate patient choice and will be a cost driver.

Persons Testifying: (In support) Representative Riccelli, prime sponsor; Brad Tower and Kim White, Optometric Physicians of Washington; and Lisa Thatcher, Opticians Association of Washington.

(Opposed) Chris Marr, Group Health Cooperative; Chris Bandoli, Regence Blue Shield; Bill Stauffacher, National Association of Vision Care Plans; Len Sorrin, Premera Blue Cross; and Sydney Smith Zvara, Association of Washington Healthcare Plans.

Persons Signed In To Testify But Not Testifying: None.