SENATE BILL REPORT
E2SHB 1471

As Reported by Senate Committee On:
Health Care, March 31, 2015

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: Passed House: 3/09/15, 82-16.
Committee Activity: Health Care: 3/26/15, 3/31/15 [DPA].

SENATE COMMITTEE ON HEALTH CARE

Majority Report: Do pass as amended.
Signed by Senators Becker, Chair; Dammeier, Vice Chair; Frockt, Ranking Minority Member; Angel, Bailey, Brown, Cleveland, Conway, Jayapal, Keiser and Parlette.

Staff: Mich'l Needham (786-7442)

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.

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 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 the provider 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 Bill (Recommended Amendments): 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; or
- require a provider to provide a discount from the provider's usual and customary rates for non-covered services.

The health carrier or health plan offered to public employees must post on its website, and disclose upon request, any prior authorization standards, criteria, or information the health plan uses 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 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.

EFFECT OF CHANGES MADE BY HEALTH CARE COMMITTEE (Recommended Amendments):

- Removes the requirement for prior authorization standards and criteria to be based on the plan's medical necessity standards;
- Plans must post the prior authorization standards, criteria, or information the plan uses for medical necessity;
- Removes the requirement to have cost sharing and copayments for the listed services that do not exceed the cost sharing for primary care; and
- Removes the definition of new episode of care.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

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

Staff Summary of Public Testimony on Engrossed Second Substitute House Bill: PRO: Regence has contracted with CareCore National, out of South Carolina, to oversee physical therapy, massage, and chiropractic care. They have instituted a prior authorization process for referrals to physical therapy and they deny care based on a medical necessity definition that is different from the one Regence is using. They authorize small numbers of services for providers in the lowest tier, such as one or two visits, which results in a time delay and extra paperwork for providers. The extra step of requiring a primary care visit before a patient can access the most appropriate treatment just delays care. The study handed out demonstrates patients can get better treatment response the sooner they see their chiropractor and the treatment is more cost effective than when it is delayed. Most chiropractic benefits only cover ten visits per year so patients end up paying for the extra services out of pocket and there is no reason to deny that access. The episode of care definition used in the bill matches the definition used by another carrier and the Veterans Administration. Unless we can bring a group of 20 or more providers, we cannot negotiation any contracts. The person used to review access to care is not up to date with the appropriate care – in at least one case we know they used a doctor of ministry who has no training to determine medically appropriate care for anyone. We would like the reviewer to be in the same field with up-to-date knowledge of the field and knowledge of evidence-based practices. The coinsurance to access therapies is discouraging appropriate care. We have patients that come to the ALS Clinic that need physical therapy, occupational therapy, and speech therapy and they can get them all in the same day but the charges are very high. We don't want patients to have to choose whether they learn to talk again or walk again. The bill passed the House with a strong bi-partisan vote. It started out more broad and has been narrowed and refined. Information about the decisionmaking about access to care should be available for patients. It is not available now and the decisions made by CareCorp are not consistent.

CON: This bill has been worked considerably but it is still problematic. The approach is aimed at restricting our utilization management tools that ensure access to safe patient care. Prior authorization is one of the few tools we have. We have proposed an alternative amendment that was offered on the House floor but it was defeated. We are particularly concerned with the cost-sharing provision. Primary care visit charges are low to incent the visit to ensure the primary care provider is managing the whole person. We are interested in a broader resolution that does not prohibit prior authorization. We would like the language to focus on provide types not benefit categories such as rehabilitation. Some providers do not use the visit structure. The medical necessity criteria used by the carrier is very broad so that it encompasses the whole span of care and is not specific enough for these services. We are expected to extract the best value for every dollar and one of our techniques is benchmarking practices with best practices and managing provider practices that deviate from the best practices. These providers that are outliers are placed in tiers that allow us to manage those that need more management, and lessen the oversight of providers with best practices.

Persons Testifying: PRO: Melissa Johnson, Emilie Jones, Randy Johnson, Physical Therapy Assn. of WA; Lori Grassi, David Butters, WA State Chiropractic Assn.; Sheila Yakobina, WA Occupational Therapy Assn.; Melanie Stewart, American Massage Therapy Assn. of WA; Mercy Yule, WA East Asian Medicine Assn.; Pete Miller, citizen.

CON: Chris Bandoli, Regence BlueShield; Andrea Tull, Assn. of WA Healthcare Plan; Len Sorrin, Premera Blue Cross; Mel Sorenson, America's Health Insurance Plans, CareCore National; Chris Marr, Group Health.

Persons Signed in to Testify But Not Testifying: No one.