SENATE BILL REPORT
ESHB 1762

As of March 24, 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: Passed House: 3/09/15, 82-16.
Committee Activity: Health Care: 3/24/15.

SENATE COMMITTEE ON HEALTH CARE

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. 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 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: A health carrier may not:

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- 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 the carrier's 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 mean 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 are defined as professional work performed by an optometrist or ophthalmologist within that person's scope of practice.

Non-covered vision materials or services are 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.

Committee/Commission/Task Force Created: No.

Effective Date: The bill takes effect on January 1, 2016.

Staff Summary of Public Testimony: PRO: There are a number of protections provided in medical care services like anti-kickback requirements and contracting standards, and the same types of protections should be applied to vision care plans. This promotes transparency and doesn't allow patients to be steered to special arrangements where the carrier has a financial interest, and it ensures providers are not forced to participate in an arrangement they do not want to participate in. This prevents the cross subsidization of plans, allows patients to contract for non-covered services, and requires contract change notice. The stability of the eye care market is being impacted by greedy plans that require patients to use labs or dispensaries they have an interest in. The carriers and vision care plans have been allowed to control the vision care and limit services and billing for our usual and customary rates by requiring discounts. This prevents that requirement and allows patients to choose where they select their materials.

CON: This is problematic with a number of provisions. It segments covered and non-covered services and vision care plans will not get the cost savings allowed under the insurance contracts. We have continued to work on concerns but the language still leaves confusion about when the vision care plan is regulated vs. the insurance carrier. The plans may choose to delegate to a vision care plan with a provider may choose not to do business with the vendor but that will create a gap in the services for a patient. We are concerned about the language that lets providers opt out of the contract amendment while maintaining the underlying contract terms. We issue few system wide amendments but they need to be implemented system wide. We give 75 days notice for contract changes now. This bill interferes with negotiations between two entities and will treat vision care providers differently from other providers for contract opt-in and opt-out standards.

OTHER: We have a concern with the language that prevents the referral to a lab owned by a carrier. United owns the lab and we believe forcing patients to use a different lab will result in higher costs for consumers. We have one remaining concern about the notice period with 60 days for provider response. Allowing 30 days to accept or reject the change would be consistent across all provider types.

Persons Testifying: PRO: Representative Riccelli, prime sponsor; Brad Tower, Optometric Physicians of WA; Ken White, Optometric Physician.

CON: Bill Stauffacher, National Assn. of Vision Care Plans; Sydney Smith Zvara, Assn. of WA Healthcare Plans; Chris Bandoli, Regence BlueShield; Len Sorrin, Premera Blue Cross; Mel Sorensen, America's Health Insurance Plans.

OTHER: David Knutson, United Healthcare; Amber Ulvenes, Group Health.

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