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ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1471

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State of Washington

64th Legislature

2015 Regular Session

By House Appropriations (originally sponsored by Representatives Cody, Schmick, Harris, Van De Wege, DeBolt, Hurst, Kretz, Moeller, Jinkins, and Tharinger)

READ FIRST TIME 02/27/15.

1 AN ACT Relating to mitigating barriers to patient access to care  
2 resulting from health insurance contracting practices; adding a new  
3 section to chapter 41.05 RCW; adding a new section to chapter 48.43  
4 RCW; and providing an effective date.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6 NEW SECTION. **Sec. 1.** A new section is added to chapter 41.05  
7 RCW to read as follows:

8 (1) A health plan offered to public employees and their covered  
9 dependents under this chapter that imposes different prior  
10 authorization standards and criteria for a covered service among  
11 tiers of contracting providers of the same licensed profession in the  
12 same health plan shall inform an enrollee which tier an individual  
13 provider or group of providers is in. The health care authority shall  
14 post the information on its web site in a manner accessible to both  
15 enrollees and providers.

16 (2) The health plan may not require prior authorization for an  
17 evaluation and management visit or an initial treatment visit with a  
18 contracting provider in a new episode of habilitative,  
19 rehabilitative, East Asian medicine, or chiropractic care.

20 (3) Any prior authorization standards and criteria used by the  
21 health plan, or a subcontractor or third-party administrator

1 administering all or part of the plan, must be based on the plan's  
2 medical necessity standards.

3 (4) The health care authority shall post on its web site and  
4 provide upon the request of a covered person or contracting provider  
5 any standards, criteria, or information the health plan uses for  
6 prior authorization decisions.

7 (5) A health care provider with whom the administrator of the  
8 health plan consults regarding a decision to deny, limit, or  
9 terminate a person's covered health care services must hold a  
10 license, certification, or registration, in good standing and must be  
11 in the same or related health field as the health care provider being  
12 reviewed or of a specialty whose practice entails the same or similar  
13 covered health care service.

14 (6) The health plan may not require a provider to provide a  
15 discount from usual and customary rates for health care services not  
16 covered under the health plan, policy, or other agreement, to which  
17 the provider is a party.

18 (7) A health plan offered to employees and their covered  
19 dependents under this chapter may not require a covered person's cost  
20 sharing, including copayments, for habilitative, rehabilitative, East  
21 Asian medicine, or chiropractic care to exceed the cost-sharing  
22 amount the plan requires for primary care.

23 (8) For purposes of this section, "new episode of care" means  
24 treatment for a new condition that has not been presented to the  
25 provider:

26 (a) Less than sixty days prior to the first encounter for the  
27 condition; and

28 (b) Less than sixty days after the most recent encounter for the  
29 condition.

30 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43  
31 RCW to read as follows:

32 (1) A health carrier that imposes different prior authorization  
33 standards and criteria for a covered service among tiers of  
34 contracting providers of the same licensed profession in the same  
35 health plan shall inform an enrollee which tier an individual  
36 provider or group of providers is in. The carrier shall post the  
37 information on its web site in a manner accessible to both enrollees  
38 and providers.

1 (2) A health carrier may not require prior authorization for an  
2 evaluation and management visit or an initial treatment visit with a  
3 contracting provider in a new episode of habilitative,  
4 rehabilitative, East Asian medicine, or chiropractic care.

5 (3) Any prior authorization standards and criteria used by a  
6 health plan, or a subcontractor administering all or part of the  
7 health plan, must be based on the carrier's medical necessity  
8 standards on file with the commissioner.

9 (4) A health carrier shall post on its web site and provide upon  
10 the request of a covered person or contracting provider any  
11 standards, criteria, or information the carrier uses for prior  
12 authorization decisions.

13 (5) A health care provider with whom a health carrier consults  
14 regarding a decision to deny, limit, or terminate a person's covered  
15 health care services must hold a license, certification, or  
16 registration, in good standing and must be in the same or related  
17 health field as the health care provider being reviewed or of a  
18 specialty whose practice entails the same or similar covered health  
19 care service.

20 (6) A health carrier may not require a provider to provide a  
21 discount from usual and customary rates for health care services not  
22 covered under a health plan, policy, or other agreement, to which the  
23 provider is a party.

24 (7) A health carrier may not require a covered person's cost  
25 sharing, including copayments, for habilitative, rehabilitative, East  
26 Asian medicine, or chiropractic care to exceed the cost-sharing  
27 amount the carrier requires for primary care.

28 (8) For purposes of this section, "new episode of care" means  
29 treatment for a new condition that has not been presented to the  
30 provider:

31 (a) Less than sixty days prior to the first encounter for the  
32 condition; and

33 (b) Less than sixty days after the most recent encounter for the  
34 condition.

35 NEW SECTION. **Sec. 3.** This act takes effect January 1, 2017.

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