# HOUSE BILL REPORT
# HB 1647

**As Reported by House Committee On:**
Health Care & Wellness

**Title**: An act relating to establishing streamlined and uniform administrative procedures for payors and providers of health care services.

**Brief Description**: Concerning administrative procedures for payors and providers of health care services.

**Sponsors**: Representatives Driscoll, Morrell, Green, Clibborn, Moeller, Williams, Wood, Simpson, Kenney and Ormsby.

**Brief History:**
**Committee Activity:**
Health Care & Wellness: 2/17/09, 2/20/09 [DPS].

**Brief Summary of Substitute Bill**

- Directs the Insurance Commissioner to designate an entity to establish streamlined and uniform procedures for payors and providers of health care.

## HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

**Majority Report**: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 13 members: Representatives Cody, Chair; Driscoll, Vice Chair; Ericksen, Ranking Minority Member; Bailey, Campbell, Clibborn, Green, Herrera, Hinkle, Kelley, Moeller, Morrell and Pedersen.

**Staff**: Dave Knutson (786-7146)

**Background**:

At the request of the Blue Ribbon Commission on Health Care Costs and Access, the Office of the Insurance Commissioner (OIC) initiated some efforts to identify the administrative costs associated with health care. Legislation that passed in 2007 directed the OIC to formally report on opportunities to lower administrative expenses. The 2008 Legislature directed the OIC to convene a work group of health care providers, carriers, and payors, and

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to identify the five highest priority goals for achieving significant efficiencies and reducing health care administrative costs.

The five highest priority goals for achieving efficiencies and reducing health care administrative costs have been identified in a report submitted to the Legislature to:

- establish a standardized process and central data source for provider credentialing and other provider demographic data needs;
- amend state regulations regarding coordination-of-benefits claims processing to eliminate estimated payment requirements;
- expand electronic sharing of patient eligibility and benefits information and efficient patient cost-share collection processes;
- standardize use of pre-authorization requirements and introduce transparency where standardization is not reasonable; and
- standardize code edits and payment policies, and introduce transparency of variations where standardization is not reasonable.

The report recommends that the state establish a formal public-private partnership to develop and promote standards for simplifying these top priority administrative processes.

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**Summary of Substitute Bill**:

The Insurance Commissioner (Commissioner) must designate a lead organization to identify and convene work groups to define key processes, guidelines, and standards by December 31, 2010. The Commissioner is directed to participate in and review the work of the lead organization, adopt rules and draft any necessary legislation, form an executive-level work group, and consult with the Office of the Attorney General to determine whether an antitrust safe harbor is necessary to enable carriers and providers to develop common rules and standards.

The lead organization must develop a uniform electronic process for collecting and transmitting provider data to support credentialing, admitting privileges, and other related processes that will serve as the source of credentialing information. The work must assure that data used in the uniform electronic process can be electronically exchanged with the Department of Health's professional licensing process.

The lead organization must establish a uniform standard companion document and data set for electronic eligibility and coverage verification. Patient information must provide detailed information on the eligibility and the benefit coverage and cost-sharing requirements that assist the provider with collection of the patient cost-sharing.

The lead organization must develop implementation guidelines for the use of code edits, including use of the National Correct Coding Initiative code edit policy, publication of any variations in codes, and use of the Health Insurance Portability and Accountability Act standard group codes, reason codes, and remark codes. The lead organization must develop a proposed set of goals and a work plan for additional code standardization efforts by October 31, 2010.

The lead organization must develop guidelines to ensure payors do not automatically deny claims for services when extenuating circumstances interfere with a provider obtaining preauthorization before services are performed, or delayed provider notification to the payor of a patient's admission. The guidelines should require that payors use common and consistent time frames for reviewing requests for medical management, consistent where possible with standards established by the National Committee for Quality Assurance. The lead organization must develop a single, common website for providers to obtain payors' preauthorization, benefits advisory, and preadmission requirements. By October 31, 2010, the lead organization must develop a set of goals and a work plan for the development of medical management protocols.

The Department of Social and Health Services, the Health Care Authority, and the Department of Labor and Industries, to the extent possible under their laws in Title 51, must adopt the processes and guidelines recommended by the lead organization.

**Substitute Bill Compared to Original Bill**:

The Department of Labor and Industries will participate in the implementation of the guidelines to the extent allowed under Title 51 RCW. Health care provider credentialing information is clarified. The requirement for electronic identification cards is removed. The goals for additional code standardization are delayed to October 31, 2010. The development of a common website is modified to include preauthorization, benefits advisory, and preadmission requirements. The information on medical management information is no longer required on the website. The additional set of goals and consideration of medical management protocols is delayed to October 31, 2010.

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**Appropriation**: None.

**Fiscal Note**: Not requested.

**Effective Date of Substitute Bill**: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

**Staff Summary of Public Testimony**:

(In support) All the parties have been working collaboratively on this proposal and it represents logical, feasible steps that will streamline the processes and administrative impacts on providers. Each area has been carefully evaluated with respect to timelines and resources available, and this approach is both feasible and meaningful. It is important to move forward collaboratively with a public-private partnership. It is critical that state agencies participate in the standards and guidelines to achieve the greatest simplicity and savings.

There are some concerns with the eligibility burdens placed on carriers and with the medical management guidelines. The administrative complexity with multiple insurance payors is a tremendous burden on providers. Centralized credentialing would be helpful. The safety net

trigger for the Office of the Insurance Commissioner to move forward if the products are not completed by 2010 is appropriate. The Forum has made good efforts to standardize and eliminate processes, and it is time now for a new phase focusing on electronic processes.

(Opposed) None.

**Persons Testifying**: Representative Driscoll, prime sponsor; Steve Gano, Premera; Abbi Kaplan, The Forum; Sydney Smith Zvara, Association of Washington Healthcare Plans; Len Eddinger, Washington State Medical Association; and Carrie Tellefson, Regence.

**Persons Signed In To Testify But Not Testifying**: None.