
SUBSTITUTE HOUSE BILL 1647

State of Washington 61st Legislature 2009 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Driscoll, Morrell, Green, Clibborn, Moeller, Williams, Wood, Simpson, Kenney, and Ormsby)

READ FIRST TIME 02/23/09.

1 AN ACT Relating to establishing streamlined and uniform
2 administrative procedures for payors and providers of health care
3 services; amending RCW 70.47.130; adding a new section to chapter 70.14
4 RCW; adding a new section to chapter 18.122 RCW; adding a new chapter
5 to Title 48 RCW; and creating a new section.

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

7 NEW SECTION. **Sec. 1.** The legislature finds that:

8 (1) The health care system in the nation and in Washington state
9 costs nearly twice as much per capita as other industrialized nations.

10 (2) The fragmentation and variation in administrative processes
11 prevalent in our health care system contribute to the high cost of
12 health care, putting it increasingly beyond the reach of small
13 businesses and individuals in Washington.

14 (3) In 2006, the legislature's blue ribbon commission on health
15 care costs and access requested the office of the insurance
16 commissioner to conduct a study of administrative costs and
17 recommendations to reduce those costs. Findings in the report
18 included:

1 (a) In Washington state approximately thirty cents of every dollar
2 received by hospitals and doctors' offices is consumed by the
3 administrative expenses of public and private payors and the providers;

4 (b) Before the doctors and hospitals receive the funds for
5 delivering the care, approximately fourteen percent of the insurance
6 premium has already been consumed by payor administration. The payor's
7 portion of expense totals approximately four hundred fifty dollars per
8 insurance member per year in Washington state;

9 (c) Over thirteen percent of every dollar received by a physician's
10 office is devoted to interactions between the provider and payor;

11 (d) Between 1997 and 2005, billing and insurance related costs for
12 hospitals in Washington grew at an average pace of nineteen percent per
13 year; and

14 (e) The greatest opportunity for improved efficiency and
15 administrative cost reduction in our health care system would involve
16 standardizing and streamlining activities between providers and payors.

17 (4) To address these inefficiencies, constrain health care
18 inflation, and make health care more affordable for Washingtonians, the
19 legislature seeks to establish streamlined and uniform procedures for
20 payors and providers of health care services in the state. It is the
21 intent of the legislature to foster a continuous quality improvement
22 cycle to simplify health care administration. This process should
23 involve leadership in the health care industry and health care
24 purchasers, with regulatory oversight from the office of the insurance
25 commissioner.

26 NEW SECTION. **Sec. 2.** The definitions in this section apply
27 throughout this chapter unless the context clearly requires otherwise.

28 (1) "Commissioner" means the insurance commissioner as established
29 under chapter 48.02 RCW.

30 (2) "Health care provider" or "provider" has the same meaning as in
31 RCW 48.43.005 and, for the purposes of this act, shall include
32 facilities licensed under chapter 70.41 RCW.

33 (3) "Lead organization" means a private sector organization or
34 organizations designated by the commissioner to lead development of
35 processes, guidelines, and standards to streamline health care
36 administration and to be adopted by payors and providers of health care
37 services operating in the state.

1 (4) "Medical management" means administrative activities
2 established by the payor to manage the utilization of services through
3 preservice or postservice reviews. "Medical management" includes, but
4 is not limited to:

- 5 (a) Prior authorization or preauthorization of services;
- 6 (b) Precertification of services;
- 7 (c) Postservice review;
- 8 (d) Medical necessity review; and
- 9 (e) Benefits advisory.

10 (5) "Payor" means public purchasers, as defined in this section,
11 carriers licensed under chapters 48.20, 48.21, 48.44, 48.46, and 48.62
12 RCW, and the Washington state health insurance pool established in
13 chapter 48.41 RCW.

14 (6) "Public purchaser" means the department of social and health
15 services, the department of labor and industries, and the health care
16 authority.

17 (7) "Secretary" means the secretary of the department of health.

18 (8) "Third-party payor" has the same meaning as in RCW 70.02.010.

19 NEW SECTION. **Sec. 3.** A new section is added to chapter 70.14 RCW
20 to read as follows:

21 The following state agencies are directed to cooperate with the
22 insurance commissioner and adopt the processes, guidelines, and
23 standards to streamline health care administration pursuant to sections
24 2, 5, 6, and 8 through 10 of this act: The department of social and
25 health services, the health care authority, and, to the extent
26 permissible under Title 51 RCW, the department of labor and industries.

27 **Sec. 4.** RCW 70.47.130 and 2004 c 115 s 2 are each amended to read
28 as follows:

29 (1) The activities and operations of the Washington basic health
30 plan under this chapter, including those of managed health care systems
31 to the extent of their participation in the plan, are exempt from the
32 provisions and requirements of Title 48 RCW except:

- 33 (a) Benefits as provided in RCW 70.47.070;
- 34 (b) Managed health care systems are subject to the provisions of
35 RCW 48.43.022, 48.43.500, 70.02.045, 48.43.505 through 48.43.535,
36 43.70.235, 48.43.545, 48.43.550, 70.02.110, and 70.02.900;

1 (c) Persons appointed or authorized to solicit applications for
2 enrollment in the basic health plan, including employees of the health
3 care authority, must comply with chapter 48.17 RCW. For purposes of
4 this subsection (1)(c), "solicit" does not include distributing
5 information and applications for the basic health plan and responding
6 to questions; (~~and~~)

7 (d) Amounts paid to a managed health care system by the basic
8 health plan for participating in the basic health plan and providing
9 health care services for nonsubsidized enrollees in the basic health
10 plan must comply with RCW 48.14.0201; and

11 (e) Administrative simplification requirements as provided in this
12 act.

13 (2) The purpose of the 1994 amendatory language to this section in
14 chapter 309, Laws of 1994 is to clarify the intent of the legislature
15 that premiums paid on behalf of nonsubsidized enrollees in the basic
16 health plan are subject to the premium and prepayment tax. The
17 legislature does not consider this clarifying language to either raise
18 existing taxes nor to impose a tax that did not exist previously.

19 NEW SECTION. Sec. 5. (1) The commissioner shall designate one or
20 more lead organizations to coordinate development of processes,
21 guidelines, and standards to streamline health care administration and
22 to be adopted by payors and providers of health care services operating
23 in the state. The lead organization designated by the commissioner for
24 this act shall:

25 (a) Be representative of providers and payors across the state;

26 (b) Have expertise and knowledge in the major disciplines related
27 to health care administration; and

28 (c) Be able to support the costs of its work without recourse to
29 public funding.

30 (2) The lead organization shall:

31 (a) In collaboration with the commissioner, identify and convene
32 work groups, as needed, to define the processes, guidelines, and
33 standards required in sections 6 through 10 of this act;

34 (b) In collaboration with the commissioner, promote the
35 participation of representatives of health care providers, payors of
36 health care services, and others whose expertise would contribute to
37 streamlining health care administration;

1 (c) Conduct outreach and communication efforts to maximize adoption
2 of the guidelines, standards, and processes developed by the lead
3 organization;

4 (d) Submit regular updates to the commissioner on the progress
5 implementing the requirements of this act; and

6 (e) With the commissioner, report to the legislature annually
7 through December 1, 2012, on progress made, the time necessary for
8 completing tasks, and identification of future tasks that should be
9 prioritized for the next improvement cycle.

10 (3) The commissioner shall:

11 (a) Participate in and review the work and progress of the lead
12 organization, including the establishment and operation of work groups
13 for this act;

14 (b) Adopt into rule, or submit as proposed legislation, the
15 guidelines, standards, and processes set forth in this act if:

16 (i) The lead organization fails to timely develop or implement the
17 guidelines, standards, and processes set forth in sections 6 through 10
18 of this act; or

19 (ii) It is unlikely that there will be widespread adoption of the
20 guidelines, standards, and processes developed under this act;

21 (c) Consult with the office of the attorney general to determine
22 whether an antitrust safe harbor is necessary to enable licensed
23 carriers and providers to develop common rules and standards; and, if
24 necessary, take steps, such as implementing rules or requesting
25 legislation, to establish such safe harbor; and

26 (d) Convene an executive level work group with broad payor and
27 provider representation to advise the commissioner regarding the goals
28 and progress of implementation of the requirements of this act.

29 NEW SECTION. **Sec. 6.** By December 31, 2010, the lead organization
30 shall:

31 (1) Develop a uniform electronic process for collecting and
32 transmitting the necessary provider-supplied data to support
33 credentialing, admitting privileges, and other related processes that:

34 (a) Reduces the administrative burden on providers;

35 (b) Improves the quality and timeliness of information for
36 hospitals and payors;

37 (c) Is interoperable with other relevant systems;

1 (d) Enables use of the data by authorized participants for other
2 related applications; and

3 (e) Serves as the sole source of credentialing information required
4 by hospitals and payors from providers for data elements included in
5 the electronic process, except this shall not prohibit:

6 (i) A hospital, payor, or other credentialing entity subject to the
7 requirements of this section from seeking clarification of information
8 obtained through use of the uniform electronic process, if such
9 clarification is reasonably necessary to complete the credentialing
10 process; or

11 (ii) A hospital, payor, other credentialing entity, or a university
12 from using information not provided by the uniform process for the
13 purpose of credentialing, admitting privileges, or faculty appointment
14 of providers, including peer review and coordinated quality improvement
15 information, that is obtained from sources other than the provider;

16 (2) Promote widespread adoption of such process by payors and
17 hospitals, their delegates, and subcontractors in the state that
18 credential health professionals and by such health professionals as
19 soon as possible thereafter; and

20 (3) Work with the secretary to assure that data used in the uniform
21 electronic process can be electronically exchanged with the department
22 of health professional licensing process under chapter 18.122 RCW.

23 NEW SECTION. **Sec. 7.** A new section is added to chapter 18.122 RCW
24 to read as follows:

25 Pursuant to sections 5 and 6 of this act, the secretary or his or
26 her designee shall participate in the work groups and implement the
27 standards to enable the department to transmit data to and receive data
28 from the uniform process.

29 NEW SECTION. **Sec. 8.** The lead organization shall:

30 (1) Establish a uniform standard companion document and data set
31 for electronic eligibility and coverage verification. Such a companion
32 guide will:

33 (a) Be based on nationally accepted ANSI X12 270/271 standards for
34 eligibility inquiry and response and, wherever possible, be consistent
35 with the standards adopted by nationally recognized organizations, such
36 as the centers for medicare and medicaid services;

1 (b) Enable providers and payors to exchange eligibility requests
2 and responses on a system-to-system basis or using a payor supported
3 web browser;

4 (c) Provide reasonably detailed information on a consumer's
5 eligibility for health care coverage, scope of benefits, limitations
6 and exclusions provided under that coverage, cost-sharing requirements
7 for specific services at the specific time of the inquiry, current
8 deductible amounts, accumulated or limited benefits, out-of-pocket
9 maximums, any maximum policy amounts, and other information required
10 for the provider to collect the patient's portion of the bill; and

11 (d) Reflect the necessary limitations imposed on payors by the
12 originator of the eligibility and benefits information;

13 (2) Recommend a standard or common process to the commissioner to
14 protect providers and hospitals from the costs of, and payors from
15 claims for, services to patients who are ineligible for insurance
16 coverage in circumstances where a payor provides eligibility
17 verification based on best information available to the payor at the
18 date of the request; and

19 (3) Complete, disseminate, and promote widespread adoption by
20 payors of such document and data set by December 31, 2010.

21 NEW SECTION. **Sec. 9.** (1) By December 31, 2010, the lead
22 organization shall develop implementation guidelines and promote
23 widespread adoption of such guidelines for:

24 (a) The use of the national correct coding initiative code edit
25 policy by payors and providers in the state;

26 (b) Publishing any variations from component codes, mutually
27 exclusive codes, and status b codes by payors in a manner that makes
28 for simple retrieval and implementation by providers;

29 (c) Use of health insurance portability and accountability act
30 standard group codes, reason codes, and remark codes by payors in
31 electronic remittances sent to providers;

32 (d) The processing of corrections to claims by providers and
33 payors; and

34 (e) A standard payor denial review process for providers when they
35 appeal a denial of a claim that results from differences in clinical
36 edits where no single, common standards body or process exists and
37 multiple conflicting sources are in use by payors and providers.

1 (2) By October 31, 2010, the lead organization shall develop a
2 proposed set of goals and work plan for additional code standardization
3 efforts for 2011 and 2012.

4 NEW SECTION. **Sec. 10.** (1) By December 31, 2010, the lead
5 organization shall:

6 (a) Develop and promote widespread adoption by payors and providers
7 of guidelines to:

8 (i) Ensure payors do not automatically deny claims for services
9 when extenuating circumstances make it impossible for the provider to:

10 (A) Obtain a preauthorization before services are performed; or (B)
11 notify a payor within twenty-four hours of a patient's admission; and

12 (ii) Require payors to use common and consistent time frames when
13 responding to provider requests for medical management approvals.
14 Whenever possible, such time frames shall be consistent with those
15 established by the national committee for quality assurance and be
16 based upon the acuity of the patient's need for care or treatment;

17 (b) Develop, maintain, and promote widespread adoption of a single
18 common web site where providers can obtain payors' preauthorization,
19 benefits advisory, and preadmission requirements;

20 (c) Establish guidelines for payors to develop and maintain a web
21 site that providers can employ to:

22 (i) Request a preauthorization, including a prospective clinical
23 necessity review;

24 (ii) Receive an authorization number; and

25 (iii) Transmit an admission notification.

26 (2) By October 31, 2010, the lead organization shall propose to the
27 commissioner a set of goals and work plan for the development of
28 medical management protocols, including whether to develop evidence-
29 based medical management practices addressing specific clinical
30 conditions and make its recommendation to the commissioner, who shall
31 report the lead organization's findings and recommendations to the
32 legislature.

33 NEW SECTION. **Sec. 11.** Sections 2, 5, 6, and 8 through 10 of this
34 act constitute a new chapter in Title 48 RCW.

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