S-3529.1

SENATE BILL 6266

State of Washington 64th Legislature 2016 Regular Session

By Senators Warnick, Keiser, Conway, Angel, Pearson, Frockt, Dammeier, Rolfes, and Benton

Read first time 01/13/16. Referred to Committee on Health Care.

AN ACT Relating to mitigating barriers to patient access to care resulting from health insurance contracting practices; amending RCW 41.05.074 and 48.43.016; and providing an effective date.

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

Sec. 1. RCW 41.05.074 and 2015 c 251 s 1 are each amended to read as follows:

(1) A health plan offered to public employees and their covered dependents under this chapter 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 shall inform an enrollee which tier an individual provider or group of providers is in by posting the information on its web site in a manner accessible to both enrollees and providers.

(2) The health plan 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 chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapies. Notwithstanding RCW 48.43.515(5) this section may not be interpreted to limit the ability of a health plan to require a referral or prescription for the therapies listed in this section.

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

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

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

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

(7) For purposes of this section:

(a) "New episode of care" means treatment for a new or recurrent condition for which the enrollee has not been treated by the provider within the previous ninety days and is not currently undergoing any active treatment.

(b) "Contracting provider" does not include providers employed within an integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW.

Sec. 2. RCW 48.43.016 and 2015 c 251 s 2 are each amended to read as follows:

(1) A health carrier 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 shall inform an enrollee which tier an individual provider or group of providers is in by posting the information on its web site in a manner accessible to both enrollees and providers.

(2) A health carrier 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 chiropractic, physical

therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapies. Notwithstanding RCW 48.43.515(5) this section may not be interpreted to limit the ability of a health plan to require a referral or prescription for the therapies listed in this section.

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

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

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

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

(7) For purposes of this section:

(a) "New episode of care" means treatment for a new or recurrent condition for which the enrollee has not been treated by the provider within the previous ninety days and is not currently undergoing any active treatment.

(b) "Contracting provider" does not include providers employed within an integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW.

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

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