SENATE BILL REPORT
SB 6470

As of February 1, 2018

Title: An act relating to health carrier provider networks.

Brief Description: Concerning health carrier provider networks.

Sponsors: Senators Becker, Keiser, Rivers, Bailey, Brown, Cleveland and Hasegawa.

Brief History:
Committee Activity: Health & Long Term Care: 2/01/18.

Brief Summary of Bill

- Requires the insurance commissioner (commissioner) to affirmatively approve health plan provider network adequacy.
- Requires health plans to maintain up to date provider directories and allows individuals enrolled in those plans to petition to receive coverage of services if they rely on the directory and end up receiving care from an out-of-network provider.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Staff: Evan Klein (786-7483)

Background: Issuers must maintain provider networks for every health plan offered, in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services provided to enrollees will be accessible in a timely manner. An issuer must demonstrate that for each health plan's defined service area, a comprehensive range of primary, specialty, institutional, and ancillary services are readily available without unreasonable delay to all enrollees and that emergency services are accessible 24-hours-per-day, seven-days-per-week without unreasonable delay. Each health plan enrollee must have adequate choice among health care providers, including those providers which must be included in the network.

Health carriers must submit network access reports including provider network documents, to the Office of the Insurance Commissioner (OIC), when the health carrier files its plans in the

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individual and small group markets. For groups other than individual and small, the submission must occur when the health carrier files a new health plan.

Summary of Bill: The commissioner must affirmatively approve the adequacy of a health plan's proposed provider network. In determining adequacy, the commissioner must consider whether the proposed network includes a sufficient number of contracted providers at contracted facilities to reasonably ensure that enrollees have in-network access to covered health services.

A health plan must allow enrolled individuals to petition the plan to cover health care services delivered by an out-of-network provider if the plan has an absence or insufficient number or type of in-network providers or facilities and the health care services would be covered if provided by an in-network provider. A health plan must ensure that cost-sharing obligation is included in the in-network deductible and maximum out-of-pocket expenses if the enrollee receives health care services from an out-of-network provider at an in-network facility and the services would have been covered if provided by an in-network provider.

Health plans issued or renewed beginning January 1, 2019, must publish and maintain a provider directory on the plan's website. The directory must indicate if a provider is accepting new patients and may not include information on a provider that is not currently under contract with the health plan. Health plans must design a process for individuals to identify and report misleading or inaccurate information in the provider directory. Health plans must update the directory within seven days of confirming any information is inaccurate.

If the commissioner receives a complaint that an individual enrolled in a health plan obtained health care services from an out-of-network provider that would have been covered, because the individual reasonably relied on materially inaccurate or misleading information in the directory, the commissioner may require the health plan to provide coverage or reimburse the enrollee for any excess expense.

Appropriation: None.

Fiscal Note: Requested on January 27, 2018.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: Patients are seeing specialists and not finding out until they get the bill, that the specialist was out of network. When the office of the insurance commissioner is looking to approve a plan to provide services in Washington, they need to be looking at provider networks. This will help protect patients who think they are receiving services from an in-network provider. Patients mistakenly assume that if they are receiving services at a hospital in network, that all of the providers who see them are in network. It is important to ensure the commissioner has enough authority to ensure there is network adequacy and that carriers are providing the networks they say they are. This should pull carriers, providers and others together to ensure adequate networks. If health plans have

robust provider networks, it limits the ability of balance billing questions to arise. Carriers are moving to more narrow and closed networks and state laws need to be updated to confront this. Currently, enforcement of network adequacy is not happening on the front end, but OIC is instead waiting for patient complaints. Everyone in healthcare is concerned about cost, but if adequate networks do not exist, the increased costs will be paid by patients. This is the current law in California and Louisiana. Administrative costs for physician practices in the United States contribute to the overall costs of health care, and this bill would help reduce those costs.

CON: Health plans currently form networks that are sufficient in the number and type of providers to deliver the benefits offered by the plans. Carriers have to report on a monthly basis, whatever material changes have happened to their networks. Carriers must list all of the licensed providers in their network on a county by county basis. If a carrier identifies that there are not enough providers of a specific type, they have to file an alternate access plan with the OIC. The OIC currently requires carriers to hold members harmless if there are not enough providers in certain provider types. This bill will undermine the willingness of providers to contract with carriers. If a carrier's network becomes inadequate, then providers are allowed to charge billed charges. This would lead to networks collapsing and then the market collapsing. Most of what is in here is already done by carriers. However, the seven-day turnaround type to post updated networks online does not fit with carrier business models. This bill would, for the first time, insert hospital-based provider network requirements into law. The problem with this is that the choice is already made for the consumer and the health plan. Hospitals choose which providers provide services at the facility, so the decision on who will provide care has already been made and the health plan cannot and will not change that through contracting. By placing no obligations on hospitals or providers, this bill creates an imbalance for carriers. This bill would unintentionally drive prices up.

OTHER: Some of what is in this bill is already in rule, but not in statute. The insurance commissioner does have some concerns. The OIC is not sure what affirmative means. It appears that the legislation does away with the monthly reporting by the plans. OIC currently requires that hospitals have enough provider types with each carrier they contract with to ensure that in-network services are available.

Persons Testifying: PRO: Senator Randi Becker, Prime Sponsor; Sean Graham, Washington State Medical Association; Dave Kimberling, Washington Managed Imaging; Kate White-Tudor, Washington State Society of Pathologists; College of American Pathologists; Center for Diagnostic Imaging; Lisa Thatcher, Washington State Hospital Association; Ruben Krishnananthan, Radia.

CON: Meg Jones, AWHP; Len Sorrin, Premera; Mel Sorensen, America's Health Insurance Plans.

OTHER: Lonnie Johns-Brown, Office of the Insurance Commissioner.

Persons Signed In To Testify But Not Testifying: No one.