

CERTIFICATION OF ENROLLMENT
SECOND SUBSTITUTE SENATE BILL 5346

Chapter 298, Laws of 2009

61st Legislature
2009 Regular Session

HEALTH CARE--UNIFORM ADMINISTRATIVE PROCEDURES--DEVELOPMENT

EFFECTIVE DATE: 07/26/09

Passed by the Senate April 20, 2009
YEAS 43 NAYS 0

BRAD OWEN

President of the Senate

Passed by the House April 13, 2009
YEAS 97 NAYS 0

FRANK CHOPP

Speaker of the House of Representatives

Approved April 30, 2009, 11:07 a.m.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SECOND SUBSTITUTE SENATE BILL 5346** as passed by the Senate and the House of Representatives on the dates hereon set forth.

THOMAS HOEMANN

Secretary

FILED

May 1, 2009

**Secretary of State
State of Washington**

SECOND SUBSTITUTE SENATE BILL 5346

AS AMENDED BY THE HOUSE

Passed Legislature - 2009 Regular Session

State of Washington 61st Legislature 2009 Regular Session

By Senate Ways & Means (originally sponsored by Senators Keiser, Franklin, Marr, Parlette, Murray, and Kohl-Welles)

READ FIRST TIME 02/26/09.

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, within funds appropriated specifically for
23 this purpose, adopt the processes, guidelines, and standards to
24 streamline health care administration pursuant to sections 2, 5, 6, and
25 8 through 10 of this act: The department of social and health
26 services, the health care authority, and, to the extent permissible
27 under Title 51 RCW, the department of labor and industries.

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

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

- 34 (a) Benefits as provided in RCW 70.47.070;
- 35 (b) Managed health care systems are subject to the provisions of

1 RCW 48.43.022, 48.43.500, 70.02.045, 48.43.505 through 48.43.535,
2 43.70.235, 48.43.545, 48.43.550, 70.02.110, and 70.02.900;

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

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

13 (e) Administrative simplification requirements as provided in this
14 act.

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

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

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

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

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

32 (2) The lead organization shall:

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

36 (b) In collaboration with the commissioner, promote the

1 participation of representatives of health care providers, payors of
2 health care services, and others whose expertise would contribute to
3 streamlining health care administration;

4 (c) Conduct outreach and communication efforts to maximize adoption
5 of the guidelines, standards, and processes developed by the lead
6 organization;

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

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

13 (3) The commissioner shall:

14 (a) Participate in and review the work and progress of the lead
15 organization, including the establishment and operation of work groups
16 for this act;

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

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

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

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

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

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

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

37 (a) Reduces the administrative burden on providers;

1 (b) Improves the quality and timeliness of information for
2 hospitals and payors;

3 (c) Is interoperable with other relevant systems;

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

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

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

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

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

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

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

28 Pursuant to sections 5 and 6 of this act, the secretary or his or
29 her designee shall participate in the work groups and, within funds
30 appropriated specifically for this purpose, implement the standards to
31 enable the department to transmit data to and receive data from the
32 uniform process.

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

34 (1) Establish a uniform standard companion document and data set
35 for electronic eligibility and coverage verification. Such a companion
36 guide will:

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

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

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

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

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

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

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

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

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

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

36 (d) The processing of corrections to claims by providers and
37 payors; and

1 (e) A standard payor denial review process for providers when they
2 request a reconsideration of a denial of a claim that results from
3 differences in clinical edits where no single, common standards body or
4 process exists and multiple conflicting sources are in use by payors
5 and providers.

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

9 (3) Nothing in this section or in the guidelines developed by the
10 lead organization shall inhibit an individual payor's ability to
11 employ, and not disclose to providers, temporary code edits for the
12 purpose of detecting and deterring fraudulent billing activities.
13 Though such temporary code edits are not required to be disclosed to
14 providers, the guidelines shall require that:

15 (a) Each payor disclose to the provider its adjudication decision
16 on a claim that was denied or adjusted based on the application of such
17 an edit; and

18 (b) The provider have access to the payor's review and appeal
19 process to challenge the payor's adjudication decision, provided that
20 nothing in this subsection (3)(b) shall be construed to modify the
21 rights or obligations of payors or providers with respect to procedures
22 relating to the investigation, reporting, appeal, or prosecution under
23 applicable law of potentially fraudulent billing activities.

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

26 (a) Develop and promote widespread adoption by payors and providers
27 of guidelines to:

28 (i) Ensure payors do not automatically deny claims for services
29 when extenuating circumstances make it impossible for the provider to:
30 (A) Obtain a preauthorization before services are performed; or (B)
31 notify a payor within twenty-four hours of a patient's admission; and

32 (ii) Require payors to use common and consistent time frames when
33 responding to provider requests for medical management approvals.
34 Whenever possible, such time frames shall be consistent with those
35 established by leading national organizations and be based upon the
36 acuity of the patient's need for care or treatment;

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

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

6 (i) Request a preauthorization, including a prospective clinical
7 necessity review;

8 (ii) Receive an authorization number; and

9 (iii) Transmit an admission notification.

10 (2) By October 31, 2010, the lead organization shall propose to the
11 commissioner a set of goals and work plan for the development of
12 medical management protocols, including whether to develop evidence-
13 based medical management practices addressing specific clinical
14 conditions and make its recommendation to the commissioner, who shall
15 report the lead organization's findings and recommendations to the
16 legislature.

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

Passed by the Senate April 20, 2009.

Passed by the House April 13, 2009.

Approved by the Governor April 30, 2009.

Filed in Office of Secretary of State May 1, 2009.