SENATE BILL REPORT
SB 5215

As of February 28, 2013

Title: An act relating to health care professionals not being required to participate in any public or private third-party reimbursement program as a condition of licensure.

Brief Description: Providing that health care professional licensees may not be required to participate in any public or private third-party reimbursement program.

Sponsors: Senators Becker, Holmquist Newbry, Ericksen, Dammeier, Honeyford and Schlicher.

Brief History:
Committee Activity: Health Care: 1/31/13, 2/21/13 [DPS-WM].
Ways & Means: 2/28/13.

SENATE COMMITTEE ON HEALTH CARE

Majority Report: That Substitute Senate Bill No. 5215 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.
Signed by Senators Becker, Chair; Dammeier, Vice Chair; Keiser, Ranking Member; Bailey, Cleveland, Ericksen, Frockt, Parlette and Schlicher.

Staff: Mich'l Needham (786-7442)

SENATE COMMITTEE ON WAYS & MEANS

Staff: Michael Bezanson (786-7449)

Background: The contractual agreements between health care providers and insurance carriers or third-party payors are privately negotiated contractual agreements. The Office of the Insurance Commissioner (OIC) requires insurance carriers to report their master list of participating providers to review network adequacy, but OIC does not have regulatory authority over the terms of the agreement in other cases. Public programs contract with insurance carriers in some cases, and directly with providers with their own contract terms and reimbursement agreements. Providers are not required by law to sign contracts as participating providers with insurance carriers or public programs. Some contracts include provisions that require providers to accept changes and may require providers to contract with all products offered by the third-party payor.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Summary of Bill: The bill as referred to committee not considered.

Summary of Bill (Recommended Substitute): Third-party payors must provide 60 days' notice to health care providers of any material amendments to the health care provider's contract with the third-party payor. Any material amendments to the provider's contract only become effective if the provider attests in writing or electronic form the acceptance to the contract changes. Failure to accept the material amendment does not affect the terms of the provider's existing contract.

A material amendment is a contract between a payor and health care provider that would result in requiring a provider to participate in a health plan, product, or line of business with a lower fee schedule. A material amendment does not include the following:

- a decrease in payment or compensation resulting solely from a change in a published fee schedule with the date of applicability clearly identified in the contract;
- a decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract; or
- changes unrelated to compensation so long as reasonable notice of not less than 60 days is provided.

A payor may not, without the express written agreement of the provider, require a provider to extend Medicaid rates, or some percentage above Medicaid rates, to a commercial plan or line of business offered by the payor that is not administered by a public purchaser. Commercial coverage offered through the Health Benefit Exchange may not be included in the definition of a public purchaser.

Licensed health professionals are not required to participate in any public or private third-party payor arrangement as a condition of licensure.

Health care providers include all health professionals regulated under Title 18, home health and hospice providers regulated under Chapter 70.126 RCW, and hospitals licensed under RCW 70.41. Payor or third-party payor means all licensed health insurance carriers, the Washington State Health Insurance Pool, Medicaid-managed care plans, employer welfare benefit plans, or the state or federal health benefit program. Public purchaser means the Department of Social and Health Services, the Department of Labor and Industries, and the Health Care Authority.

EFFECT OF CHANGES MADE BY HEALTH CARE COMMITTEE (Recommended Substitute): The definition of material amendments is created to mean an amendment that would result in requiring a provider to participate in a health plan, product, or line of business with a lower fee schedule. A material amendment does not include the following: a decrease in payment or compensation resulting solely from a change in a published fee schedule with the date of applicability clearly identified in the contract; a decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract; or changes unrelated to compensation so long as reasonable notice of not less than 60 days is provided. References to all-products clauses are removed.

A payor may not, without the express written agreement of the provider, require a provider to extend Medicaid rates, or some percentage above Medicaid rates, to a commercial plan or line of business offered by the payor that is not administered by a public purchaser. Commercial coverage offered through the Health Benefit Exchange may not be included in the definition of a public purchaser.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

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

Staff Summary of Public Testimony on Proposed Substitute as Heard in Committee (Health Care): PRO: There is some fear in the provider community that they may be forced to contract with everyone which may threaten the viability of their practice. This bill sends a message that Washington is physician friendly. The influx of newly insured patients anticipated in 2014 with the exchange and Medicaid expansion raises concerns about how patients will access care. The newly emerging all-product clauses are problematic. We would like to have a level playing field to negotiate with carriers. This bill includes principles that are important to send a message of support for maintaining independent practices. The all-product clause has been used to expand provider contracts to cover other lines of business like property and casualty, so we would like to see opt-in contract language specific to each line of business.

CON: We do not use all-products clauses and have no plans to use one. We could support a bill that had language limited to a simple prohibition of all products clauses, if well defined. The other areas in the bill are far-reaching and would jeopardize the business and force us to renegotiate thousands of contracts for simple changes. The WAC requires carriers to provide 60 days' notice of any change in the policy, procedure, or reimbursement and providers have the opportunity to reject the contract changes at any time without forcing an affirmative attestation.

Persons Testifying (Health Care): PRO: Senator Becker, prime sponsor; Dr. Nick Rajacich, WA State Medical Assn.; Brad Tower, Optometric Physicians of WA; Mary Clogton, WA Academy of Family Physicians; Lori Grassi, WA State Chiropractic Assn.

CON: Len Sorrin, Premera Blue Cross; Chris Bandoli, Regence Blue Shield.