# SENATE BILL REPORT
# E2SHB 1471

As of March 23, 2015

**Title**: An act relating to mitigating barriers to patient access to care resulting from health insurance contracting practices.

**Brief Description**: Mitigating barriers to patient access to care resulting from health insurance contracting practices.

**Sponsors**: House Committee on Appropriations (originally sponsored by Representatives Cody, Schmick, Harris, Van De Wege, DeBolt, Hurst, Kretz, Moeller, Jinkins and Tharinger).

**Brief History:** Passed House: 3/09/15, 82-16.
**Committee Activity**: Health Care: 3/26/15.

## SENATE COMMITTEE ON HEALTH CARE

**Staff**: Mich'l Needham (786-7442)

**Background**: Health carriers enter into contracts with health care providers under which the providers agree to accept a specified reimbursement rate for their services. Health carriers may require prior authorization for certain health procedures. Prior authorization is the requirement that a health care provider seek approval of a drug, procedure, or test before seeking reimbursement from an insurer. A health carrier may not retrospectively deny coverage for care that had prior authorization unless the prior authorization was based upon a material misrepresentation by the provider.

A health carrier may not require a provider to extend the carrier's Medicaid rates, or some percentage above the carrier's Medicaid rates, to a commercial plan or line of business, unless the provider has expressly agreed in writing to the extension. The requirement that the provider expressly agree to the extension does not prohibit the carrier from using its Medicaid rates, or some percentage above its Medicaid rates, as a base when negotiating payment rates with a provider.

A health carrier must provide at least 60 days' notice to a health care provider of any proposed material amendments to the provider's contract. A material amendment is an amendment to a contract that would result in requiring the provider to participate in a health plan, product, or line of business with a lower fee schedule in order to continue to participate in a health plan, product, or line of business with a higher fee schedule. During the 60-day

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period, the provider may reject the material amendment without affecting the terms of the existing contract. The material amendment must be clearly defined in a notice to the provider before the notice period begins. The notice must inform the provider that the provider may choose to reject the terms of the material amendment through written or electronic means at any time during the notice period and that such rejection will not affect the terms of the existing contract. The health carrier's failure to comply with the notice requirements voids the effectiveness of the material amendment.

**Summary of Bill**: A health carrier or a health plan offered to public employees 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 habilitative, rehabilitative, East Asian medicine, or chiropractic care – a new episode of care means treatment for a new condition that has not been presented to the provider in the 60 days prior to the first encounter with the provider or the 60 days after the most recent encounter;
- require a provider to provide a discount from the provider's usual and customary rates for non-covered services; or
- impose a cost-sharing requirement for habilitative, rehabilitative, East Asian medicine, or chiropractic care that exceeds the cost-sharing requirements for primary care.

The health carrier or health plan offered to public employees must:

- post on its website – or the Health Care Authority's website for health plans offered to public employees – and disclose upon request the prior authorization standards, criteria, and information used for prior authorization decisions; and
- base its prior authorization standards and criteria on the plan's medical necessity standards, which, for private health carriers, must be on file with the Office of the Insurance Commissioner.

A health carrier or health plan offered to public employees 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 must inform an enrollee which tier an individual provider or group of providers is in. A health carrier must post the information on its website in a manner accessible to both enrollees and providers. The Health Care Authority must post the information on its website for a health plan offered to public employees.

A provider with whom the carrier or administrator of the health plan offered to public employees consults regarding decisions to deny, limit, or terminate a person's coverage must hold a license, certification, or registration in good standing and must be in the same or related field as the health care provider being reviewed or be a specialist whose practice entails the same or similar covered health care service.

**Appropriation**: None.

**Fiscal Note**: Available. New fiscal note requested on March 18, 2015.

**Committee/Commission/Task Force Created**: No.

**Effective Date**: The bill takes effect on January 1, 2017.