ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1471

State of Washington 64th Legislature 2015 Regular Session

By House Appropriations (originally sponsored by Representatives Cody, Schmick, Harris, Van De Wege, DeBolt, Hurst, Kretz, Moeller, Jinkins, and Tharinger)

READ FIRST TIME 02/27/15.

AN ACT Relating to mitigating barriers to patient access to care resulting from health insurance contracting practices; adding a new section to chapter 41.05 RCW; adding a new section to chapter 48.43 RCW; and providing an effective date.

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

NEW SECTION. **Sec. 1.** A new section is added to chapter 41.05 RCW 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. The health care authority shall post 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 habilitative, rehabilitative, East Asian medicine, or chiropractic care.

(3) Any prior authorization standards and criteria used by the health plan, or a subcontractor or third-party administrator

administering all or part of the plan, must be based on the plan's medical necessity standards.

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

(5) 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.

(6) 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.

(7) 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.

(8) For purposes of this section, "new episode of care" means treatment for a new condition that has not been presented to the provider:

(a) Less than sixty days prior to the first encounter for the condition; and

(b) Less than sixty days after the most recent encounter for the condition.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW 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. The carrier shall post 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 habilitative, rehabilitative, East Asian medicine, or chiropractic care.

(3) Any prior authorization standards and criteria used by a health plan, or a subcontractor administering all or part of the health plan, must be based on the carrier's medical necessity standards on file with the commissioner.

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

(5) 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.

(6) 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.

(7) 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.

(8) For purposes of this section, "new episode of care" means treatment for a new condition that has not been presented to the provider:

(a) Less than sixty days prior to the first encounter for the condition; and

(b) Less than sixty days after the most recent encounter for the condition.

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

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