
ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1471

AS AMENDED BY THE SENATE

Passed Legislature - 2015 Regular Session

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.

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

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

6 NEW SECTION. **Sec. 1.** A new section is added to chapter 41.05
7 RCW to read as follows:

8 (1) A health plan offered to public employees and their covered
9 dependents under this chapter that imposes different prior
10 authorization standards and criteria for a covered service among
11 tiers of contracting providers of the same licensed profession in the
12 same health plan shall inform an enrollee which tier an individual
13 provider or group of providers is in by posting the information on
14 its web site in a manner accessible to both enrollees and providers.

15 (2) The health plan may not require prior authorization for an
16 evaluation and management visit or an initial treatment visit with a
17 contracting provider in a new episode of chiropractic, physical
18 therapy, occupational therapy, East Asian medicine, massage therapy,
19 or speech and hearing therapies. Notwithstanding RCW 48.43.515(5)
20 this section may not be interpreted to limit the ability of a health

1 plan to require a referral or prescription for the therapies listed
2 in this section.

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

7 (4) A health care provider with whom the administrator of the
8 health plan consults regarding a decision to deny, limit, or
9 terminate a person's covered health care services must hold a
10 license, certification, or registration, in good standing and must be
11 in the same or related health field as the health care provider being
12 reviewed or of a specialty whose practice entails the same or similar
13 covered health care service.

14 (5) The health plan may not require a provider to provide a
15 discount from usual and customary rates for health care services not
16 covered under the health plan, policy, or other agreement, to which
17 the provider is a party.

18 (6) For purposes of this section:

19 (a) "New episode of care" means treatment for a new or recurrent
20 condition for which the enrollee has not been treated by the provider
21 within the previous ninety days and is not currently undergoing any
22 active treatment.

23 (b) "Contracting provider" does not include providers employed
24 within an integrated delivery system operated by a carrier licensed
25 under chapter 48.44 or 48.46 RCW.

26 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43
27 RCW to read as follows:

28 (1) A health carrier that imposes different prior authorization
29 standards and criteria for a covered service among tiers of
30 contracting providers of the same licensed profession in the same
31 health plan shall inform an enrollee which tier an individual
32 provider or group of providers is in by posting the information on
33 its web site in a manner accessible to both enrollees and providers.

34 (2) A health carrier may not require prior authorization for an
35 evaluation and management visit or an initial treatment visit with a
36 contracting provider in a new episode of chiropractic, physical
37 therapy, occupational therapy, East Asian medicine, massage therapy,
38 or speech and hearing therapies. Notwithstanding RCW 48.43.515(5)
39 this section may not be interpreted to limit the ability of a health

1 plan to require a referral or prescription for the therapies listed
2 in this section.

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

7 (4) A health care provider with whom a health carrier consults
8 regarding a decision to deny, limit, or terminate a person's covered
9 health care services must hold a license, certification, or
10 registration, in good standing and must be in the same or related
11 health field as the health care provider being reviewed or of a
12 specialty whose practice entails the same or similar covered health
13 care service.

14 (5) A health carrier may not require a provider to provide a
15 discount from usual and customary rates for health care services not
16 covered under a health plan, policy, or other agreement, to which the
17 provider is a party.

18 (6) For purposes of this section:

19 (a) "New episode of care" means treatment for a new or recurrent
20 condition for which the enrollee has not been treated by the provider
21 within the previous ninety days and is not currently undergoing any
22 active treatment.

23 (b) "Contracting provider" does not include providers employed
24 within an integrated delivery system operated by a carrier licensed
25 under chapter 48.44 or 48.46 RCW.

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

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