ESSB 6511 - H COMM AMD
By Committee on Health Care & Wellness

ADOPTED AS AMENDED 03/06/2014

1 Strike everything after the enacting clause and insert the
2 following:

3 "NEW SECTION. **Sec. 1.** A new section is added to chapter 48.165
4 RCW to read as follows:
5 (1) The insurance commissioner must reauthorize the efforts with
6 the lead organization established in RCW 48.165.030, and establish a
7 new work group to develop recommendations for prior authorization
8 requirements. The focus of the prior authorization efforts must
9 include the full scope of health care services including pharmacy
10 issues. The work group must submit recommendations to the commissioner
11 by October 31, 2014.
12 (2) The lead organization and work group established to review
13 prior authorization requirements must consider the following areas in
14 their efforts:
15 (a) Requiring carriers and pharmacy benefit managers to provide a
16 listing of prior authorization requirements electronically on a web
17 site. The listing of requirements for any procedure, supply, or
18 service requiring preauthorization must include criteria needed by the
19 carrier specific to that medical or procedural code, to allow a
20 provider's office to submit all information needed on the initial
21 request for prior authorization, along with instructions for submitting
22 that information;
23 (b) Requiring a carrier or pharmacy benefit manager to issue an
24 acknowledgement of receipt or reference number for prior authorization
25 within a specified time frame, such as two business days of receipt of
26 a prior authorization request from a provider;
27 (c) Recommendations for the best practices for exchanging
28 information, including alternatives to fax requests;
29 (d) Recommendations for the best practices if the acknowledgement

1 has not been received by the provider or pharmacy benefit manager
2 within the specified time frame, such as two business days;
3 (e) Recommendations if the carrier or pharmacy benefit manager
4 fails to approve, deny, or respond to the request for authorization
5 within the specified time frame and options for deeming approval;
6 (f) Recommendations to refine the time frames in current rule; and
7 (g) Recommendations specific to pharmacy services, including
8 communication between the pharmacy to the carrier or pharmacy benefit
9 manager, communications between the carrier or pharmacy benefit manager
10 with the providers' office, communication of the authorization number,
11 posting of the criteria for pharmacy related prior authorization on a
12 web site and other recommended alternatives; and options for prior
13 authorizations involving urgent and emergent care with short-term
14 prescription fill, such as a three-day supply, while the authorization
15 is obtained.
16 (3) In preparing the recommendations, the work group must consider
17 the opportunities to align with national mandates and regulatory
18 guidance in the health insurance portability and accountability act and
19 the patient protection and affordable care act, and use information
20 technologies and electronic health records to increase efficiencies in
21 health care and reengineer and automate age-old practices to improve
22 business functions and ensure timely access to care for patients.
23 (4) The commissioner shall adopt rules implementing the
24 recommendations of the work group. The rules adopted under this
25 subsection may only implement, and may not expand or limit, the
26 recommendations of the work group.

27 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW
28 to read as follows:
29 (1) A health carrier may not directly, indirectly through
30 contracted networks, or otherwise require a covered person to obtain
31 prior authorization for routine health care services for which a person
32 may self refer.
33 (2) A carrier, whether directly or indirectly through subcontracted
34 networks, shall disclose:
35 (a) Its criteria and methods for establishing limits on access to
36 network providers, including, but not limited to, the carrier's method

1 used to determine that a network provider may provide care to a covered
2 person without prior authorization while imposing prior authorization
3 requirements on other network providers; and
4 (b) Its methods and clinical protocols for authorizing coverage of
5 health care services, including, but not limited to, the carrier's
6 method for determining initial visit limits for a particular health
7 care service."

8 Correct the title.

EFFECT: Removes the requirement that the work group make recommendations to limit or eliminate the application of prior authorization to routine health care services for which a person may self-refer. Requires the Insurance Commissioner (Commissioner) to adopt rules implementing the recommendations of the work group (the underlying bill required the Commissioner to revise the rules for prior authorization with the work group's recommendations). Prohibits the rules from expanding or limiting the work group's recommendations. Prohibits health carriers from requiring prior authorization for routine health care services for which a person may self-refer. Requires a carrier to disclose: (1) Its criteria and methods for establishing limits on access to network providers, including the carrier's method to determine that a network provider may provide care to a covered person without prior authorization while imposing prior authorization requirements on other network providers and (2) its methods and clinical protocols for authorizing coverage of health care services, including the carrier's method for determining initial visit limits.

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