HOUSE BILL REPORT
ESSB 6511

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to prior authorization of health care services.

Brief Description: Addressing the prior authorization of health care services.

Sponsors: Senate Committee on Health Care (originally sponsored by Senators Becker and King).

Brief History:
Committee Activity:
Health Care & Wellness: 2/24/14, 2/26/14 [DPA].

Brief Summary of Engrossed Substitute Bill
(As Amended by Committee)

- Requires the Office of the Insurance Commissioner to reauthorize efforts to develop processes, guidelines, and standards to streamline health care administration.
- Requires the Office of the Insurance Commissioner to establish a work group to develop recommendations for prior authorization requirements.
- Prohibits health carriers from requiring prior authorization for routine health care services for which a person may self-refer.
- Requires a health carrier to disclose its criteria and methods for establishing limits on access to network providers.
- Requires a carrier to disclose its methods and clinical protocols for authorizing coverage of health care services.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 14 members: Representatives Cody, Chair; Riccelli, Vice Chair; Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; Green, G. Hunt, Jinkins, Manweller, Morrell, Rodne, Ross, Short, Tharinger and Van De Wege.

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.

Staff: Jim Morishima (786-7191).

Background:

Prior authorization is the requirement that a health care provider seek approval of a drug, procedure, or test before seeking reimbursement from an insurer. Health carriers and other payors use a variety of different forms for different services.

Pursuant to legislation passed in 2009, the Office of the Insurance Commissioner (OIC) designated a lead organization, OneHealthPort, to develop processes, guidelines, and standards to streamline health care administration. The OIC and OneHealthPort facilitated a work group to develop best practice recommendations, including best practice recommendations on prior authorization. The best practice recommendations on prior authorization include recommendations on browser-based prior authorization requests, standard notification timelines, and extenuating circumstances around prior authorization.

In 2013 a legislative work group was established to develop criteria to streamline the prior authorization process for prescription drugs, medical procedures, and medical tests, with the goal of simplification and uniformity. The work group was to submit its recommendations by November 15, 2013, and the OIC was to adopt those recommendations in rule by July 1, 2014. The work group, however, did not submit any recommendations to the Legislature and expired on January 1, 2014.

Summary of Amended Bill:

The OIC must reauthorize the efforts with OneHealthPort and establish a work group to develop recommendations for prior authorization requirements. The prior authorization efforts must focus on the full scope of health care services, including pharmacy issues. OneHealthPort and the work group must consider the following areas:

- requiring carriers and pharmacy benefit managers to provide a listing of prior authorization requirements electronically on a website. The listing of requirements for any procedure, supply, or service requiring prior authorization must include criteria needed by the carrier specific to the medical or procedural code, along with instructions for submitting the information, in order to allow a provider's office to submit all information needed on the initial request for prior authorization;
- requiring a carrier or pharmacy benefit manager to issue an acknowledgment of receipt or reference number for prior authorization within a specific time frame, such as within two business days of receipt of a request for prior authorization;
- recommendations for the best practices for exchanging information, including alternatives to fax requests;
- recommendations for the best practices if the provider or pharmacy benefit manager has not received the acknowledgment within the specified time frame;
- recommendations for the best practices if the carrier or pharmacy benefit manager fails to approve, deny, or respond to the request for authorization within the specified time frame and options for deeming approval;
- recommendations to refine the time frames in current administrative rules; and

- recommendations specific to pharmacy services, including:
    - communication between the pharmacy and the carrier or pharmacy benefit manager;
    - communication between the carrier or pharmacy benefit manager and the provider's office;
    - communication of the authorization number;
    - posting the criteria for pharmacy-related prior authorization on a website; and
    - options for prior authorizations involving urgent and emergency care with short-term prescription fill while the authorization is obtained.

The work group must consider opportunities to align its recommendations with national mandates and regulatory guidance in the federal Health Insurance Portability and Accountability Act and the Patient Protection and Affordable Care Act. The work group must also consider opportunities to use information technologies and electronic health records to increase efficiencies in health care and re-engineer and automate age-old practices to improve business functions and timely access to care.

The work group must submit its recommendations to the OIC by October 31, 2014. The OIC must adopt rules implementing the recommendations. The rules may only implement, and may not expand or limit, the work group recommendations.

A health carrier may not directly, indirectly through contracted networks, or otherwise require a covered person to obtain prior authorization for routine health care services for which the person may self-refer.

A health carrier, whether directly or indirectly through subcontracted networks, must disclose:

- 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
- its methods and clinical protocols for authorizing coverage of health care services, including the carrier's method for determining initial visit limits for a particular health care service.

Amended Bill Compared to Engrossed Substitute Bill:

The amended bill:

- 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; and

- 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.

Appropriation: None.

Fiscal Note: Available on the original bill.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) Patients often have to go through burdensome prior authorization processes in order to get access to needed treatments; this takes a toll on patients and families. The prior authorization process is difficult for providers to follow, increases health care costs, and should be streamlined. Last year, the Legislature convened a work group to deal with this issue, which came close to consensus, but ran out of time. This bill makes streamlining the prior authorization process a priority and will make information on prior authorization available online in a format that is easily understandable. Small business owners should not have necessary medical treatments denied or delayed because of paperwork hurdles. In the world after federal health care reform, people are forced to purchase insurance, but are denied coverage because paperwork is not filled out. Many states have developed a streamlined process and a single form for prior authorization. The strongest part of this bill is the requirement that the OIC adopt rules. The OIC should be allowed, not required, to adopt rules. The membership of the work group should be more transparent and should include providers and patients who are adversely affected by the prior authorization process.

(In support with amendments) This bill is a step in the right direction. Prior authorization is a substitution of the carrier's judgment over the provider's judgment. Prior authorization is a delaying tactic to save carriers money. Prior authorization requirements can be hard to obtain. Prior authorization should be prohibited for self-referred services.

(In support with concerns) The prior authorization process has become more and more burdensome and is costly and counterproductive. Prior authorization is a complex issue and the list of tasks in this bill is comprehensive. The timeline for the work group recommendations should be extended by a year. As drafted, this bill reopens issues that have already been resolved; the scope of the bill should be narrowed to prior authorization for pharmacy services. This bill is about the prior authorization process and should not be a venue for discussing the appropriateness of prior authorization for specific services. This issue is too important to let languish. The ultimate goal should be a single, standardized form. The OIC should not be bound by the work group recommendations. The bill should not be silent on the composition of the work group or it will be dominated by carriers; the

work group should have representation by the people who have experienced this problem. Using a web-based portal does not simplify the process.

(Opposed) None.

Persons Testifying: (In support) Senator Becker, prime sponsor; John Fogarty, Us Too in Seattle Prostate Cancer Support Group; Patrick Connor, National Federation of Independent Business; Katie Kolan, Washington State Medical Association; and Debi Johnson, Washington State Urology Society.

(In support with amendments) Lori Grassi, Washington State Chiropractic Association; Brad Tower, Optometric Physicians of Washington; and Amber Ulvenes, Group Health.

(In support with concerns) Rick Rubin, OneHealthPort; Shelia Tallman, Premera Blue Cross; Chris Bandoli, Regence Blue Cross; Sydney Smith Zvara, Association of Washington Healthcare Plans; Peter Newbould, Autoimmune Advocacy Alliance; Kerry Hernandez, Valley Medical Center; and Mel Sorensen, America's Health Insurance Plans.

Persons Signed In To Testify But Not Testifying: None.