SENATE BILL REPORT
SB 5267

As of February 6, 2013

Title: An act relating to improving patient health care through a more efficient and standardized prior authorization process for health care services.

Brief Description: Concerning prior authorization for health care services.

Sponsors: Senators Becker, Keiser, Conway, Ericksen, Bailey, Dammeier, Frockt and Schlicher.

Brief History:
Committee Activity: Health Care: 2/05/13.

SENATE COMMITTEE ON HEALTH CARE

Staff: Mich'l Needham (786-7442)

Background: Legislation passed in 2009 directed the Office of the Insurance Commissioner (OIC) to select a lead organization and focus on opportunities for administrative simplification in health insurance processes and offer recommendations on best practices. OIC and the lead organization, OneHealthPort, have facilitated a workgroup with broad participation of insurance carriers, state purchasers, and providers and they have recently developed recommendations on streamlining pre-authorization of insurance services. Currently, each insurance carrier or payor requires specific pre-authorization forms for specific services, with vast variation in numbers of forms and types of pre-authorization requirements.

The federal Affordable Care Act requires a number of changes in administrative simplification efforts. OneHealthPort and other workgroup participants have been actively engaged in the development of new national operating rules. For example, the Department of Health and Human Services (HHS) is required to adopt operating rules for several Health Insurance Portability and Accountability Act transactions, beginning with the eligibility and the claims status transactions. HHS has designated the Council on Affordable Quality Health Care (CAQH) and its Committee on Operating Rules for Information Exchange (CORE) as the lead for development of the initial operating rules. Operating rules required for 2016 will address some remaining transactions: health claims or equivalent encounter information; enrollment and disenrollment in a health plan; health plan premium payments; referral certification and authorization; and claims attachment.

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.

Summary of Bill: The administrative simplification requirements established within state insurance laws are expanded and require OIC to develop a uniform prior authorization form, or data fields for different health care services and benefits, by July 1, 2014. The forms must apply to at least the following health care services: provider office visits; prescription drug benefits; imaging and other diagnostic testing; and laboratory testing.

All forms and data fields must be developed in consultation with physicians, osteopathic physicians or surgeons, or pharmacists who are board certified in the specialty to which the forms apply and have been actively practicing in that specialty for a minimum of five years. OIC must seek input from interested stakeholders and seek to use forms and data fields that have been mutually agreed upon by payors and providers. In addition, OIC must ensure that the forms are consistent with existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services, and consider other national standards pertaining to electronic prior authorization.

All payors or any entity acting for a payor must use and accept only the prior authorization forms or data fields designated for specific types of services. A payor must respond to a request for a prior authorization within two business days after receiving the completed request on the required form. If a payor fails to use or accept the uniform form after six months from the data of release, or fails to respond within two business days, the prior authorization request is deemed accepted.

All payors must use the uniform forms or data fields, and every payor must accept the form as sufficient to request prior authorization for the health care service by January 1, 2015.

Payors are not prohibited from using a prior authorization methodology that uses an internet web page, internet web page portal, or similar electronic internet or web-based system in lieu of a paper form, provided it is consistent with the paper form. Nothing prohibits a health plan from requiring prior authorization for services.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: Having worked in the medical industry for years, I am very familiar with the variety of forms and how much time is spent managing paper work and filling out forms. Having one uniform form would save a lot of time for provider's offices and get patients the care they need faster. We had a workgroup look at pharmacy prior authorization issues and we did produce a number of recommendations. One of them was to use a common form and we believe this will streamline pharmacy activities in community pharmacies. The workgroup with One Health Port has looked at pharmacy issues but the focus has been on hospitals and clinics and they haven't really focused on community pharmacies. Our pharmacy hired two full-time employees just to manage the prior-authorization forms and that has sped up the process considerably but it can still take one day

or 30 days to hear back on an approval. These are complex issues and we support the efforts of the workgroup, but the delays in getting a service authorized delay timely treatment for patients. The state should become the 19th state to use a uniform form. We support the step process used to manage care and expenses but we are concerned with the paperwork and hope we can have protocols for a quick path to the right care at the right time. The patient is impacted when there is a delay in treatment. Pharmacy pre-authorization is the most time consuming and has the broadest range of forms from carriers.

CON: We support the efforts of the workgroup lead by One Health Port and support their comments. Our plans were founding members of the WorkSmart Institute and One Health Port and we support the voluntary efforts being made by all participants. Regence uses only three forms now and they are also used by the Uniform Medical Plan. The collaborative effort with the workgroup is the best place to bring stakeholders together. We believe a web-based process will be more efficient than producing paper forms. The pharmacy issues are more complicated and may need a special workgroup.

OTHER: The 2009 legislation initiated the formal administrative simplification efforts and the workgroup has been making good progress, including a report of best practice recommendations on prior authorization. The workgroup believes the best practices are based in using an application with a web browser, not going backward to paper forms. The two-day turn-around in the bill is a concern since different levels of severity require different levels of response. For example, a process now for immediate response requires response within 60 minutes and you would be delaying that two days, while some others require much more time to process and gather the appropriate documentation. A range of timing is more appropriate. The workgroup recommendations are in the process of being implemented now – that is the hard part. Adoption takes time and requires process change from payors and providers.

Persons Testifying: PRO: Senator Becker, prime sponsor; Jeff Rochon, WA State Pharmacy Assn.; Julie Akers, Everett Clinic; Susie Tracy, WA State Medical Assn.; Josh Halpin, Autoimmune Advocacy Alliance; Erin Dziedzic, American Cancer Society, Cancer Action Network; Helen Nilon, Mental Health Action.

CON: Sydney Zvara, Assn. of WA Healthcare Plans; Chris Bandoli, Regence Blue Shield; Len Sorrin, Premera Blue Cross; Mel Sorensen, America's Health Insurance Plans.

OTHER: Rick Rubin, OneHealthPort.