SENATE BILL REPORT
SB 5267

As of April 27, 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, 2/21/13 [DPS-WM].
Ways & Means: 2/27/13.

SENATE COMMITTEE ON HEALTH CARE

Majority Report: That Substitute Senate Bill No. 5267 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Becker, Chair; Dammeier, Vice Chair; Keiser, Ranking Member; Bailey, Cleveland, Ericksen, Frockt, Parlette and Schlicher.

Staff: Mich'l Needham (786-7442)

SENATE COMMITTEE ON WAYS & MEANS

Staff: Michael Bezanson (786-7449)

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

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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.

Summary of Bill (Recommended Substitute): The administrative simplification requirements established within state insurance laws are modified with requirements for the lead organization – OneHealthPort and the workgroup – to streamline prior authorization for prescription drug benefits. The lead organization must present a plan by November 15, 2013, for the implementation of a uniform electronic prior authorization form and data fields for prescription drug benefits. The Commissioner must review the plan and if it meets the criteria established in the bill, the Commissioner must implement the prior authorization process by May 15, 2014.

The plan must include the following: a defined response time for prior authorization approval or denial that cannot exceed the timeframes provided in WAC for health carriers' utilization review – WAC allows a range of time corresponding to the severity of the condition; if there is not a response within the given time frame, the prior authorization request is deemed approved; data elements, not to exceed the equivalent of two pages that are electronically submissible; capacity of being electronically accepted by the payor after being completed; and compliance with National Council for Prescription Drug Programs prior authorization transactions for the SCRIPT standard.

If a plan is not presented by the deadline, the Commissioner must establish a uniform prior authorization process that meets the criteria by May 15, 2014. If the plan presented meets the criteria the Commissioner must require all third-party payors or any entity acting on behalf of a payor to use and accept only the form developed.

EFFECT OF CHANGES MADE BY HEALTH CARE COMMITTEE (Recommended Substitute): Refocuses efforts on the administrative simplification lead organization – OneHealthPort and work group – to streamline the prior authorization for prescription drug benefits. The lead organization must present a plan by November 15, 2013, for the implementation of a uniform electronic prior authorization form and data fields for prescription drug benefits. The Commissioner must review the plan and if it meets criteria established in the bill, the Commissioner must implement the prior authorization process by May 15, 2014. The plan must include the following: a defined response time for prior authorization approval or denial that cannot exceed the time frames provided in WAC for health carriers utilization review – WAC allows a range of time corresponding to the severity of the condition; if there is not a response within the given timeframe, the prior authorization request is deemed approved; data elements, not to exceed the equivalent of two pages that are electronically submissible; capacity of being electronically accepted by the payor after being completed; and compliance with National Council for Prescription Drug Programs prior authorization transactions for the SCRIPT standard. If a plan is not presented by the

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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 on Original Bill (Health Care): 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 OneHealthPort 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 OneHealthPort 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 turnaround 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 (Health Care): 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.

Staff Summary of Public Testimony (Ways & Means): PRO: Current prior authorization processes are cumbersome, create waste, and cost money. There is too much variation from carriers ranging is several pages to only one. There is a large burden placed on pharmacists and doctors. We have staff dedicated to only managing prior authorization. Simplification of prior authorization processes will help reduce administrative burden and lower health care costs.

The number of processes should be reduced but we do not want to pay more for doing the right thing already. We also want to continue to innovate beyond this point in time. We just want to make sure the exemption standards are clearer.

Persons Testifying (Ways & Means): PRO: Julie Akers, The Everett Clinic; Jeff Rochon, WA State Pharmacy Assn.; Katie Kolan, WA State Medical Assn.; Carrie Tellefson, Premera Blue Cross; Len Sorrin, Regence Blue Shield.