E2SHB 1471 - S COMM AMD **375**
By Senators Dammeier, Frockt

ADOPTED 4/13/2015

Strike everything after the enacting clause and insert the following:

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

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

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

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

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

(5) The health plan may not require a provider to provide a discount from usual and customary rates for health care services not

covered under the health plan, policy, or other agreement, to which the provider is a party.

(6) For purposes of this section:

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

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

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

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

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

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

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

(5) A health carrier may not require a provider to provide a discount from usual and customary rates for health care services not

covered under a health plan, policy, or other agreement, to which the provider is a party.

(6) For purposes of this section:

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

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

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

E2SHB 1471 - S COMM AMD **375**
By Senators Dammeier, Frockt

ADOPTED 4/13/2015

On page 1, line 2 of the title, after "practices;" strike the remainder of the title and insert "adding a new section to chapter 41.05 RCW; adding a new section to chapter 48.43 RCW; and providing an effective date."

EFFECT: (1) Removes the requirement for prior authorization standards and criteria to be based on the plan's medical necessity standards.

(2) Plans must post the prior authorization standards, criteria, or information the plan uses for medical necessity.

(3) Modifies the list of care, removing terms habilitative and rehabilitative, and adding physical therapy, occupational therapy, massage therapy, or speech and hearing therapies, in addition to chiropractic and East Asian medicine. Clarifies health plans may require a referral or prescription for listed therapies and references the chiropractic direct access law.

(4) Removes the requirement to have cost sharing and copayments for the listed services that do not exceed the cost sharing for primary care.

(5) Modifies the definition of new episode of care.

(6) Clarifies that the reference to a contracting provider does not include providers employed within an integrated delivery system operated by a health insurance carrier.

--- END ---