# HOUSE BILL REPORT
# ESSB 6157

**As Reported by House Committee On:**
Health Care & Wellness

**Title**: An act relating to prior authorization.

**Brief Description**: Regarding prior authorization.

**Sponsors**: Senate Committee on Health & Long Term Care (originally sponsored by Senators Short, Kuderer, Rivers, Cleveland, Palumbo, Nelson, Becker, Walsh, Warnick and Van De Wege).

**Brief History:**
**Committee Activity:**
Health Care & Wellness: 2/20/18, 2/23/18 [DP].

**Brief Summary of Engrossed Substitute Bill**

- Increases the number of treatment visits that a health plan must cover without prior authorization for chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapy.

## HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

**Majority Report**: Do pass. Signed by 10 members: Representatives Cody, Chair; Macri, Vice Chair; Caldier, Clibborn, Maycumber, Riccelli, Robinson, Slatter, Stonier and Tharinger.

**Minority Report**: Do not pass. Signed by 5 members: Representatives Schmick, Ranking Minority Member; Graves, Assistant Ranking Minority Member; DeBolt, MacEwen and Rodne.

**Minority Report**: Without recommendation. Signed by 1 member: Representative Harris.

**Staff**: Jim Morishima (786-7191).

**Background**:

*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.*

Health carriers may require prior authorization for certain health care procedures. Prior authorization is the requirement that a health care provider seek approval of a drug, procedure, or test before seeking reimbursement from an insurer. A health carrier may not retrospectively deny coverage for care that had prior authorization unless the prior authorization was based on a material misrepresentation by the provider.

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 therapy. This prohibition does not affect the ability of a health plan to require a referral or prescription for these therapies. 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 90 days and is not currently undergoing any active treatment.

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**Summary of Bill**:

The prohibition against requiring prior authorization for an evaluation and management visit for chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapy applies only to an initial evaluation and management visit. The prohibition applies to up to six consecutive treatment visits that meet the standards of medical necessity and are subject to quantitative treatment limits of the health plan, instead of only to an initial treatment visit.

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**Appropriation**: None.

**Fiscal Note**: Available.

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

**Staff Summary of Public Testimony**:

(In support) This bill is about patient access. Prior authorization blocks patient access to needed care. Prior authorization is used as a stalling and evasion tactic. Prior authorization requests are often improperly denied. It often takes a lot of effort on behalf of the consumer to convince the insurer to grant authorization. Benefit managers obstruct timely care and diminish clinical outcomes. The insurer and the benefit manager often have different policies and practices. Denials of prior authorization requests are frustrating and lead to inconsistent and interrupted care, impeded patient-provider relationships, and hindered clinical outcomes. Prior authorization is unnecessary and leads to higher administrative costs to providers, which artificially increases the costs of care to consumers. The administrative burden on providers decreases the time that can be spent on patient care, which inhibits providers from achieving their patients' potentials and takes away hope for better outcomes. Patients do not want anything for free, but they pay for these services and should be able to decide what is

best for themselves and their kids in consultation with medical providers. This bill codifies current practice by allowing six visits that are medically necessary and within the policy limits. This bill will help providers deliver quality care to patients.

(Opposed) Codifying plan designs in statute is poor public policy. Prior authorization is not a barrier. Rather, it allows insurers to make sure the right care is provided at the right time by the right provider. Appropriate, medically necessary, and effective care must be encouraged. Ineffective, unnecessary care should not be paid for. Purchasers have demanded that insurers put prior authorization processes in place. Overutilization is a significant problem that is harmful to patients and drives up costs. A federal study on chiropractic care found a significant amount of unnecessary services were being provided. Overbilling and fraud are a problem. The current prior authorization process is working. The prior authorization process has improved care and saved customers money, but this bill will take away this progress. The prior authorization process is transparent and non-discriminatory. The Insurance Commissioner has adopted new prior authorization rules that require an electronic system. Concerns about prior authorization should be addressed by these rules, not by putting visit numbers in statute. If the visits required by this bill are determined to be medically unnecessary, the patient may end up paying for them out-of-pocket. This bill will place substantial limits on an insurer's ability to provide its members with the best care.

**Persons Testifying**: (In support) Senator Short, prime sponsor; Ben Boyle, Physical Therapy Association of Washington; Adana Protonentis; and Jessica McMurdie, Stepping Stones Therapy Network.

(Opposed) Meg Jones, Association of Washington Healthcare Plans; Zach Snyder, Regence Blue Shield; Len Sorrin, Premera Blue Cross; and Mel Sorenson, America's Health Insurance Plans.

**Persons Signed In To Testify But Not Testifying**: None.