SENATE BILL REPORT
SB 6157

As Reported by Senate Committee On:
Health & Long Term Care, February 1, 2018

Title: An act relating to prior authorization.

Brief Description: Regarding prior authorization.

Sponsors: Senators Short, Kuderer, Rivers, Cleveland, Palumbo, Nelson, Becker, Walsh, Warnick and Van De Wege.

Brief History:
Committee Activity: Health & Long Term Care: 1/30/18, 2/01/18 [DPS, w/oRec].

Brief Summary of First Substitute Bill

- Prohibits the use of prior authorization by a health carrier for up to eight treatment visits for certain types of new episodes of care.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 6157 be substituted therefor, and the substitute bill do pass.
Signed by Senators Cleveland, Chair; Kuderer, Vice Chair; Rivers, Ranking Member; Bailey, Becker, Conway, Fain, Keiser and Van De Wege.

Minority Report: That it be referred without recommendation.
Signed by Senator Mullet.

Staff: Evan Klein (786-7483)

Background: Prior authorization is a requirement that a health care provider obtain approval from a patient's insurance plan to prescribe a specific medication or treatment. Health carriers may impose different prior authorization standards and criteria for a covered service among tiers of contracting providers. Health carriers may not require prior authorization for evaluation and management visits or initial treatment visits in a new episode of care. This prohibition applies to chiropractic, physical therapy, occupational therapy, east Asian medicine, massage therapy, and speech and hearing therapies. Health carriers must post their

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prior authorization standards on their website and provide covered individuals the standards upon request.

Summary of Bill: The bill as referred to committee not considered.

Summary of Bill (First Substitute): Health carriers are prohibited from requiring prior authorization for:

- initial evaluation and management visits; and
- up to eight consecutive treatment visits in a new episode of care of chiropractic, physical therapy, occupational therapy, east Asian medicine, massage therapy, and speech and hearing therapies that meet the standards of medical necessity and are subject to quantitative treatment limits of the health plan.

Appropriation: None.

Fiscal Note: Not requested.

Creates Committee/Commission/Task Force that includes Legislative members: No.

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

Staff Summary of Public Testimony on First Substitute: PRO: Prior authorization practices impact patient access to care for medically necessary care. This bill does not impact the need for prior authorization or plan benefits. This bill merely impacts the consecutive number of visits that may be allowed with a single authorization. Prior authorization services have expanded to second-guess what a primary physician is prescribing. This bill does not change anything about how an insurance plan can put limits on visits. Plans are currently using third party benefit managers to impose restrictions on visit limits so that a patient is not even able to get the visits that their plan benefit allows. These treatment therapies are supposed to be intense for a short period of time, and these restrictions are not allowing patients to get the intensity of treatment that they need. Prior authorization requirements are also taking up significant time for practitioners. Approving three, two or one visit at a time prevents patients from making progress towards their treatment goals. Employers are also concerned about unnecessary care, but this bill is about accessing care without extra paperwork. This bill will help employees get scheduled for care and get back to work.

CON: In this era of highly volatile insurance coverage, any bill that increases costs will decrease the affordability of the market. This bill allows unfettered access to eight visits without prior authorization for treatment visits. As a result, carriers would not be able to identify if the treatments are medically necessary or cost effective for members. This may result in patients receiving unneeded care. Certain health plans in Washington were reviewed in 2017 by the insurance commissioner, and these plans were deemed in compliance with the law at that time. Employers and health care purchasers have pushed health plans since the 1970s and 80s to ensure that effective and appropriate care is provided to ensure that the services are efficacious. Self-insured plans may provide additional benefits than other plans. However, all plans will meet the statutory limits for providing certain numbers of treatment visits. There is quite a bit of unnecessary care provided in the United States that the country

is paying for. Prior authorization and other oversight processes are some of the few tools that carriers can use to prevent unnecessary care.

Persons Testifying: PRO: Senator Shelly Short, Prime Sponsor; Melissa Johnson, Physical Therapy Association of Washington; Washington Speech-Language-Hearing Association; Chris Tuohy, Advantage Sports Therapy; Adana Protonentis, citizen; Patrick Connor, National Federation of Independent Business, Washington.

CON: Meg Jones, Association of Washington Healthcare Plans; Len Sorrin, Premera; Mel Sorensen, America's Health Insurance Plans.

Persons Signed In To Testify But Not Testifying: No one.