HOUSE BILL REPORT
ESB 5887

As Passed House - Amended:
April 12, 2019

Title: An act relating to health carrier requirements for prior authorization standards.

Brief Description: Concerning health carrier requirements for prior authorization standards.

Sponsors: Senators Short, Keiser and Nguyen.

Brief History:
Committee Activity:
Health Care & Wellness: 3/22/19, 4/2/19 [DPA].
Floor Activity:
Passed House - Amended: 4/12/19, 95-0.

Brief Summary of Engrossed Bill
(As Amended by House)

- Changes prior authorization requirements applicable to health carriers.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 13 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Chambers, Davis, Harris, Jinkins, Riccelli, Robinson, Stonier, Thai and Tharinger.

Staff: Jim Morishima (786-7191).

Background:

Prior authorization is the requirement that a provider receive approval from a health carrier prior to performing a health care service for reimbursement. 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 must inform an enrollee which tier a provider is in by posting the information on its web site in a manner accessible to both enrollees and providers.

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.

Additionally, a health carrier may not require prior authorization for an initial evaluation and management visit and up to six consecutive treatment visits in a new episode of care for the following types of services: chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapy. The visits are subject to the carrier's medical necessity standards and are subject to any quantitative treatment limits of the health plan.

Summary of Amended Bill:

The prohibition against prior authorization for chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapy visits is expanded to prohibit any kind of utilization management or review, including prior, concurrent, or post-service authorization. The prohibition against utilization management or review applies to an initial evaluation and management visit and up to six treatment visits for each of chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapy visits.

The medical necessity requirement is removed for the visits. Coverage for the visits may not be limited on the basis of medical necessity or appropriateness if the patient's treating or referring provider determines that the visits are medically necessary. Care may not be retroactively denied and payment may not be retroactively refused for the visits.

The requirement that the visits be consecutive and the requirement that the visits be part of a new episode of care are eliminated. The definition of "new episode of care" is altered by making it applicable to new conditions or diagnoses, instead of new or recurrent conditions, and lengthening the time period within which the enrollee may not have been treated for the new condition or diagnosis to within the plan year, instead of within the previous 90 days.

The requirements related to prior authorization tiers and chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapy visits are made applicable to a health carrier's contracted entity, in addition to the health carrier itself.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony:

(In support) The providers covered by this bill provide drugless therapies. Current law requires enrollees to be able to access six visits without prior authorization. Health carriers and benefit managers, however, are changing terminology to get around these requirements. This causes time and effort to be expended by patients and providers, which increases costs. Patients are being wrongfully denied coverage for these services. Many of these therapies

require consistent access to providers and these practices are causing gaps in patient care. Enrollees are not able to use the care for which they pay.

(Opposed) Attaching the six visits to new episodes of care and having the medical necessity determination made by the provider is misguided. Health insurers are trying to keep health insurance affordable and this is a cost driver. Every time a provider determines a new episode has occurred, it would trigger an additional six visits. This bill should be amended to allow six visits without a medical necessity determination, but without additional visits triggered by new episodes of care. The initial six visits could still be reviewed for fraud, waste, or abuse and would still be subject to a health plan's quantitative limits.

Persons Testifying: (In support) Senator Short, prime sponsor; Lori Grassi, Washington State Chiropractic Association; Ben Boyle, Physical Therapy Association; and Adana Protonentis.

(Opposed) Meg Jones, Association of Washington Healthcare Plans.

Persons Signed In To Testify But Not Testifying: None.