HOUSE BILL REPORT
ESSB 6404

As Passed House - Amended:
March 5, 2020

Title: An act relating to reducing barriers to patient care through appropriate use of prior authorization and adoption of appropriate use criteria.

Brief Description: Adopting prior authorization and appropriate use criteria in patient care.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Frockt, O'Ban, Dhingra, Becker, Kuderer, Rivers, Lovelett, Wellman, Pedersen, Nguyen, Darneille, Hasegawa, McCoy, Wilson, C., Das, Conway and Saldaña).

Brief History:
Committee Activity:
Health Care & Wellness: 2/26/20, 2/27/20 [DPA].
Floor Activity:
Passed House - Amended: 3/5/20, 97-0.

Brief Summary of Engrossed Substitute Bill
(As Amended by House)

- Requires carriers to submit certain information related to prior authorization requests, approvals, denials, and response times to the Insurance Commissioner.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 13 members: Representatives Cody, Chair; Macri, Vice Chair; Chambers, Chopp, Davis, DeBolt, Harris, Maycumber, Riccelli, Robinson, Stonier, Thai and Tharinger.

Minority Report: Do not pass. Signed by 1 member: Representative Schmick, Ranking Minority Member.

Staff: Kim Weidenaar (786-7120).

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.

Prior Authorization.
Prior authorization is the requirement that a health care provider seek approval of a drug, procedure, or test before seeking reimbursement from an insurer. Health carriers may impose different prior authorization standards and criteria for a covered service among tiers of contracting providers. In 2018 the Legislature prohibited health carriers from requiring prior authorization for initial evaluation and management visits, and up to six consecutive treatment visits in a new episode of care of chiropractic, physical therapy, occupational therapy, acupuncture and Eastern 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.

Summary of Amended Bill:

Insurance Commissioner Duties.
By April 1, 2021, and annually thereafter, for health plans issued by a carrier, a carrier must report the following deidentified and aggregated data to the Insurance Commissioner (Commissioner) for the prior plan year:

- lists of the 10 inpatient and 10 outpatient medical or surgical codes, lists of the 10 inpatient and 10 outpatient mental health and substance use disorder codes, list of the 10 diabetes supplies and equipment codes, and lists of the 10 durable medical equipment codes:
  - with the highest total number of prior authorization requests, including the number of requests and percent of approved requests for each code;
  - with the highest percentage of approved prior authorization requests, including the number of requests and percent of approved requests for each code; and
  - with the highest percentage or prior authorization requests that were initially denied and then subsequently approved on appeal, including the number of requests and the percent of requests initially denied and then subsequently approved for each code;
- the average determination response time in hours for prior authorization requests to the plan with respect to each covered service included in the lists for each of the following prior authorization categories:
  - expedited decisions;
  - standard decisions; and
  - extenuating circumstances decisions.

By July 1, 2021, and annually thereafter, the Commissioner must aggregate and deidentify the data collected into a standard report that may not identify the carrier that submitted the data. The Commissioner must make the report available to interested parties.

The Commissioner may request additional data from carriers and adopt rules.

"Prior authorization" is defined as a mandatory process that a carrier or its designated or contracted representative requires a provider or facility to follow before a service is delivered, to determine if a service is a benefit and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness in relation to the applicable

plan, including any term used by a carrier or its designated or contracted representative to describe this process.

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) By one estimation prior authorization costs the entire health care system $250 billion per year. When you speak with physicians, regardless of their specialty or practice setting, they will say that prior authorization is one of the biggest issues they face in terms of time wasted. Physicians are commonly frustrated by the increasing number of prior authorizations required and the varying standards across plans. Health care providers spend significant resources trying to obtain prior authorization from plans and very often the provider at the plan handling the prior authorization request is not trained in the specialty that the service relates to.

This bill does not suggest that we should get rid of utilization management, but there is very little transparency in this area. We do not know how often prior authorization requests are denied, or are denied and subsequently approved on appeal. Some of this work has been done in Medicaid and it should be expanded to private insurance.

This bill has been scaled back and narrowed from how it was introduced. At this point, the proponents of the bill are focusing on transparency and would like the bill to be limited to the data collection piece. There are many anecdotes about prior authorization and the costs and problems, but this bill will provide objective data.

(Opposed) None.

(Other) The Office of the Insurance Commissioner (OIC) has embarked on a two-year process to look at mental health parity. As part of the project, the OIC did a very large data call that resulted in tens of thousands of pages of information about prior authorization that the OIC is currently assessing.

Some appreciate the stakeholder process this bill has gone through and that the bill has been narrowed down. However, the carriers would appreciate it if the data collection requirement was delayed. The plans ask for an additional six months to get the processes in place to efficiently and accurately provide the requested data.

If section 2 of the bill remains, it should be amended so that the Work Group's recommendations include possible impacts to utilizations, cost, and patient outcomes. This would provide the Legislature with a more robust picture of the situation.

There are groups that develop care guidelines that have no financial stake in health care decisions that follow standards of the National Academy of Medicine. These companies review peer-reviewed papers and research studies to develop care guidelines in strict accordance with the principle of evidence-based medicine. To allow these companies to be included in the bill, an amendment to expand the definition of who can develop appropriate use criteria to include nationally recognized independent authors of clinical care guidelines is requested.

Persons Testifying: (In support) Senator Frockt, prime sponsor; Chelene Whiteaker, Washington State Hospital Association; Matt Miller, CHI Franciscan; and Sean Graham, Washington State Medical Association.

(Other) Lonnie Johns-Brown, Office of the Insurance Commissioner; Chris Bandoli, Association of Washington Healthcare Plans; and Donna Baker-Miller, MCG Health.

Persons Signed In To Testify But Not Testifying: None.