SENATE BILL REPORT
ESB 5887

As Amended by House, 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 & Long Term Care: 2/18/19, 2/19/19 [DPS, w/oRec].
Floor Activity:
Passed Senate: 3/06/19, 45-2.
Passed House: 4/12/19, 95-0.

Brief Summary of Engrossed Bill

- Prohibits a health carrier from requiring certain treatment visits to meet medical necessity standards, so long as the patient's treating or referring provider determines the visit is medically necessary.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 5887 be substituted therefor, and the substitute bill do pass.
Signed by Senators Randall, Vice Chair; Bailey, Conway, Frockt, Keiser, Rivers and Van De Wege.

Minority Report: That it be referred without recommendation.
Signed by Senators O'Ban, Ranking Member; Becker.

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.

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.

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, 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.

Summary of Engrossed Bill: A health carrier may not require prior authorization, or require a treatment visit to meet the standards of medical necessity, for initial evaluation and management visits and up to six consecutive treatment visits for new episodes of care of chiropractic, physical therapy, occupational therapy, east Asian medicine, massage, or speech and hearing therapies that are subject to quantitative treatment limits of the health plan. A determination by the patient's treating or referring provider that a treatment visit is medically necessary is sufficient for accessing the initial six visits.

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 Original Bill: *The committee recommended a different version of the bill than what was heard.* PRO: This bill should not be necessary to clarify legislation that was enacted in 2018. The practice of prior authorization is referred to as medical necessity review and other terms. These semantics are delaying access to care. Benefit managers are retroactively denying payment after patients get to use their six visits. The intent is to ensure patients have access to their visits, and that intent is being violated by the current language in statute.

CON: There is concern that this bill would equate chiropractors with primary care physicians, and there is an interest in removing that specific language. Last year's legislation was a balanced compromise that allowed access to services that is not afforded for any other non-primary care services. This bill would guarantee that carriers have no ability to do managed care for visits, without any oversight. This would impinge on care quality and raise costs.

OTHER: There is a concern around the phrase "or other primary care physicians" in the bill, and would like the phrase to be deleted from the bill.

Persons Testifying: PRO: Senator Shelly Short, Prime Sponsor; Lori Grassi, Washington State Chiropractic Association; Melissa Johnson, Physical Therapy Association of Washington.

CON: Katie Kolan, Washington State Medical Association; Meg Jones, Association of Washington Healthcare Plans.

OTHER: Patricia Seib, Washington Academy of Family Physicians.

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

EFFECT OF HOUSE AMENDMENT(S):

- Makes provisions relating to prior authorization applicable to a health carrier's contracting entity, in addition to the carrier itself.
- Expands the prohibition against prior authorization to include utilization management or review of any kind, including prior, concurrent, or post-service review.
- Clarifies that utilization management or review may not be required for six visits for each of the following: chiropractic, physical therapy, occupational therapy, acupuncture, massage therapy, or speech and hearing therapy.
- Removes the requirement that the six visits be consecutive or for a new episode of care.
- Changes the definition of new episode of care by making it applicable to new conditions or diagnoses, instead of new or recurrent conditions, and lengthens 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 ninety days.
- Prohibits a health carrier or its contracting entity from retroactively denying care or refusing payment for the six visits.
- Inserts an intent section.