SENATE BILL REPORT
SB 6404

As Reported by Senate Committee On:
Health & Long Term Care, February 5, 2020
Ways & Means, February 11, 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: 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 & Long Term Care: 1/31/20, 2/05/20 [DPS-WM].
Ways & Means: 2/10/20, 2/11/20 [DPS (HLTC), w/oRec].

Brief Summary of First Substitute Bill

- Requires carriers to submit certain information related to prior authorization practices to the insurance commissioner (commissioner).
- Establishes a work group to review prior authorization standards and to make prior authorization recommendations to the Legislature.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 6404 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Cleveland, Chair; Randall, Vice Chair; O'Ban, Ranking Member; Becker, Conway, Dhingra, Frockt, Keiser, Muzzall, Rivers and Van De Wege.

Staff: Evan Klein (786-7483)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass.

Signed by Senators Rolfes, Chair; Frockt, Vice Chair, Operating, Capital Lead; Mullet, Capital Budget Cabinet; Brown, Assistant Ranking Member, Operating; Honeyford, Assistant

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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.

Ranking Member, Capital; Becker, Billig, Carlyle, Conway, Darneille, Dhingra, Hasegawa, Hunt, Keiser, Liias, Muzzall, Pedersen, Rivers, Van De Wege, Wagoner, Warnick and Wilson, L..

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

Staff: Sandy Stith (786-7710)

Background: Prior Authorization. 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.

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.

Dr. Robert Bree Collaborative. The Dr. Robert Bree Collaborative (Collaborative) is an organization funded by the Health Care Authority (HCA) which convenes public and private stakeholders to improve the quality, health outcomes, and cost effectiveness of health care in Washington State. The Collaborative identifies health care services that have substantial variations in practice patterns or high utilization trends and investigates evidence-based practices that will improve quality and reduce variation in the use of the services. Members of the Collaborative are appointed by the Governor. The Collaborative has published reports on topics such as accountable payment models, addiction and dependence treatment, cardiovascular health, obstetrics, potentially avoidable hospital readmissions, and pediatric psychotropic use.

All state purchased health care programs must implement evidence-based best practice guidelines or protocols developed by the Collaborative after the HCA administrator, in consultation with participating agencies, has affirmatively reviewed and endorsed the recommendations. Beginning in 2021, qualified health plans contracted by HCA to be offered on the individual market, will be required to incorporate recommendations of the Collaborative.

Summary of Bill (First Substitute): By October 1, 2020 and annually thereafter, for health plans issued by a carrier, a carrier must report the following deidentified and aggregated data to the commissioner for the 2019 plan year:

- lists of the ten inpatient and lists of the ten outpatient medical or surgical services, which may include mental health and substance use disorder:
    - with the highest total volume of prior authorization requests during the previous plan year;
    - with the highest number of approved prior authorization requests during the previous plan year; and

    - with the highest number or prior authorization requests that were initially denied and then subsequently approved on appeal;
  - 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 categories:
    - urgent concurrent decisions;
    - urgent preservice decisions;
    - nonurgent preservice decisions; and
    - post-service decisions.

The commissioner must:
- compile and provide data collected to the work group;
- develop standardized reports of the data and make the reports available upon request to interested parties; and
- post recommendations of the work group on the commissioner's website.

A prior authorization work group (work group) is created to enhance the understanding of prior authorization in Washington. The work group must be hosted and staffed by the Collaborative. The Governor must appoint 15 members to the work group comprised of representatives from providers, hospitals, clinics, carriers, and the HCA. Work group membership must be comprised of at least 50 percent representatives of hospitals, clinics, and providers, and at least 25 percent representatives of carriers.

By January 1, 2021, and annually thereafter, the work group must select at least five medical or surgical services subject to prior authorization by insurance carriers for review. In 2021, the work group must review as one of the services selected, noninvasive cardiac diagnostic imaging procedures. The work group must prioritize other services for review based on:
- the volume of the service;
- indications based on medical literature that prior authorization is not appropriate for the service;
- the potential for negative impact on patient care caused by prior authorization delays; and
- input from providers, facilities, carriers, and purchasers.

Beginning December 1, 2021, the work group must annually develop and submit recommendations to the health care committees of the Legislature. The work group must review and make updates to its recommendations as necessary.

For each service selected, the work group must assess:
1. Whether the utilization and approval patterns and literature justify the use of prior authorization. If not, the work group must recommend no prior authorization for the service;
2. Whether adoption of uniform appropriate use criteria or evidence-based criteria confirmed through a clinical decision support mechanism for the service in lieu of prior authorization is appropriate. If so, the work group must identify and select or develop appropriate use criteria. If the work group recommends the use of appropriate use criteria related to noninvasive cardiac diagnostic imaging procedures,

the work group must recommend adoption of appropriate use criteria developed by a federally qualified provider led entity;
3. Whether an appropriate federal policy or initiative exists for the service. If so, the work group recommendations should align; and
4. The services as provided to adults and pediatric patients, and must provide separate recommendations where appropriate.

The work group must establish subcommittees, comprised of practicing clinicians with relevant expertise, to focus on specific services selected for review. Each subcommittee must include at least two members of the specialty or subspecialty most experienced for the review. Each subcommittee must make recommendations to the work group.

EFFECT OF CHANGES MADE BY HEALTH & LONG TERM CARE COMMITTEE (First Substitute):

- Removes the requirement for carriers to report on all covered services subject to prior authorization.
- Requires carriers to report lists of ten inpatient and ten outpatient medical or surgical services, for:
    - the highest total volume of prior authorization requests, including the total number of requests for each service;
    - the highest number of approved requests, including the total number of requests for each service; and
    - the highest number of requests initially denied and then subsequently approved, including the total number of request for each service;
- Requires carriers to submit data annually, instead of requiring an initial submission of all data, and then annual/periodic updates of the data submissions.
- Removes permission for the OIC to request subsequent data submissions.
- Requires the work group, if it recommends the use of appropriate use criteria related to noninvasive cardiac diagnostic imaging procedures, to recommend adoption of appropriate use criteria developed by a federally qualified provider led entity.
- Removes the requirement that the OIC adopt prior authorization standards in rule.
- Removes the requirement that carriers, Public Employees' and School Employees' Benefits Boards, and Medicaid must adopt the prior authorization standards.
- Requires at least 25 percent of the work group to consist of representatives from carriers.

Appropriation: None.

Fiscal Note: Available.

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 (Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: It is time for Washington, in its health care delivery system, to take a hard look at the prior

authorization process. This process impacts physicians and patients. The prior authorization system is a burden and overly complex. Providers eventually get procedures approved, but have to call health plans multiple times to do so. We do not know the rates at which health plans are denying procedures. A key part of the bill is transparency for providers. The process is also terrible for patients. Patients do not have time to fight insurance to get their services approved. There may be times where prior authorization controls are appropriate. Medicare is moving towards ensuring routine procedures can be done without prior authorization. The health care system is far too administratively complex. The Medicaid Managed Care Organizations have made notes that they want to standardize prior authorization processes, but it is unclear whether they have implemented standard practices. After initial denials of a prior authorization, 92 percent or more of the time, the service is approved. Over $266 billion is wasted in the United State health care system due to administrative costs. Prior authorization has led to serious adverse events and even to patients abandoning treatment. This is not an attempt to ban prior authorization all-together. When used appropriately, prior authorization is a good tool for cost containment. When over-used and not standardized, prior authorization leads to issues for physicians and patients. Use of prior authorization has increased year over year. The benefit of standardization is that providers can build uniform criteria in their practices, reducing patient delays and expediting care.

CON: Health plans use prior authorization for the same reasons that public entities and other purchasers use these tools. These are used to address gaps between evidence based practices and the care that is delivered to patients, to avoid overuse and misuse of treatments. Prior authorization ensures prescriptions are not co-prescribed, it ensures that providers have the appropriate training to make the appropriate diagnosis, and to ensure there is no overuse, misuse, or underuse of services. Prior authorization ensures that services are delivered timely in a way that reflects appropriate practice patterns. Provider practice patterns that lack accountability are the third leading cause of death in the United States. Patients are being overprescribed opioids and other psychotropic drugs. The Legislature has enacted a series of prior authorization requirements in recent years. This bill has a breathtaking delegation of authority to an entity that does not have rulemaking authority and is not subject to the Administrative Procedures Act. The OIC just implemented the third phase of prior authorization rulemaking that includes an online portal to help standardize practices. Some of the information required to be produced by this report may be information that is not currently tracked, or based on services that are not even provided. An unelected board has never been able to require an agency to develop a rule, and would be prohibited by the administrative procedures act's requirement to allow public comment in developing a rule. Health plans have panels of providers that are consulted for prior authorization decisions.

OTHER: The OIC did a data request for health plans to compare how prior authorization is treated for mental health services and medical services. The request uncovered tens of thousands of pages of prior authorization criteria from the health plans. There is a desire to focus the bill on the top prior authorization criteria for review first. There is a desire to refine the rulemaking proposal in the bill, but there is definitely work needed around prior authorization and utilization review. The Health Care Authority has concerns associated with the impact of the legislation on Medicaid. Prior authorization certainly creates burdens for patients and providers. However, the implementation of this bill might violate certain federal requirements. Medicaid must be the sole decision maker for how money is spent under the

program, and it is unclear whether the work group in the bill would compromise this federal funding. The hope is also to avoid reinventing the wheel, and to incorporate prior authorization recommendations already being developed at the federal level.

Persons Testifying (Health & Long Term Care): PRO: Senator David Frockt, Prime Sponsor; Sean Graham, Washington State Medical Association; James Hudson, Woodcreek Provider Services; Eugene Yang, MD, UW Medicine; Abby Moore, Washington Council for Behavioral Health; Erin Dziedzic, Bleeding Disorder Foundation of Washington and Foundations for Healthy Generations; Christine Palermo, Virginia Mason Medical Center; Diane Pirak, CHI Franciscan Health; Lisa Thatcher, Washington State Hospital Association.

CON: Chris Bandoli, Association of Washington Healthcare Plans; Mel Sorensen, America's Health Insurance Plans.

OTHER: Emily Transue, Health Care Authority; Lonnie Johns-Brown, Office of the Insurance Commissioner; Kate White Tudor, Center for Diagnostic Imaging.

Persons Signed In To Testify But Not Testifying (Health & Long Term Care): No one.

Staff Summary of Public Testimony on First Substitute (Ways & Means): PRO: Prior authorization (PA) is a top concern and priority of WSMA. Time spent on PA is time the physician or staff spends with the carrier and not with the patient. We assume that approximately 15 hours per week is spent on PA that could be spent on patient care. We are not proposing to abolish PA, but to improve it. The current fiscal note is high based on the underlying bill. We believe there are more changes to be made to improve the bill that will reduce the costs. We have internal staff who work on denials. Between April and December, 2019, 738 denials were overturned out of approximately 1300 representing over $50 million in billed charges. These were based on payer error. Smaller providers do not have the money to fight these. We are in strong agreement on the policy. There is a cost to not move forward and a cost to delay care. Hospitals receive 437 PAs per day. Ninety-one percent of these are routinely approved. PA criteria for plans are different. There is a cost when these are different. One hospital has 54 people on staff to deal with PA. This is an administrative burden.

OTHER: We are still working on this bill that accomplishes the goal of transparency. We are working on a version where the data is manageable. We have concerns about the cost of not having utilization management. Twenty to thirty percent of care is unnecessary or duplicative. We are unclear about how the data would be collected. We would like to see more information about the workgroup. We would also like to see more equity in how the workgroup is structured so one group cannot block another group. We would like to see full scope of cost and utilization included in the recommendations of the workgroup.

Persons Testifying (Ways & Means): PRO: Matt Miller, CHI Franciscan; Lisa Thatcher, Washington State Hospital Association; Sean Graham, Washington State Medical Association.

OTHER: Lonnie Johns-Brown, Office of the Insurance Commissioner; Chris Bandoli, Association of Washington Healthcare Plans.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.