**WSCA OPPOSES PRIOR AUTHORIZATION**

For over forty years, the Washington State Legislature has consistently promoted patient choice and access to care. Nobody is arguing that there has to be cost and quality control. The argument is when and how that is accomplished. The way that the insurance industry handles this is to limit access to a complete class of providers. Below you will find an outline of laws that have been passed during the past 40 years that we believe support our position that a prior-authorization policy on a single class of services, or profession, is inappropriate at the minimum and illegal at best. Bold and underscore emphasis provided.

---

**1971**
**RCW 48.21.142**
**Chiropractic.**

Notwithstanding any provision of any group disability insurance contract or blanket disability insurance contract as provided for in this chapter, benefits shall not be denied thereunder for any health service performed by a holder of a license issued pursuant to **chapter 18.25 RCW** if (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to chapter 18.71 RCW: PROVIDED, HOWEVER, That no provision of chapter 18.71RCW shall be asserted to deny benefits under this section.

The provisions of this section are intended to be remedial and procedural to the extent they do not impair the obligation of any existing contract.

Then in 1983 the following statute was passed addressing discrimination against chiropractic.

---

**1983**
**RCW 48.44.309**
**Legislative finding**.

**The legislature finds and declares that there is a paramount concern that the right of the people to obtain access to health care in all its facets is being impaired**. The legislature further finds that there is a heavy reliance by the public upon prepaid health care service agreements and insurance, whether profit or nonprofit, as the only effective manner in which the large majority of the people can obtain access to quality health care. Further, the legislature finds that **health care service agreements may be anticompetitive because of the exclusion of other licensed forms of health care** and that because of the high costs of health care, there is a need for competition to reduce these costs. It is, therefore, declared to be in the public interest that these contracts as a form of insurance be regulated under the police power of the state to assure that all the people have the greatest access to health care services.

---

**1983**
**RCW 48.44.310**
**Chiropractic care, coverage required, exceptions.**

(1) Each group contract for comprehensive health care service which is entered into, or renewed, on or after September 8, 1983, between a health care service contractor and the person or persons to receive such care shall offer coverage for chiropractic care on the same basis as any other care.

**(2) A patient of a chiropractor shall not be denied benefits under a contract because the practitioner is not licensed under chapter 18.57 or 18.71RCW.**

(3) This section shall not apply to a group contract for comprehensive health care services entered into in accordance with a collective bargaining agreement between management and labor representatives. Benefits for chiropractic care shall be **offered by the employer in good faith on the same basis as any other care as a subject for collective bargaining for group contracts for health care services.**

Then the “every category of provider” law was passed with a delayed implementation date of 2000. This law was challenged by the insurers en masse through the courts and the 9th Circuit Court of Appeals allowed the law to stand. This was a pivotal law for Washington State providers in allowing all providers to be allowed into provider networks giving patient choice a solid standing.

---

**1995**

RCW 48.43.045
Health plan requirements — Annual reports — Exemptions.

(1) Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, shall:

(a) Permit every category of health care provider to provide health services or care for conditions included in the basic health plan services to the extent that:

(i) The provision of such health services or care is within the health care providers' permitted scope of practice; and

(ii) The providers agree to abide by standards related to:

(A) Provision, utilization review, and cost containment of health services;

(B) Management and administrative procedures; and

(C) Provision of cost-effective and clinically efficacious health services.

(b) Annually report the names and addresses of all officers, directors, or trustees of the health carrier during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals, unless substantially similar information is filed with the commissioner or the national association of insurance commissioners. This requirement does not apply to a foreign or alien insurer regulated under chapter 48.20 or 48.21 RCW that files a supplemental compensation exhibit in its annual statement as required by law.

(2) The requirements of subsection (1)(a) of this section do not apply to a licensed health care profession regulated under Title 18 RCW when the licensing statute for the profession states that such requirements do not apply.

Then in 1996 the Legislature extended non-discrimination protection to all provider types.

---

**1996**
**RCW 48.43.085**
**Health carrier may not prohibit its enrollees from contracting for services outside the health care plan.**

Notwithstanding any other provision of law, **no health carrier subject to the jurisdiction of the state of Washington may prohibit directly or indirectly its enrollees from freely contracting at any time to obtain any health care services outside the health care plan on any terms or conditions the enrollees choose.** Nothing in this section shall be construed to bind a carrier for any services delivered outside the health plan. The provisions of this section shall be disclosed pursuant to *RCW 48.43.095(2). The insurance commissioner is prohibited from adopting rules regarding this section.

When carriers required a referral to block access to care, the legislature again passed laws preserving patient choice.

---

**2000**
**RCW 48.43.515**

**Access to appropriate health services — Enrollee options — Rules.**

(1) Each enrollee in a health plan must have adequate choice among health care providers.

(2) Each carrier must allow an enrollee to choose a primary care provider who is accepting new enrollees from a list of participating providers. Enrollees also must be permitted to change primary care providers at any time with the change becoming effective no later than the beginning of the month following the enrollee's request for the change.

(3) Each carrier must have a process whereby an enrollee with a complex or serious medical or psychiatric condition may receive a standing referral to a participating specialist for an extended period of time.

(4) Each carrier must provide for appropriate and timely referral of enrollees to a choice of specialists within the plan if specialty care is warranted. If the type of medical specialist needed for a specific condition is not represented on the specialty panel, enrollees must have access to nonparticipating specialty health care providers.

(5) **Each carrier shall provide enrollees with direct access to the participating chiropractor of the enrollee's choice for covered chiropractic health care without the necessity of prior referral.** Nothing in this subsection shall prevent carriers from restricting enrollees to seeing only providers who have signed participating provider agreements or from utilizing other managed care and cost containment techniques and processes. For purposes of this subsection, "covered chiropractic health care" means covered benefits and limitations related to chiropractic health services as stated in the plan's medical coverage agreement, with the exception of any provisions related to prior referral for services.

(6) Each carrier must provide, upon the request of an enrollee, access by the enrollee to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the enrollee's choice.

(7) Each carrier must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract for at least sixty days following notice of termination to the enrollees or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. The provider's relationship with the carrier or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the carrier assign new enrollees to the terminated provider.

(8) Every carrier shall meet the standards set forth in this section and any rules adopted by the commissioner to implement this section. In developing rules to implement this section, the commissioner shall consider relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

Then in 2008 the legislature passed language that required carriers to treat chiropractors fairly in payment for services that were shared by other providers (evaluation and management and physical medicine and rehabilitation) requiring they pay chiropractors the same rate. **However, the carriers then decreased the payments for spinal manipulation to cover the increased payments they were required to pay for the services that were shared with other providers.**

---

**2008**
**RCW 48.43.190**
**Payment of chiropractic services — Parity**.

(1)(a) **A health carrier may not pay a chiropractor less for a service or procedure identified under a particular physical medicine and rehabilitation code or evaluation and management code, as listed in a nationally recognized services and procedures code book such as the American medical association current procedural terminology code book, than it pays any other type of provider licensed under Title 18 RCW for a service or procedure under the same code, except as provided in (b) of this subsection.** A carrier may not circumvent this requirement by creating a chiropractor-specific code not listed in the nationally recognized code book otherwise used by the carrier for provider payment.

(b) This section does not affect a health carrier's:

(i) Implementation of a health care quality improvement program to promote cost-effective and clinically efficacious health care services, including but not limited to pay-for-performance payment methodologies and other programs fairly applied to all health care providers licensed under Title 18 RCW that are designed to promote evidence-based and research-based practices;

(ii) Health care provider contracting to comply with the network adequacy standards;

(iii) Authority to pay in-network providers differently than out-of-network providers; and

(iv) Authority to pay a chiropractor less than another provider for procedures or services under the same code based upon geographic differences in the cost of maintaining a practice.

(c) This section does not, and may not be construed to:

(i) Require the payment of provider billings that do not meet the definition of a clean claim as set forth in rules adopted by the commissioner;

(ii) Require any health plan to include coverage of any condition; or

(iii) Expand the scope of practice for any health care provider.

(2) This section applies only to payments made on or after January 1, 2009.

---

**2012**

**284.43.878 (1)**
**WAC 284-43-878**
**Essential health benefit categories.**

(1) A health benefit plan must cover "ambulatory patient services." For purposes of determining a plan's actuarial value, an issuer must classify as ambulatory patient services medically necessary services delivered to enrollees in settings other than a hospital or skilled nursing facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury, **in a substantially equal manner to the base-benchmark plan**.

Specifically

d) The base-benchmark plan's visit limitations on services in this category include:
(i) Ten spinal manipulation services per calendar year without referral;

And;

(e) State benefit requirements classified to this category are:
(i) Chiropractic care (RCW 48.44.310);

Closing Comments: Employers and individuals purchase policies that include chiropractic care and are allowed to limit chiropractic care already. Most copays ($20-$30 per visit) exceed the cost of the services allowed by the insurer and must meet medical necessity standards. This new policy on specific services now adds that a provider must **seek permission** before having access to a benefit that was purchased. We believe this is illegal.