H-1266.2

SUBSTITUTE HOUSE BILL 1357

State of Washington 68th Legislature 2023 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Simmons, Schmick, Stonier, Cortes, Reed, Bateman, Harris, Alvarado, Pollet, and Caldier)

1 AN ACT Relating to modernizing the prior authorization process;
2 amending RCW 48.43.0161; adding new sections to chapter 48.43 RCW;
3 adding a new section to chapter 41.05 RCW; and adding a new section
4 to chapter 74.09 RCW.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43
7 RCW to read as follows:
8 (1) Each carrier offering a health plan issued or renewed on or
9 after January 1, 2024, shall comply with the following standards
10 related to prior authorization:
11 (a) The carrier shall meet the following time frames for prior
12 authorization determinations and notifications to a participating
13 provider or facility that submits the prior authorization request
14 through an electronic standardized prior authorization process, as
15 designated by each carrier, that meets the requirements of subsection
16 (2) of this section:
17 (i) For electronic standard prior authorization requests, the
18 carrier shall make a decision and notify the provider or facility of
19 the results of the decision within three business days of submission
20 of an electronic prior authorization request by the provider or
21 facility that contains the necessary information to make a

1 determination. If insufficient information has been provided to the
2 carrier to make a decision, the carrier shall request any additional
3 information from the provider or facility within one business day of
4 submission of the electronic prior authorization request.
5 (ii) For electronic expedited prior authorization requests, the
6 carrier shall make a decision and notify the provider or facility of
7 the results of the decision within one business day of submission of
8 an electronic prior authorization request by the provider or facility
9 that contains the necessary information to make a determination. If
10 insufficient information has been provided to the carrier to make a
11 decision, the carrier shall request any additional information from
12 the provider or facility within one business day of submission of the
13 electronic prior authorization request.
14 (b) The carrier shall meet the following time frames for prior
15 authorization determinations and notifications to a participating
16 provider or facility that submits the prior authorization request
17 through a process other than an electronic standardized prior
18 authorization process described in subsection (2) of this section:
19 (i) For nonelectronic standard prior authorization requests, the
20 carrier shall make a decision and notify the provider or facility of
21 the results of the decision within five calendar days of submission
22 of a nonelectronic prior authorization request by the provider or
23 facility that contains the necessary information to make a
24 determination. If insufficient information has been provided to the
25 carrier to make a decision, the carrier shall request any additional
26 information from the provider or facility within five calendar days
27 of submission of the nonelectronic prior authorization request.
28 (ii) For nonelectronic expedited prior authorization requests,
29 the carrier shall make a decision and notify the provider or facility
30 of the results of the decision within two calendar days of submission
31 of a nonelectronic prior authorization request by the provider or
32 facility that contains the necessary information to make a
33 determination. If insufficient information has been provided to the
34 carrier to make a decision, the carrier shall request any additional
35 information from the provider or facility within one calendar day of
36 submission of the nonelectronic prior authorization request.
37 (c) In any instance in which a carrier has determined that a
38 provider or facility has not provided sufficient information for
39 making a determination under (a) and (b) of this subsection, a
40 carrier may establish a specific reasonable time frame for submission

of the additional information. This time frame must be communicated to the provider or enrollee with a carrier's request for additional information.

(d) The carrier's prior authorization requirements must be described in detail and written in easily understandable language. The carrier shall make its most current prior authorization requirements and restrictions, including the written clinical review criteria, available to providers and facilities in an electronic format upon request. The prior authorization requirements must be based on peer-reviewed clinical review criteria. The clinical review criteria must be evidence-based criteria and must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous people, other people of color, gender, and underserved populations. The clinical review criteria must be evaluated and updated, if necessary, at least annually.

(2) By January 1, 2024, each carrier shall make available an electronic standardized prior authorization process using an internet webpage, internet webpage portal, or similar electronic, internet, or web-based system. The electronic standardized prior authorization process must be a standardized transmission process using national transaction standards for prior authorization and, as necessary, application programming interfaces, to enable prior authorization requests to be accessible, submitted by health care providers via a certified electronic health records system, and accepted by carriers and their designated health care benefit managers electronically through secure electronic transmission with the goal of maximizing administrative simplification, efficiency, and timeliness. Each carrier must develop its own standardized process that meets the requirements of this section. The electronic standardized prior authorization process must:

(a) Allow health care providers to supply clinical information under the electronic standardized prior authorization process;

(b) Provide an explanation of the information necessary to submit a complete prior authorization request, including the minimum amount of clinical information necessary to review the request;

(c) Allow for the electronic exchange of clinical information and documents;

(d) Provide information necessary to determine if a service is a benefit under the enrollee's health plan;

(e) Provide explanations of prior authorization and step therapy requirements and restrictions, relative costs, and covered alternatives;

(f) Include written clinical review criteria utilized in making a determination; and

(g) Indicate that a prior authorization denial or authorization of a service less intensive than that included in the original request is an adverse benefit determination and is subject to the carrier's grievance and appeal process under RCW 48.43.535.

(3) Nothing in this section applies to prior authorization determinations made pursuant to RCW 48.43.400 through 48.43.420 or 48.43.761.

(4) For the purposes of this section:

(a) "Expedited prior authorization request" means a request by a provider or facility for approval of a health care service where the passage of time could seriously jeopardize the life or health of the enrollee, seriously jeopardize the enrollee's ability to regain maximum function, or, in the opinion of a provider or facility with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the health care service that is the subject of the request.

(b) "Standard prior authorization request" means a request by a provider or facility for approval of a health care service where the request is made in advance of the enrollee obtaining a health care service that is not required to be expedited.

NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05 RCW to read as follows:

(1) A health plan offered to public employees and their covered dependents under this chapter issued or renewed on or after January 1, 2024, shall comply with the following standards related to prior authorization:

(a) The carrier offering the health plan shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior authorization request through an electronic standardized prior authorization process, as designated by each carrier, that meets the requirements of subsection (2) of this section:

(i) For electronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of

the results of the decision within three business days of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within one business day of submission of the electronic prior authorization request.

(ii) For electronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within one business day of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within one business day of submission of the electronic prior authorization request.

(b) The carrier shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior authorization request through a process other than an electronic standardized prior authorization process described in subsection (2) of this section:

(i) For nonelectronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within five calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within five calendar days of submission of the nonelectronic prior authorization request.

(ii) For nonelectronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within two calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within one calendar day of submission of the nonelectronic prior authorization request.

(c) In any instance in which a carrier has determined that a provider or facility has not provided sufficient information for making a determination under (a) and (b) of this subsection, a carrier may establish a specific reasonable time frame for submission of the additional information. This time frame must be communicated to the provider or enrollee with a carrier's request for additional information.

(d) The prior authorization requirements of the carrier offering the health plan must be described in detail and written in easily understandable language. The carrier shall make its most current prior authorization requirements and restrictions, including the written clinical review criteria, available to providers and facilities in an electronic format upon request. The prior authorization requirements must be based on peer-reviewed clinical review criteria. The clinical review criteria must be evidence-based criteria and must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous people, other people of color, gender, and underserved populations. The clinical review criteria must be evaluated and updated, if necessary, at least annually.

(2) By January 1, 2024, each carrier shall make available electronic standardized prior authorization process using an internet webpage, internet webpage portal, or similar electronic, internet, or web-based system. The electronic standardized prior authorization process must be a standardized transmission process using national transaction standards for prior authorization and, as necessary, application programming interfaces, to enable prior authorization requests to be accessible, submitted by health care providers via a certified electronic health records system, and accepted by carriers and their designated health care benefit managers electronically through secure electronic transmission with the goal of maximizing administrative simplification, efficiency, and timeliness. Each carrier must develop its own standardized process that meets the requirements of this section. The electronic standardized prior authorization process must:

(a) Allow health care providers to supply clinical information under the electronic standardized prior authorization process;

(b) Provide an explanation of the information necessary to submit a complete prior authorization request, including the minimum amount of clinical information necessary to review the request;

1 (c) Allow for the electronic exchange of clinical information and
2 documents;
3 (d) Provide information necessary to determine if a service is a
4 benefit under the enrollee's health plan;
5 (e) Provide explanations of prior authorization and step therapy
6 requirements and restrictions, relative costs, and covered
7 alternatives;
8 (f) Include written clinical review criteria utilized in making a
9 determination; and
10 (g) Indicate that a prior authorization denial or authorization
11 of a service less intensive than that included in the original
12 request is an adverse benefit determination and is subject to the
13 carrier's grievance and appeal process under RCW 48.43.535.
14 (3) The authority shall prohibit health plans from requiring
15 prior authorization to the same extent that the insurance
16 commissioner has established such prohibitions pursuant to rules
17 adopted under RCW 48.43.0161(6).
18 (4) Nothing in this section applies to prior authorization
19 determinations made pursuant to RCW 41.05.526.
20 (5) For the purposes of this section:
21 (a) "Expedited prior authorization request" means a request by a
22 provider or facility for approval of a health care service where the
23 passage of time could seriously jeopardize the life or health of the
24 enrollee, seriously jeopardize the enrollee's ability to regain
25 maximum function, or, in the opinion of a provider or facility with
26 knowledge of the enrollee's medical condition, would subject the
27 enrollee to severe pain that cannot be adequately managed without the
28 health care service that is the subject of the request.
29 (b) "Standard prior authorization request" means a request by a
30 provider or facility for approval of a health care service where the
31 request is made in advance of the enrollee obtaining a health care
32 service that is not required to be expedited.

33 NEW SECTION. **Sec. 3.** A new section is added to chapter 74.09
34 RCW to read as follows:
35 (1) Beginning January 1, 2024, the authority shall require all
36 managed health care systems, including managed care organizations, to
37 comply with the following standards related to prior authorization:
38 (a) The managed health care system shall meet the following time
39 frames for prior authorization determinations and notifications to a

participating provider or facility that submits the prior authorization request through an electronic standardized prior authorization process, as designated by each managed health care system, that meets the requirements of subsection (2) of this section:

(i) For electronic standard prior authorization requests, the managed health care system shall make a decision and notify the provider or facility of the results of the decision within three business days of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the managed health care system to make a decision, the managed health care system shall request any additional information from the provider or facility within one business day of submission of the electronic prior authorization request.

(ii) For electronic expedited prior authorization requests, the managed health care system shall make a decision and notify the provider or facility of the results of the decision within one business day of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the managed health care system to make a decision, the managed health care system shall request any additional information from the provider or facility within one business day of submission of the electronic prior authorization request.

(b) The managed health care system shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior authorization request through a process other than an electronic standardized prior authorization process described in subsection (2) of this section:

(i) For nonelectronic standard prior authorization requests, the managed health care system shall make a decision and notify the provider or facility of the results of the decision within five calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the managed health care system to make a decision, the managed health care system shall request any additional

information from the provider or facility within five calendar days of submission of the nonelectronic prior authorization request.

(ii) For nonelectronic expedited prior authorization requests, the managed health care system shall make a decision and notify the provider or facility of the results of the decision within two calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the managed health care system to make a decision, the managed health care system shall request any additional information from the provider or facility within one calendar day of submission of the nonelectronic prior authorization request.

(c) In any instance in which a managed health care system has determined that a provider or facility has not provided sufficient information for making a determination under (a) and (b) of this subsection, a managed health care system may establish a specific reasonable time frame for submission of the additional information. This time frame must be communicated to the provider or enrollee with a managed health care system's request for additional information.

(d) The prior authorization requirements of the managed health care system must be described in detail and written in easily understandable language. The managed health care system shall make its most current prior authorization requirements and restrictions, including the written clinical review criteria, available to providers and facilities in an electronic format upon request. The prior authorization requirements must be based on peer-reviewed clinical review criteria. The clinical review criteria must be evidence-based criteria and must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous people, other people of color, gender, and underserved populations. The clinical review criteria must be evaluated and updated, if necessary, at least annually.

(2) By January 1, 2024, each managed health care system, including managed care organizations, shall make available electronic standardized prior authorization process using an internet webpage, internet webpage portal, or similar electronic, internet, or web-based system. The electronic standardized prior authorization process must be a standardized transmission process using national transaction standards for prior authorization and, as necessary, application programming interfaces, to enable prior authorization

requests to be accessible, submitted by health care providers via a certified electronic health records system, and accepted by managed health care systems and their designated health care benefit managers electronically through secure electronic transmission with the goal of maximizing administrative simplification, efficiency, and timeliness. Each managed health care system must develop its own standardized process that meets the requirements of this section. The electronic standardized prior authorization process must:

(a) Allow health care providers to supply clinical information under the electronic standardized prior authorization process;

(b) Provide an explanation of the information necessary to submit a complete prior authorization request, including the minimum amount of clinical information necessary to review the request;

(c) Allow for the electronic exchange of clinical information and documents;

(d) Provide information necessary to determine if a service is a benefit under the enrollee's health plan;

(e) Provide explanations of prior authorization and step therapy requirements and restrictions, relative costs, and covered alternatives;

(f) Include written clinical review criteria utilized in making a determination; and

(g) Indicate that a prior authorization denial or authorization of a service less intensive than that included in the original request is an adverse benefit determination and is subject to the managed health care system's grievance and appeal process under RCW 48.43.535.

(3) The authority shall prohibit managed health care systems, including managed care organizations, from requiring prior authorization to the same extent that the insurance commissioner has established such prohibitions pursuant to rules adopted under RCW 48.43.0161(6).

(4) Nothing in this section applies to prior authorization determinations made pursuant to RCW 71.24.618.

(5) For the purposes of this section:

(a) "Expedited prior authorization request" means a request by a provider or facility for approval of a health care service where the passage of time could seriously jeopardize the life or health of the enrollee, seriously jeopardize the enrollee's ability to regain maximum function, or, in the opinion of a provider or facility with

knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the health care service that is the subject of the request.

(b) "Standard prior authorization request" means a request by a provider or facility for approval of a health care service where the request is made in advance of the enrollee obtaining a health care service that is not required to be expedited.

NEW SECTION. **Sec. 4.** A new section is added to chapter 48.43 RCW to read as follows:

(1) For health plans issued on or after January 1, 2024, a carrier may not require prior authorization for any code covered by the reporting requirements in RCW 48.43.0161 that, as reported for calendar year 2021, had at least 50 prior authorization requests submitted to carriers and a prior authorization approval threshold that was 98 percent or greater as aggregated across carriers and reported health service categories.

(2) The commissioner shall publish on the office of the insurance commissioner's website, without engaging in rule making, a list of the codes that meet the criteria of subsection (1) of this section.

Sec. 5. RCW 48.43.0161 and 2020 c 316 s 1 are each amended to read as follows:

(1) Except as provided in subsection ((~~(2)~~)) (3) of this section, by October 1, 2020, and annually thereafter, for individual and group health plans issued by a carrier that has written at least one percent of the total accident and health insurance premiums written by all companies authorized to offer accident and health insurance in Washington in the most recently available year, the carrier shall report to the commissioner the following aggregated and deidentified data related to the carrier's prior authorization practices and experience for the prior plan year:

(a) Lists of the ((~~ten~~)) 10 inpatient medical or surgical codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of

prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(b) Lists of the ((~~ten~~)) 10 outpatient medical or surgical codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(c) Lists of the ((~~ten~~)) 10 inpatient mental health and substance use disorder service codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; ((~~[and]~~)) and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(d) Lists of the ((~~ten~~)) 10 outpatient mental health and substance use disorder service codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior

1 authorization requests for each code and the percent of approved
2 requests for each code;
3 (ii) With the highest percentage of approved prior authorization
4 requests during the previous plan year, including the total number of
5 prior authorization requests for each code and the percent of
6 approved requests for each code; (([and])) and
7 (iii) With the highest percentage of prior authorization requests
8 that were initially denied and then subsequently approved on appeal,
9 including the total number of prior authorization requests for each
10 code and the percent of requests that were initially denied and then
11 subsequently approved;
12 (e) Lists of the ((ten)) 10 durable medical equipment codes:
13 (i) With the highest total number of prior authorization requests
14 during the previous plan year, including the total number of prior
15 authorization requests for each code and the percent of approved
16 requests for each code;
17 (ii) With the highest percentage of approved prior authorization
18 requests during the previous plan year, including the total number of
19 prior authorization requests for each code and the percent of
20 approved requests for each code; (([and])) and
21 (iii) With the highest percentage of prior authorization requests
22 that were initially denied and then subsequently approved on appeal,
23 including the total number of prior authorization requests for each
24 code and the percent of requests that were initially denied and then
25 subsequently approved for each code;
26 (f) Lists of the ((ten)) 10 diabetes supplies and equipment
27 codes:
28 (i) With the highest total number of prior authorization requests
29 during the previous plan year, including the total number of prior
30 authorization requests for each code and the percent of approved
31 requests for each code;
32 (ii) With the highest percentage of approved prior authorization
33 requests during the previous plan year, including the total number of
34 prior authorization requests for each code and the percent of
35 approved requests for each code; (([and])) and
36 (iii) With the highest percentage of prior authorization requests
37 that were initially denied and then subsequently approved on appeal,
38 including the total number of prior authorization requests for each
39 code and the percent of requests that were initially denied and then
40 subsequently approved for each code;

1 (g) The average determination response time in hours for prior
2 authorization requests to the carrier with respect to each code
3 reported under (a) through (f) of this subsection for each of the
4 following categories of prior authorization:
5 (i) Expedited decisions;
6 (ii) Standard decisions; and
7 (iii) Extenuating circumstances decisions.
8 (2) <u>In addition to the reporting requirements in subsection (1)</u>
9 <u>of this section, the October 1, 2025, and October 1, 2026, data</u>
10 <u>submissions by carriers must include information on utilization of</u>
11 <u>each of the codes identified in section 4 of this act during calendar</u>
12 <u>years 2024 and 2025, as necessary to inform the commissioner's</u>
13 <u>January 1, 2027, utilization reporting requirement in subsection (4)</u>
14 <u>of this section.</u>
15 <u>(3)</u> For the October 1, 2020, reporting deadline, a carrier is not
16 required to report data pursuant to subsection (1)(a)(iii), (b)(iii),
17 (c)(iii), (d)(iii), (e)(iii), or (f)(iii) of this section until April
18 1, 2021, if the commissioner determines that doing so constitutes a
19 hardship.
20 ((~~(3)~~)) <u>(4)</u> By January 1, 2021, and annually thereafter, the
21 commissioner shall aggregate and deidentify the data collected under
22 subsection (1) of this section into a standard report and may not
23 identify the name of the carrier that submitted the data. ((~~The~~
24 ~~initial report due on January 1, 2021, may omit data for which a~~
25 ~~hardship determination is made by the commissioner under subsection~~
26 ~~(2) of this section. Such data must be included in the report due on~~
27 ~~January 1, 2022.~~)) <u>The January 1, 2027, report shall include</u>
28 <u>information on trends in the utilization of the codes identified in</u>
29 <u>section 4 of this act during calendar years 2024 and 2025, drawn from</u>
30 <u>data reported by carriers or from an independent data source or</u>
31 <u>sources, such as the statewide all-payer health care claims database</u>
32 <u>established under RCW 43.371.020.</u> The commissioner must make the
33 report available to interested parties.
34 ((~~(4)~~)) <u>(5)</u> The commissioner may request additional information
35 from carriers reporting data under this section.
36 ((~~(5)~~)) <u>(6)</u> The commissioner may adopt rules to implement this
37 section. In adopting rules, the commissioner must consult
38 stakeholders including carriers, health care practitioners, health
39 care facilities, and patients.

1 ((~~(6)~~)) (7) For the purpose of this section, "prior
2 authorization" means a mandatory process that a carrier or its
3 designated or contracted representative requires a provider or
4 facility to follow before a service is delivered, to determine if a
5 service is a benefit and meets the requirements for medical
6 necessity, clinical appropriateness, level of care, or effectiveness
7 in relation to the applicable plan, including any term used by a
8 carrier or its designated or contracted representative to describe
9 this process.

--- END ---