Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1357

Brief Description: Modernizing the prior authorization process.

Sponsors: Representatives Simmons, Schmick, Stonier, Cortes, Reed, Bateman, Harris, Alvarado, Pollet and Caldier.

Brief Summary of Bill

- Establishes requirements for the prior authorization process for private health insurance, Public Employee Benefit Board and School Employee Benefit Board health programs, and Medicaid programs related to time frames for decisions, qualifications for reviewers, electronic authorization options, and communication requirements.
- Directs the Office of the Insurance Commissioner to adopt rules to prohibit carriers from requiring prior authorization for billing codes with an approval rate over 95 percent.
- Eliminates the requirement that the affected enrollee must have suffered substantial harm and sought independent review of the health care treatment decision in order to bring a cause of action against a health carrier for failure to meet the standard of care.

Hearing Date: 1/25/23

Staff: Christopher Blake (786-7392).

Background:

Prior Authorization.
Prior authorization is the requirement that a health care provider seek approval of a drug, procedure, or test before seeking reimbursement from a health carrier. Health carriers may

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impose different prior authorization standards and criteria for a covered service among tiers of contracting providers.

The Office of the Insurance Commissioner maintains rules regarding prior authorization practices for health carriers in the private health insurance market. Under the rules, health carriers must have a documented prior authorization program description and use evidence-based clinical review criteria. Health carriers must also maintain an online prior authorization process. In addition, health carriers must comply with specified time frames for making a prior authorization determination and for notifying a provider. The time frames are five calendar days for a standard prior authorization request and two calendar days for an expedited request.

The Health Care Authority requires prior authorization for medical assistance programs as specified in administrative rules, billing instructions, and memoranda for certain health care services, including treatment, equipment, related supplies, and drugs. For managed health care systems, standards are specified in contract and require that standard authorizations for health care determinations be made and notices of decisions sent within five calendar days and within two calendar days for expedited authorization decisions.

In 2020, legislation was passed to require health carriers to annually report to the Office of the Insurance Commissioner information about prior authorization requests received, approved requests, requests denied and then approved, and the average determination response time.

Health Carrier Standard of Care.
Health carriers are required to adhere to the accepted standard of care that is applicable to health care providers when arranging for the provision of medically necessary health care services to their enrollees. Health carriers are liable for any harm proximately caused by their failure to follow the standard of care when the failure results in a denial, delay, or modification of a health care service to the enrollee. In order to maintain such a cause of action against a health carrier, the affected enrollee must have suffered substantial harm and the affected enrollee or the enrollee's representative must have sought independent review of the health care treatment decision. The term "substantial harm" means the loss of life; loss or significant impairment of limb, bodily, or cognitive function; significant disfigurement; or severe or chronic physical pain. Such an action must be commenced within three years of completion of the independent review process.

Summary of Bill:

Prior Authorization Standards.
Beginning January 1, 2024, prior authorization standards are established for health plans offered by health carriers in the private health insurance market or to public or school employees, as well as for medical assistance coverage offered through managed health care systems. The standards do not apply to prior authorizations for withdrawal management services or inpatient or resident substance use disorder services. In the case of health carriers in the private health insurance market, the standards do not apply to prior authorizations associated with prescription drug

utilization management.

Timing of Review.
Time frames for health carriers and managed health care systems to make prior authorization determinations and notify a participating health care provider or health care facility are established for both standard prior authorization requests and expedited prior authorization requests.

An expedited prior authorization request is a request by a health care provider or health care facility for approval of a health care service where the passage of time could either seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function or subject the enrollee to severe pain that cannot be adequately managed without the requested health care service. For an expedited prior authorization request, a health carrier or managed health care system must make a decision and notify the health care provider or health care facility within 24 hours of submission of the prior authorization request. If the health carrier or managed health care system was not provided sufficient information to make a decision, they must request any additional information in a timely manner to allow them to comply with the 24-hour notification requirement.

A standard prior authorization request is a request by a health care provider or health care facility for advance approval of a health care service that does not include a condition requiring the request to be expedited. For a standard prior authorization request, a health carrier or managed health care system must make a decision and notify the health care provider or health care facility within 48 hours of submission of the prior authorization request. If the health carrier or managed health care system was not provided sufficient information to make a decision, they must request any additional information in a timely manner to allow them to comply with the 48-hour notification requirement.

Reviewer Qualifications.
The initial review of a prior authorization request must be conducted and approved by a licensed health care professional. Only a physician or osteopathic physician may deny a prior authorization request made by a physician, osteopathic physician, physician assistant, or advanced registered nurse practitioner. When a prior authorization request is denied, a health carrier or managed health care system must make a peer-to-peer review discussion available to the requesting provider. The peer reviewer must be licensed in the same or similar medical specialty as the requesting provider and have the authority to modify or overturn the prior authorization decision.

Communication of Criteria.
Health carriers and managed health care systems must describe their prior authorization requirements in detailed, easily understandable language. Health carriers and managed health care systems must make the most current prior authorization requirements and restrictions available upon request as well as readily accessible and conspicuously posted on their websites. The prior authorization requirements must be based on peer-reviewed, evidence-based clinical

review criteria which is evaluated and updated at least annually.

Electronic Requests.
By January 1, 2024, health carriers and managed health care systems must make an electronic prior authorization request transaction process available using an internet webpage, an internet webpage portal, or similar system.

High-Approval Prior Authorizations.
The Insurance Commissioner must adopt rules to prohibit health carriers from requiring prior authorization for billing codes with a prior authorization approval rate over 95 percent. Health plans offered by health carriers to public employees and medical assistance coverage offered through managed health care systems are similarly prohibited from requiring prior authorization for billing codes proscribed by the rules. After three years, the Insurance Commissioner may reinstate eligibility of a code for prior authorization if it is later determined that the utilization of the code has changed significantly.

Health Carrier Standard of Care Liability.
The conditions under which a cause of action against a health carrier for failure to meet the standard of care are removed to the extent that they require that the affected enrollee must have suffered substantial harm and the affected enrollee or the enrollee's representative must have exercised the opportunity to seek independent review of the health care treatment decision. The action must be commenced within three years of the denial, delay, or modification of the health care service rather than three years from the completion of the independent review process.

Appropriation: None.

Fiscal Note: Requested on January 18, 2023.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.