HOUSE BILL REPORT
HB 1357

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to modernizing the prior authorization process.

Brief Description: Modernizing the prior authorization process.

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

Brief History:
Committee Activity:
Health Care & Wellness: 1/25/23, 2/15/23 [DPS].

Brief Summary of Substitute 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, electronic authorization options, and communication requirements.
- Prohibits health carriers and managed health care systems from requiring prior authorization for certain health care codes with an approval rate of 98 percent or higher.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 11 members: Representatives Riccelli, Chair; Bateman, Vice Chair; Schmick, Ranking Minority Member; Bronoske, Davis, Macri, Orwall, Simmons, Stonier, Thai and Tharinger.

Minority Report: Without recommendation. Signed by 5 members: Representatives

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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 part of the legislation nor does it constitute a statement of legislative intent.

Barnard, Graham, Harris, Maycumber and Mosbrucker.

Staff: Christopher Blake (786-7392).

Background:

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 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.

Summary of Substitute 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.

Standardized Electronic Prior Authorization Transaction Processes.
By January 1, 2024, health carriers and managed health care systems must make a standardized electronic prior authorization transaction process (electronic prior authorization process) available using an internet webpage, an internet webpage portal, or similar system. The electronic prior authorization process must use national standards for prior authorization and include capabilities related to the submission of clinical information, the provision of prior authorization information, the exchange of clinical documents, the provision of coverage information, the provision of utilization management information, and the communication of clinical review criteria and grievance and appeals process information.

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. The time frames differ depending on whether the prior authorization request was made through the electronic prior authorization process or through a nonelectronic prior authorization process.

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 that is submitted through:

- an electronic prior authorization process, a health carrier or managed health care system must make a decision and notify the health care provider or health care facility within one business day of submission of a prior authorization request. If additional information is needed to make a determination, the health carrier or managed health care system must request it within one business day of submission of the request through an electronic prior authorization process; or
- a nonelectronic process, a health carrier or managed health care system must make a decision and notify the health care provider or health care facility within two calendar days of submission of a prior authorization request. If additional information is needed to make a determination, the health carrier or managed health care system must request it within one calendar day of submission of the request through a nonelectronic prior authorization process.

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 that is submitted through:

- an electronic prior authorization process, a health carrier or managed health care system must make a decision and notify the health care provider or health care facility

within three business days of submission of a prior authorization request. If additional information is needed to make a determination, the health carrier or managed health care system must request it within one business day of submission of the request through an electronic prior authorization process; or

- a nonelectronic process, a health carrier or managed health care system must make a decision and notify the health care provider or health care facility within five calendar days of submission of a prior authorization request. If additional information is needed to make a determination, the health carrier or managed health care system must request it within five calendar days of submission of the request through a nonelectronic prior authorization process.

A health carrier or managed health care system may establish specific reasonable time frames for a health care provider or health care facility to submit additional information when needed to make a 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 in an electronic format. The prior authorization requirements must be based on peer-reviewed, evidence-based clinical review criteria which is evaluated and updated at least annually. In addition, the clinical review criteria 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.

High-Approval Prior Authorizations.
Health carriers and managed health care systems are prohibited from requiring prior authorization for any code that, during calendar year 2021, had at least 50 prior authorization requests and a prior authorization approval rate of 98 percent or higher. The Insurance Commissioner must publish a list of the codes that are exempt from prior authorization on their website. The Office of the Insurance Commissioner must include information on trends in utilization of the exempted codes during 2024 and 2025 in its January 1, 2027, utilization reporting requirement.

Substitute Bill Compared to Original Bill:

The substitute bill requires that the health carriers' electronic prior authorization process use national transaction standards for prior authorization. The standardized process must have certain capabilities related to the submission of clinical information, provision of prior authorization information, exchange of clinical documents, provision of coverage information, provision of utilization management information, and communication of clinical review criteria and appeals processes.

The substitute bill splits the prior authorization determination timelines into two categories: (1) requests submitted through the standardized electronic prior authorization transaction process; and (2) nonelectronic requests. Requests submitted through the standardized electronic prior authorization transaction process must have decision results for standard requests within three business days of a complete request and within one business day for an expedited request. Any request for additional information must be made within one business day. Requests submitted through a nonelectronic prior authorization process must have decision results for standard requests within five calendar days of a complete request and within two calendar days for an expedited request. Any request for additional information must be made within five calendar days for a standard request and within two calendar days for an expedited request. Health carriers may establish reasonable time frames for the submission of additional information.

The substitute bill replaces the prohibition on prior authorization for codes with an approval rate of 95 percent or more with a prohibition on prior authorization for codes with at least 50 prior authorization requests and a prior authorization approval rate of 98 percent or higher, as reported for calendar year 2021, aggregated across carriers and health service categories. The Office of the Insurance Commissioner must report on utilization trends related to the prohibited codes for 2024 and 2025.

The substitute bill removes standards for reviewers of prior authorization requests.

The substitute bill requires that, in addition to being based on evidence-based criteria, clinical review criteria must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous populations, other people of color, gender, and underserved populations.

The substitute bill restores current law related to causes of action against a health carrier for failure to meet the standard of care.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on February 15, 2023.

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

Staff Summary of Public Testimony:

(In support) Formularies and prior authorizations serve a purpose for managing health care costs, but they can also be an unnecessary system that drives up health care costs, delays care, and increases hurdles to access. This bill is about standardizing and modernizing the prior authorization process. This bill will establish timelines for prior authorization

decisions and standardize processes across health carriers which will result in less burden and better outcomes for patients. This bill streamlines prior authorization and brings transparency to the process. Prior authorization causes an overwhelming administrative burden that can drive health care providers out of business. This bill will create greater transparency between the carrier, the providers, and the patients. The inefficient prior authorization process results in patients having their treatment delayed, finances impacted, and quality of life affected. When dealing with a disease like cancer where there are procedures occurring on very tight timelines, a delay can mean that a patient is missing a chemotherapy appointment.

Prior authorization used to only be applied to outlier services, but is now applied to routine practices which institutionalizes delay and inefficiencies in health care delivery. This bill seeks to reduce administrative burdens by removing those rarely denied, but still required prior authorizations that create a bottleneck. Prior authorizations that are required, but rarely denied, delay access to important medication for chronic illness.

It is important to have a real peer-to-peer review because it isn't appropriate for a physician in one specialty to have a review by another specialty that knows nothing about the specialty at issue. Naturopaths should be included in the list of providers identified in the bill because, as primary care providers, they face similar barriers when submitting prior authorization requests.

(Opposed) Prior authorization is a key step to assuring that patients receive needed, safe, quality care. Patient safety may be compromised by the bill's exceptionally fast turnaround times and its authorization to the Insurance Commissioner to waive prior authorization altogether. This bill will likely result in a post-claim review process that will not be popular with some providers and patients. This bill drastically and unnecessarily cuts the amount of time to complete a prior authorization review and the times will be very difficult for health plans to meet and would likely result in an increase in denials. This bill requires a specialty-matched peer review process that will be expensive and not be a good use of limited health care staff. When Texas considered this type of legislation, it was estimated to cost nearly $1 billion.

While prior authorization programs should be made more efficient, that can be done by moving to an electronic platform. This bill does not mention the availability of technology to improve the prior authorization process. Health care providers have not been using the electronic prior authorization systems offered by health carriers. The bill's prohibition on prior authorization for procedures based on approval rates is concerning because there should be a review for quality and safety elements.

Persons Testifying: (In support) Representative Tarra Simmons, prime sponsor; Angela Ross, Washington Association of Naturopathic Physicians; Jenny Arnold, Washington State Pharmacy Association; Sean Graham, Washington State Medical Association; Matt Helder, American Cancer Society Cancer Action Network; Robin Sparks; and Teresa Girolami,

King County Medical Society.

(Opposed) Jennifer Ziegler, Association of Washington Health Care Plans; Chris Berlin, Kaiser Permanente of Washington; Heidi Kriz, Regence; and Chris Bandoli, America's Health Insurance Plans.

Persons Signed In To Testify But Not Testifying: Nancy Belcher; Katina Rue; Garrett Jeffery; Carrie Horwitch; Christopher Chen, Health Care Authority; and Anna Taylor, MultiCare Connected Care.