FINAL BILL REPORT
E2SHB 1357

C 382 L 23
Synopsis as Enacted

Brief Description: Modernizing the prior authorization process.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Simmons, Schmick, Stonier, Cortes, Reed, Bateman, Harris, Alvarado, Pollet and Caldier).

House Committee on Health Care & Wellness
House Committee on Appropriations
Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means

Background:

Prior authorization is the requirement that a health care provider seek approval of a drug, procedure, or test before receiving 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 health care determinations be made and notices of decisions sent within five calendar days for standard authorizations

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and within two calendar days for expedited authorizations.

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

Summary:

Prior Authorization Standards.
Beginning January 1, 2024, prior authorization standards are established for: health plans offered by health carriers; health plans offered to public or school employees, retirees, and their dependents; and medical assistance coverage offered through managed care organizations. The standards apply to prior authorization requests for health care services and prescription drugs, but do not apply to requests related to withdrawal management services, inpatient or resident substance use disorder services, or medication management requirements related to children with emotional or behavioral conditions who are enrolled in Medicaid. Medicare Part C and D programs are exempt from the prior authorization standards with respect to health plans offered to public or school employees, retirees, and their dependents.

Timing of Review.
Beginning January 1, 2024, time frames are established for health carriers, health plans, and managed care organizations to make prior authorization determinations and notify a participating health care provider or health care facility. The time frames are established for both standard prior authorization requests and expedited prior authorization requests and differ depending on whether the request was made through an 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 or prescription drug 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 or prescription drug. The term also applies to the approval of a prescription drug where the enrollee is undergoing a current course of treatment using a nonformulary drug. For an expedited prior authorization request that is submitted through:

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

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, health plan, or managed care organization must request it within one calendar day of submission of the request.

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 or prescription drug 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, health plan, or managed care organization must make a decision and notify the health care provider or health care facility within three calendar days, excluding holidays, of submission of a prior authorization request. If additional information is needed to make a determination, the health carrier, health plan, or managed care organization must request it within one calendar day of submission of the request; or
- a nonelectronic process, a health carrier, health plan, or managed care organization 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, health plan, or managed care organization must request it within five calendar days of submission of the request.

Health carriers, health plans, and managed care organizations 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, health plans, and managed care organizations must describe their prior authorization requirements in detailed, easily understandable language. Health carriers, health plans, and managed care organizations 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.

Electronic Standards for Prior Authorization Requests.
Health carriers, health plans, and managed care organizations must build and maintain a prior authorization application programming interface that automates the process for determining the necessity for a prior authorization, identifying information and documentation requirements, and facilitating the exchange of prior authorization requests and determinations. The application programming interface must use Health Level 7 Fast

Healthcare Interoperability Resources, automate the prior authorization determination process, allow providers to query prior authorization documentation requirements, support automated compiling and exchange of necessary data elements to populate the prior authorization requirements, and indicate that prior authorization denials or authorizations of less intensive services are adverse benefit determinations subject to grievance and appeal processes. As an alternative to using an application programming interface, health carriers, health plans, and managed care organizations may establish an interoperable electronic process for prior authorizations related to prescription drugs.

The application programming interface must support prior authorization requests and determinations for health care services beginning January 1, 2025, and for prescription drugs beginning January 1, 2027. If federal regulations on the application programming interface standards are not finalized by September 13, 2023, the commencement date for standards related to health care services will be delayed until January 1, 2026. The Office of the Insurance Commissioner must update the health policy committees of the Legislature on the status of the development of the federal regulations every six months between September 13, 2023, and September 13, 2026. If a health carrier, health plan, or managed care organization will not be able to meet the commencement dates, it may submit a request to the Office of the Insurance Commissioner or the Health Care Authority, as applicable, for a one-year delay. The request for a delay must describe the reasons for not meeting the requirements, the impact on providers and enrollees, how information will be provided to providers, and a timeline and implementation plan for compliance.

Prior Authorization Reporting.
Health carrier reporting requirements related to prior authorization information are expanded to apply to prior authorizations for prescription drugs. Specifically, health carriers must report to the Office of the Insurance Commissioner the 10 prescription drugs for the previous year with:

- the highest total number of prior authorization requests, including the total number of prior authorization requests for each prescription drug and the percent of approved requests for each;
- the highest percentage of approved prior authorization requests, including the total number of prior authorization requests for each prescription drug and the percent of approved requests for each; and
- 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 prescription drug and the percent of requests that were initially denied and then subsequently approved for each.

Votes on Final Passage:

House	96	0	
Senate	49	0	(Senate amended)
House	97	0	(House concurred)

Effective: July 23, 2023
January 1, 2024 (Section 4)