SENATE BILL REPORT
E2SHB 1357

As of March 16, 2023

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

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).

Brief History: Passed House: 3/4/23, 96-0.
Committee Activity: Health & Long Term Care: 3/16/23.

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, electronic authorization standards, and communication requirements.
- Expands the reporting requirements of health carriers related to prior authorization information to include prescription drug data.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Staff: Greg Attanasio (786-7410)

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 (OIC) maintains rules regarding prior

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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. 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 OIC information about prior authorization requests received, approved requests, requests denied and then approved, and the average determination response time.

Summary of Bill: 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 standard and expedited prior authorization requests for health care services and prescription drugs, but do not apply to requests related to withdrawal management services or inpatient or resident substance use disorder services.

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. The term also applies to approval for 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 through an electronic prior authorization process; 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 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 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 through an electronic prior authorization process; 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 through a nonelectronic prior authorization process.

A health carrier, health plan, or managed care organization 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, or managed care organizations must describe their prior authorization requirements in detailed, easily understandable language. Health carriers, health plans, or 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. 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 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.

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 health care services will be delayed until January 1, 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 OIC 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 OIC the ten 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.

Appropriation: The bill contains a null and void clause requiring specific funding be provided in an omnibus appropriation act.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill contains several effective dates. Please refer to the bill.

Staff Summary of Public Testimony: PRO: This present bill standardizes and modernizes the prior authorization process. All plans would have the same rules and expedite the process by using better technology. Easier access to information will speed up the process for providers and allow patients to understand the process. The existing process costs the

system a significant amount of money in workforce needs and delays.

OTHER: Some additional language is needed to allow flexibility for implementation of an application programming interface if the CMS rulemaking timeline changes and to including prescription drugs in the process. It is important that systems meet both the Washington requirements and coming federal requirements.

Persons Testifying: PRO: Representative Tarra Simmons, Prime Sponsor; Dr. Teresa Girolami; Garrett Jeffery, DO; Robin Sparks, American Cancer Society Cancer Action Network; Sean Graham, Washington State Medical Association.

OTHER: Jennifer Ziegler, Association of Washington Health Care Plans; Chris Bandoli, America's Health Insurance Plans; Carrie Tellefson, Regence Blue Shield; Caitlin Safford.

Persons Signed In To Testify But Not Testifying: No one.