CERTIFICATION OF ENROLLMENT

**ENGROSSED SUBSTITUTE SENATE BILL 6404**

66th Legislature

2020 Regular Session

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| Passed by the Senate March 10, 2020Yeas 46 Nays 0**President of the Senate**Passed by the House March 10, 2020Yeas 97 Nays 0**Speaker of the House of Representatives** | CERTIFICATEI, Brad Hendrickson, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE SENATE BILL 6404** as passed by the Senate and the House of Representatives on the dates hereon set forth.Secretary |
| Approved  |  |
| **Governor of the State of Washington** | **Secretary of State** **State of Washington** |

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**ENGROSSED SUBSTITUTE SENATE BILL 6404**

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AS AMENDED BY THE HOUSE

Passed Legislature - 2020 Regular Session

**State of Washington 66th Legislature 2020 Regular Session**

**By** Senate Health & Long Term Care (originally sponsored by Senators Frockt, O'Ban, Dhingra, Becker, Kuderer, Rivers, Lovelett, Wellman, Pedersen, Nguyen, Darneille, Hasegawa, McCoy, Wilson, C., Das, Conway, and Saldaña)

AN ACT Relating to reducing barriers to patient care through appropriate use of prior authorization and adoption of appropriate use criteria; and adding a new section to chapter 48.43 RCW.

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

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

(1) Except as provided in subsection (2) 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 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 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 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;

(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 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 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;

(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;

(e) Lists of the ten durable medical equipment 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;

(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;

(f) Lists of the ten diabetes supplies and equipment 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;

(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;

(g) The average determination response time in hours for prior authorization requests to the carrier with respect to each code reported under (a) through (f) of this subsection for each of the following categories of prior authorization:

(i) Expedited decisions;

(ii) Standard decisions; and

(iii) Extenuating circumstances decisions.

(2) For the October 1, 2020, reporting deadline, a carrier is not required to report data pursuant to subsection (1)(a)(iii), (b)(iii), (c)(iii), (d)(iii), (e)(iii), or (f)(iii) of this section until April 1, 2021, if the commissioner determines that doing so constitutes a hardship.

(3) By January 1, 2021, and annually thereafter, the commissioner shall aggregate and deidentify the data collected under subsection (1) of this section into a standard report and may not identify the name of the carrier that submitted the data. The initial report due on January 1, 2021, may omit data for which a hardship determination is made by the commissioner under subsection (2) of this section. Such data must be included in the report due on January 1, 2022. The commissioner must make the report available to interested parties.

(4) The commissioner may request additional information from carriers reporting data under this section.

(5) The commissioner may adopt rules to implement this section. In adopting rules, the commissioner must consult stakeholders including carriers, health care practitioners, health care facilities, and patients.

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

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