

**E2SHB 1357** - S COMM AMD

By Committee on Health & Long Term Care

**NOT CONSIDERED 04/11/2023**

1 Strike everything after the enacting clause and insert the  
2 following:

3 "NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43  
4 RCW to read as follows:

5 (1) Each carrier offering a health plan issued or renewed on or  
6 after January 1, 2024, shall comply with the following standards  
7 related to prior authorization for health care services and  
8 prescription drugs:

9 (a) The carrier shall meet the following time frames for prior  
10 authorization determinations and notifications to a participating  
11 provider or facility that submits the prior authorization request  
12 through an electronic prior authorization process, as designated by  
13 each carrier:

14 (i) For electronic standard prior authorization requests, the  
15 carrier shall make a decision and notify the provider or facility of  
16 the results of the decision within three calendar days, excluding  
17 holidays, of submission of an electronic prior authorization request  
18 by the provider or facility that contains the necessary information  
19 to make a determination. If insufficient information has been  
20 provided to the carrier to make a decision, the carrier shall request  
21 any additional information from the provider or facility within one  
22 calendar day of submission of the electronic prior authorization  
23 request.

24 (ii) For electronic expedited prior authorization requests, the  
25 carrier shall make a decision and notify the provider or facility of  
26 the results of the decision within one calendar day of submission of  
27 an electronic prior authorization request by the provider or facility  
28 that contains the necessary information to make a determination. If  
29 insufficient information has been provided to the carrier to make a  
30 decision, the carrier shall request any additional information from

1 the provider or facility within one calendar day of submission of the  
2 electronic prior authorization request.

3 (b) The carrier shall meet the following time frames for prior  
4 authorization determinations and notifications to a participating  
5 provider or facility that submits the prior authorization request  
6 through a process other than an electronic prior authorization  
7 process:

8 (i) For nonelectronic standard prior authorization requests, the  
9 carrier shall make a decision and notify the provider or facility of  
10 the results of the decision within five calendar days of submission  
11 of a nonelectronic prior authorization request by the provider or  
12 facility that contains the necessary information to make a  
13 determination. If insufficient information has been provided to the  
14 carrier to make a decision, the carrier shall request any additional  
15 information from the provider or facility within five calendar days  
16 of submission of the nonelectronic prior authorization request.

17 (ii) For nonelectronic expedited prior authorization requests,  
18 the carrier shall make a decision and notify the provider or facility  
19 of the results of the decision within two calendar days of submission  
20 of a nonelectronic prior authorization request by the provider or  
21 facility that contains the necessary information to make a  
22 determination. If insufficient information has been provided to the  
23 carrier to make a decision, the carrier shall request any additional  
24 information from the provider or facility within one calendar day of  
25 submission of the nonelectronic prior authorization request.

26 (c) In any instance in which a carrier has determined that a  
27 provider or facility has not provided sufficient information for  
28 making a determination under (a) and (b) of this subsection, a  
29 carrier may establish a specific reasonable time frame for submission  
30 of the additional information. This time frame must be communicated  
31 to the provider and enrollee with a carrier's request for additional  
32 information.

33 (d) The carrier's prior authorization requirements must be  
34 described in detail and written in easily understandable language.  
35 The carrier shall make its most current prior authorization  
36 requirements and restrictions, including the written clinical review  
37 criteria, available to providers and facilities in an electronic  
38 format upon request. The prior authorization requirements must be  
39 based on peer-reviewed clinical review criteria. The clinical review  
40 criteria must be evidence-based criteria and must accommodate new and

1 emerging information related to the appropriateness of clinical  
2 criteria with respect to black and indigenous people, other people of  
3 color, gender, and underserved populations. The clinical review  
4 criteria must be evaluated and updated, if necessary, at least  
5 annually.

6 (2) (a) Each carrier shall build and maintain a prior  
7 authorization application programming interface that automates the  
8 process for in-network providers to determine whether a prior  
9 authorization is required for health care services, identify prior  
10 authorization information and documentation requirements, and  
11 facilitate the exchange of prior authorization requests and  
12 determinations from its electronic health records or practice  
13 management system. The application programming interface must support  
14 the exchange of prior authorization requests and determinations for  
15 health care services beginning January 1, 2025, and must:

16 (i) Use health level 7 fast health care interoperability  
17 resources in accordance with standards and provisions defined in 45  
18 C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);

19 (ii) Automate the process to determine whether a prior  
20 authorization is required for durable medical equipment or a health  
21 care service;

22 (iii) Allow providers to query the carrier's prior authorization  
23 documentation requirements;

24 (iv) Support an automated approach using nonproprietary open  
25 workflows to compile and exchange the necessary data elements to  
26 populate the prior authorization requirements that are compliant with  
27 the federal health insurance portability and accountability act of  
28 1996 or have an exception from the federal centers for medicare and  
29 medicaid services; and

30 (v) Indicate that a prior authorization denial or authorization  
31 of a service less intensive than that included in the original  
32 request is an adverse benefit determination and is subject to the  
33 carrier's grievance and appeal process under RCW 48.43.535.

34 (b) Each carrier shall establish and maintain an interoperable  
35 electronic process or application programming interface that  
36 automates the process for in-network providers to determine whether a  
37 prior authorization is required for a covered prescription drug. The  
38 application programming interface must support the exchange of prior  
39 authorization requests and determinations for prescription drugs,

1 including information on covered alternative prescription drugs,  
2 beginning January 1, 2027, and must:

3 (i) Allow providers to identify prior authorization information  
4 and documentation requirements; and

5 (ii) Facilitate the exchange of prior authorization requests and  
6 determinations from its electronic health records or practice  
7 management system, and may include the necessary data elements to  
8 populate the prior authorization requirements that are compliant with  
9 the federal health insurance portability and accountability act of  
10 1996 or have an exception from the federal centers for medicare and  
11 medicaid services.

12 (c) If federal rules related to standards for using an  
13 application programming interface to communicate prior authorization  
14 status to providers are not finalized by the federal centers for  
15 medicare and medicaid services by September 13, 2023, the  
16 requirements of (a) of this subsection may not be enforced until  
17 January 1, 2026.

18 (d)(i) If a carrier determines that it will not be able to  
19 satisfy the requirements of (a) of this subsection by January 1,  
20 2025, the carrier shall submit a narrative justification to the  
21 commissioner on or before September 1, 2024, describing:

22 (A) The reasons that the carrier cannot reasonably satisfy the  
23 requirements;

24 (B) The impact of noncompliance upon providers and enrollees;

25 (C) The current or proposed means of providing health information  
26 to the providers; and

27 (D) A timeline and implementation plan to achieve compliance with  
28 the requirements.

29 (ii) The commissioner may grant a one-year delay in enforcement  
30 of the requirements of (a) of this subsection (2) if the commissioner  
31 determines that the carrier has made a good faith effort to comply  
32 with the requirements.

33 (iii) This subsection (2)(d) shall not apply if the delay in  
34 enforcement in (c) of this subsection takes effect because the  
35 federal centers for medicare and medicaid services did not finalize  
36 the applicable regulations by September 13, 2023.

37 (e) By September 13, 2023, and at least every six months  
38 thereafter until September 13, 2026, the commissioner shall provide  
39 an update to the health care policy committees of the legislature on  
40 the development of rules and implementation guidance from the federal

1 centers for medicare and medicaid services regarding the standards  
2 for development of application programming interfaces and  
3 interoperable electronic processes related to prior authorization  
4 functions. The updates should include recommendations, as  
5 appropriate, on whether the status of the federal rule development  
6 aligns with the provisions of this act. The commissioner also shall  
7 report on any actions by the federal centers for medicare and  
8 medicaid services to exercise enforcement discretion related to the  
9 implementation and maintenance of an application programming  
10 interface for prior authorization functions. The commissioner shall  
11 consult with the health care authority, carriers, providers, and  
12 consumers on the development of these updates and any  
13 recommendations.

14 (3) Nothing in this section applies to prior authorization  
15 determinations made pursuant to RCW 48.43.761.

16 (4) For the purposes of this section:

17 (a) "Expedited prior authorization request" means a request by a  
18 provider or facility for approval of a health care service or  
19 prescription drug where:

20 (i) The passage of time:

21 (A) Could seriously jeopardize the life or health of the  
22 enrollee;

23 (B) Could seriously jeopardize the enrollee's ability to regain  
24 maximum function; or

25 (C) In the opinion of a provider or facility with knowledge of  
26 the enrollee's medical condition, would subject the enrollee to  
27 severe pain that cannot be adequately managed without the health care  
28 service or prescription drug that is the subject of the request; or

29 (ii) The enrollee is undergoing a current course of treatment  
30 using a nonformulary drug.

31 (b) "Standard prior authorization request" means a request by a  
32 provider or facility for approval of a health care service or  
33 prescription drug where the request is made in advance of the  
34 enrollee obtaining a health care service or prescription drug that is  
35 not required to be expedited.

36 NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05  
37 RCW to read as follows:

38 (1) A health plan offered to public employees, retirees, and  
39 their covered dependents under this chapter issued or renewed on or

1 after January 1, 2024, shall comply with the following standards  
2 related to prior authorization for health care services and  
3 prescription drugs:

4 (a) The health plan shall meet the following time frames for  
5 prior authorization determinations and notifications to a  
6 participating provider or facility that submits the prior  
7 authorization request through an electronic prior authorization  
8 process:

9 (i) For electronic standard prior authorization requests, the  
10 health plan shall make a decision and notify the provider or facility  
11 of the results of the decision within three calendar days, excluding  
12 holidays, of submission of an electronic prior authorization request  
13 by the provider or facility that contains the necessary information  
14 to make a determination. If insufficient information has been  
15 provided to the health plan to make a decision, the health plan shall  
16 request any additional information from the provider or facility  
17 within one calendar day of submission of the electronic prior  
18 authorization request.

19 (ii) For electronic expedited prior authorization requests, the  
20 health plan shall make a decision and notify the provider or facility  
21 of the results of the decision within one calendar day of submission  
22 of an electronic prior authorization request by the provider or  
23 facility that contains the necessary information to make a  
24 determination. If insufficient information has been provided to the  
25 health plan to make a decision, the health plan shall request any  
26 additional information from the provider or facility within one  
27 calendar day of submission of the electronic prior authorization  
28 request.

29 (b) The health plan shall meet the following time frames for  
30 prior authorization determinations and notifications to a  
31 participating provider or facility that submits the prior  
32 authorization request through a process other than an electronic  
33 prior authorization process described in subsection (2) of this  
34 section:

35 (i) For nonelectronic standard prior authorization requests, the  
36 health plan shall make a decision and notify the provider or facility  
37 of the results of the decision within five calendar days of  
38 submission of a nonelectronic prior authorization request by the  
39 provider or facility that contains the necessary information to make  
40 a determination. If insufficient information has been provided to the

1 health plan to make a decision, the health plan shall request any  
2 additional information from the provider or facility within five  
3 calendar days of submission of the nonelectronic prior authorization  
4 request.

5 (ii) For nonelectronic expedited prior authorization requests,  
6 the health plan shall make a decision and notify the provider or  
7 facility of the results of the decision within two calendar days of  
8 submission of a nonelectronic prior authorization request by the  
9 provider or facility that contains the necessary information to make  
10 a determination. If insufficient information has been provided to the  
11 health plan to make a decision, the health plan shall request any  
12 additional information from the provider or facility within one  
13 calendar day of submission of the nonelectronic prior authorization  
14 request.

15 (c) In any instance in which the health plan has determined that  
16 a provider or facility has not provided sufficient information for  
17 making a determination under (a) and (b) of this subsection, the  
18 health plan may establish a specific reasonable time frame for  
19 submission of the additional information. This time frame must be  
20 communicated to the provider and enrollee with the health plan's  
21 request for additional information.

22 (d) The prior authorization requirements of the health plan must  
23 be described in detail and written in easily understandable language.  
24 The health plan shall make its most current prior authorization  
25 requirements and restrictions, including the written clinical review  
26 criteria, available to providers and facilities in an electronic  
27 format upon request. The prior authorization requirements must be  
28 based on peer-reviewed clinical review criteria. The clinical review  
29 criteria must be evidence-based criteria and must accommodate new and  
30 emerging information related to the appropriateness of clinical  
31 criteria with respect to black and indigenous people, other people of  
32 color, gender, and underserved populations. The clinical review  
33 criteria must be evaluated and updated, if necessary, at least  
34 annually.

35 (2)(a) Each health plan offered to public employees, retirees,  
36 and their covered dependents under this chapter shall build and  
37 maintain a prior authorization application programming interface that  
38 automates the process for in-network providers to determine whether a  
39 prior authorization is required for health care services, identify  
40 prior authorization information and documentation requirements, and

1 facilitate the exchange of prior authorization requests and  
2 determinations from its electronic health records or practice  
3 management system. The application programming interface must support  
4 the exchange of prior authorization requests and determinations for  
5 health care services beginning January 1, 2025, and must:

6 (i) Use health level 7 fast health care interoperability  
7 resources in accordance with standards and provisions defined in 45  
8 C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);

9 (ii) Automate the process to determine whether a prior  
10 authorization is required for durable medical equipment or a health  
11 care service;

12 (iii) Allow providers to query the health plan's prior  
13 authorization documentation requirements;

14 (iv) Support an automated approach using nonproprietary open  
15 workflows to compile and exchange the necessary data elements to  
16 populate the prior authorization requirements that are compliant with  
17 the federal health insurance portability and accountability act of  
18 1996 or have an exception from the federal centers for medicare and  
19 medicaid services; and

20 (v) Indicate that a prior authorization denial or authorization  
21 of a service less intensive than that included in the original  
22 request is an adverse benefit determination and is subject to the  
23 health plan's grievance and appeal process under RCW 48.43.535.

24 (b) Each health plan offered to public employees, retirees, and  
25 their covered dependents under this chapter shall establish and  
26 maintain an interoperable electronic process or application  
27 programming interface that automates the process for in-network  
28 providers to determine whether a prior authorization is required for  
29 a covered prescription drug. The application programming interface  
30 must support the exchange of prior authorization requests and  
31 determinations for prescription drugs, including information on  
32 covered alternative prescription drugs, beginning January 1, 2027,  
33 and must:

34 (i) Allow providers to identify prior authorization information  
35 and documentation requirements; and

36 (ii) Facilitate the exchange of prior authorization requests and  
37 determinations from its electronic health records or practice  
38 management system, and may include the necessary data elements to  
39 populate the prior authorization requirements that are compliant with  
40 the federal health insurance portability and accountability act of



1 1996 or have an exception from the federal centers for medicare and  
2 medicaid services.

3 (c) If federal rules related to standards for using an  
4 application programming interface to communicate prior authorization  
5 status to providers are not finalized by the federal centers for  
6 medicare and medicaid services by September 13, 2023, the  
7 requirements of (a) of this subsection may not be enforced until  
8 January 1, 2026.

9 (d)(i) If the health plan determines that it will not be able to  
10 satisfy the requirements of (a) of this subsection by January 1,  
11 2025, the health plan shall submit a narrative justification to the  
12 authority on or before September 1, 2024, describing:

13 (A) The reasons that the health plan cannot reasonably satisfy  
14 the requirements;

15 (B) The impact of noncompliance upon providers and enrollees;

16 (C) The current or proposed means of providing health information  
17 to the providers; and

18 (D) A timeline and implementation plan to achieve compliance with  
19 the requirements.

20 (ii) The authority may grant a one-year delay in enforcement of  
21 the requirements of (a) of this subsection (2) if the authority  
22 determines that the health plan has made a good faith effort to  
23 comply with the requirements.

24 (iii) This subsection (2)(d) shall not apply if the delay in  
25 enforcement in (c) of this subsection takes effect because the  
26 federal centers for medicare and medicaid services did not finalize  
27 the applicable regulations by September 13, 2023.

28 (3) Nothing in this section applies to prior authorization  
29 determinations made pursuant to RCW 41.05.526.

30 (4) For the purposes of this section:

31 (a) "Expedited prior authorization request" means a request by a  
32 provider or facility for approval of a health care service or  
33 prescription drug where:

34 (i) The passage of time:

35 (A) Could seriously jeopardize the life or health of the  
36 enrollee;

37 (B) Could seriously jeopardize the enrollee's ability to regain  
38 maximum function; or

39 (C) In the opinion of a provider or facility with knowledge of  
40 the enrollee's medical condition, would subject the enrollee to

1 severe pain that cannot be adequately managed without the health care  
2 service or prescription drug that is the subject of the request; or

3 (ii) The enrollee is undergoing a current course of treatment  
4 using a nonformulary drug.

5 (b) "Standard prior authorization request" means a request by a  
6 provider or facility for approval of a health care service or  
7 prescription drug where the request is made in advance of the  
8 enrollee obtaining a health care service that is not required to be  
9 expedited.

10 (5) This section shall not apply to coverage provided under the  
11 medicare part C or part D programs set forth in Title XVIII of the  
12 social security act of 1965, as amended.

13 NEW SECTION. **Sec. 3.** A new section is added to chapter 74.09  
14 RCW to read as follows:

15 (1) Beginning January 1, 2024, the authority shall require each  
16 managed care organization to comply with the following standards  
17 related to prior authorization for health care services and  
18 prescription drugs:

19 (a) The managed care organization shall meet the following time  
20 frames for prior authorization determinations and notifications to a  
21 participating provider or facility that submits the prior  
22 authorization request through an electronic prior authorization  
23 process, as designated by each managed care organization:

24 (i) For electronic standard prior authorization requests, the  
25 managed care organization shall make a decision and notify the  
26 provider or facility of the results of the decision within three  
27 calendar days, excluding holidays, of submission of an electronic  
28 prior authorization request by the provider or facility that contains  
29 the necessary information to make a determination. If insufficient  
30 information has been provided to the managed care organization to  
31 make a decision, the managed care organization shall request any  
32 additional information from the provider or facility within one  
33 calendar day of submission of the electronic prior authorization  
34 request.

35 (ii) For electronic expedited prior authorization requests, the  
36 managed care organization shall make a decision and notify the  
37 provider or facility of the results of the decision within one  
38 calendar day of submission of an electronic prior authorization  
39 request by the provider or facility that contains the necessary

1 information to make a determination. If insufficient information has  
2 been provided to the managed care organization to make a decision,  
3 the managed care organization shall request any additional  
4 information from the provider or facility within one calendar day of  
5 submission of the electronic prior authorization request.

6 (b) The managed care organization shall meet the following time  
7 frames for prior authorization determinations and notifications to a  
8 participating provider or facility that submits the prior  
9 authorization request through a process other than an electronic  
10 prior authorization process described in subsection (2) of this  
11 section:

12 (i) For nonelectronic standard prior authorization requests, the  
13 managed care organization shall make a decision and notify the  
14 provider or facility of the results of the decision within five  
15 calendar days of submission of a nonelectronic prior authorization  
16 request by the provider or facility that contains the necessary  
17 information to make a determination. If insufficient information has  
18 been provided to the managed care organization to make a decision,  
19 the managed care organization shall request any additional  
20 information from the provider or facility within five calendar days  
21 of submission of the nonelectronic prior authorization request.

22 (ii) For nonelectronic expedited prior authorization requests,  
23 the managed care organization shall make a decision and notify the  
24 provider or facility of the results of the decision within two  
25 calendar days of submission of a nonelectronic prior authorization  
26 request by the provider or facility that contains the necessary  
27 information to make a determination. If insufficient information has  
28 been provided to the managed care organization to make a decision,  
29 the managed care organization shall request any additional  
30 information from the provider or facility within one calendar day of  
31 submission of the nonelectronic prior authorization request.

32 (c) In any instance in which a managed care organization has  
33 determined that a provider or facility has not provided sufficient  
34 information for making a determination under (a) and (b) of this  
35 subsection, a managed care organization may establish a specific  
36 reasonable time frame for submission of the additional information.  
37 This time frame must be communicated to the provider and enrollee  
38 with a managed care organization's request for additional  
39 information.

1 (d) The prior authorization requirements of the managed care  
2 organization must be described in detail and written in easily  
3 understandable language. The managed care organization shall make its  
4 most current prior authorization requirements and restrictions,  
5 including the written clinical review criteria, available to  
6 providers and facilities in an electronic format upon request. The  
7 prior authorization requirements must be based on peer-reviewed  
8 clinical review criteria. The clinical review criteria must be  
9 evidence-based criteria and must accommodate new and emerging  
10 information related to the appropriateness of clinical criteria with  
11 respect to black and indigenous people, other people of color,  
12 gender, and underserved populations. The clinical review criteria  
13 must be evaluated and updated, if necessary, at least annually.

14 (2)(a) Each managed care organization shall build and maintain a  
15 prior authorization application programming interface that automates  
16 the process for in-network providers to determine whether a prior  
17 authorization is required for health care services, identify prior  
18 authorization information and documentation requirements, and  
19 facilitate the exchange of prior authorization requests and  
20 determinations from its electronic health records or practice  
21 management system. The application programming interface must support  
22 the exchange of prior authorization requests and determinations for  
23 health care services beginning January 1, 2025, and must:

24 (i) Use health level 7 fast health care interoperability  
25 resources in accordance with standards and provisions defined in 45  
26 C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);

27 (ii) Automate the process to determine whether a prior  
28 authorization is required for durable medical equipment or a health  
29 care service;

30 (iii) Allow providers to query the managed care organization's  
31 prior authorization documentation requirements;

32 (iv) Support an automated approach using nonproprietary open  
33 workflows to compile and exchange the necessary data elements to  
34 populate the prior authorization requirements that are compliant with  
35 the federal health insurance portability and accountability act of  
36 1996 or have an exception from the federal centers for medicare and  
37 medicaid services; and

38 (v) Indicate that a prior authorization denial or authorization  
39 of a service less intensive than that included in the original  
40 request is an adverse benefit determination and is subject to the

1 managed care organization's grievance and appeal process under RCW  
2 48.43.535.

3 (b) Each managed care organization shall establish and maintain  
4 an interoperable electronic process or application programming  
5 interface that automates the process for in-network providers to  
6 determine whether a prior authorization is required for a covered  
7 prescription drug. The application programming interface must support  
8 the exchange of prior authorization requests and determinations for  
9 prescription drugs, including information on covered alternative  
10 prescription drugs, beginning January 1, 2027, and must:

11 (i) Allow providers to identify prior authorization information  
12 and documentation requirements; and

13 (ii) Facilitate the exchange of prior authorization requests and  
14 determinations from its electronic health records or practice  
15 management system, and may include the necessary data elements to  
16 populate the prior authorization requirements that are compliant with  
17 the federal health insurance portability and accountability act of  
18 1996 or have an exception from the federal centers for medicare and  
19 medicaid services.

20 (c) If federal rules related to standards for using an  
21 application programming interface to communicate prior authorization  
22 status to providers are not finalized by September 13, 2023, the  
23 requirements of (a) of this subsection may not be enforced until  
24 January 1, 2026.

25 (d) (i) If a managed care organization determines that it will not  
26 be able to satisfy the requirements of (a) of this subsection by  
27 January 1, 2025, the managed care organization shall submit a  
28 narrative justification to the authority on or before September 1,  
29 2024, describing:

30 (A) The reasons that the managed care organization cannot  
31 reasonably satisfy the requirements;

32 (B) The impact of noncompliance upon providers and enrollees;

33 (C) The current or proposed means of providing health information  
34 to the providers; and

35 (D) A timeline and implementation plan to achieve compliance with  
36 the requirements.

37 (ii) The authority may grant a one-year delay in enforcement of  
38 the requirements of (a) of this subsection (2) if the authority  
39 determines that the managed care organization has made a good faith  
40 effort to comply with the requirements.

1 (iii) This subsection (2)(d) shall not apply if the delay in  
2 enforcement in (c) of this subsection takes effect because the  
3 federal centers for medicare and medicaid services did not finalize  
4 the applicable regulations by September 13, 2023.

5 (3) Nothing in this section applies to prior authorization  
6 determinations made pursuant to RCW 71.24.618 or 74.09.490.

7 (4) For the purposes of this section:

8 (a) "Expedited prior authorization request" means a request by a  
9 provider or facility for approval of a health care service or  
10 prescription drug where:

11 (i) The passage of time:

12 (A) Could seriously jeopardize the life or health of the  
13 enrollee;

14 (B) Could seriously jeopardize the enrollee's ability to regain  
15 maximum function; or

16 (C) In the opinion of a provider or facility with knowledge of  
17 the enrollee's medical condition, would subject the enrollee to  
18 severe pain that cannot be adequately managed without the health care  
19 service or prescription drug that is the subject of the request; or

20 (ii) The enrollee is undergoing a current course of treatment  
21 using a nonformulary drug.

22 (b) "Standard prior authorization request" means a request by a  
23 provider or facility for approval of a health care service or  
24 prescription drug where the request is made in advance of the  
25 enrollee obtaining a health care service or prescription drug that is  
26 not required to be expedited.

27 **Sec. 4.** RCW 48.43.0161 and 2020 c 316 s 1 are each amended to  
28 read as follows:

29 (1) (~~Except as provided in subsection (2) of this section, by~~)  
30 By October 1, 2020, and annually thereafter, for individual and group  
31 health plans issued by a carrier that has written at least one  
32 percent of the total accident and health insurance premiums written  
33 by all companies authorized to offer accident and health insurance in  
34 Washington in the most recently available year, the carrier shall  
35 report to the commissioner the following aggregated and deidentified  
36 data related to the carrier's prior authorization practices and  
37 experience for the prior plan year:

38 (a) Lists of the (~~ten~~) 10 inpatient medical or surgical codes:

1 (i) With the highest total number of prior authorization requests  
2 during the previous plan year, including the total number of prior  
3 authorization requests for each code and the percent of approved  
4 requests for each code;

5 (ii) With the highest percentage of approved prior authorization  
6 requests during the previous plan year, including the total number of  
7 prior authorization requests for each code and the percent of  
8 approved requests for each code; and

9 (iii) With the highest percentage of prior authorization requests  
10 that were initially denied and then subsequently approved on appeal,  
11 including the total number of prior authorization requests for each  
12 code and the percent of requests that were initially denied and then  
13 subsequently approved for each code;

14 (b) Lists of the (~~ten~~) 10 outpatient medical or surgical codes:

15 (i) With the highest total number of prior authorization requests  
16 during the previous plan year, including the total number of prior  
17 authorization requests for each code and the percent of approved  
18 requests for each code;

19 (ii) With the highest percentage of approved prior authorization  
20 requests during the previous plan year, including the total number of  
21 prior authorization requests for each code and the percent of  
22 approved requests for each code; and

23 (iii) With the highest percentage of prior authorization requests  
24 that were initially denied and then subsequently approved on appeal,  
25 including the total number of prior authorization requests for each  
26 code and the percent of requests that were initially denied and then  
27 subsequently approved for each code;

28 (c) Lists of the (~~ten~~) 10 inpatient mental health and substance  
29 use disorder service codes:

30 (i) With the highest total number of prior authorization requests  
31 during the previous plan year, including the total number of prior  
32 authorization requests for each code and the percent of approved  
33 requests for each code;

34 (ii) With the highest percentage of approved prior authorization  
35 requests during the previous plan year, including the total number of  
36 prior authorization requests for each code and the percent of  
37 approved requests for each code; (~~and~~) and

38 (iii) With the highest percentage of prior authorization requests  
39 that were initially denied and then subsequently approved on appeal,  
40 including the total number of prior authorization requests for each

1 code and the percent of requests that were initially denied and then  
2 subsequently approved for each code;

3 (d) Lists of the (~~ten~~) 10 outpatient mental health and  
4 substance use disorder service codes:

5 (i) With the highest total number of prior authorization requests  
6 during the previous plan year, including the total number of prior  
7 authorization requests for each code and the percent of approved  
8 requests for each code;

9 (ii) With the highest percentage of approved prior authorization  
10 requests during the previous plan year, including the total number of  
11 prior authorization requests for each code and the percent of  
12 approved requests for each code; (~~and~~) and

13 (iii) With the highest percentage of prior authorization requests  
14 that were initially denied and then subsequently approved on appeal,  
15 including the total number of prior authorization requests for each  
16 code and the percent of requests that were initially denied and then  
17 subsequently approved;

18 (e) Lists of the (~~ten~~) 10 durable medical equipment codes:

19 (i) With the highest total number of prior authorization requests  
20 during the previous plan year, including the total number of prior  
21 authorization requests for each code and the percent of approved  
22 requests for each code;

23 (ii) With the highest percentage of approved prior authorization  
24 requests during the previous plan year, including the total number of  
25 prior authorization requests for each code and the percent of  
26 approved requests for each code; (~~and~~) and

27 (iii) With the highest percentage of prior authorization requests  
28 that were initially denied and then subsequently approved on appeal,  
29 including the total number of prior authorization requests for each  
30 code and the percent of requests that were initially denied and then  
31 subsequently approved for each code;

32 (f) Lists of the (~~ten~~) 10 diabetes supplies and equipment  
33 codes:

34 (i) With the highest total number of prior authorization requests  
35 during the previous plan year, including the total number of prior  
36 authorization requests for each code and the percent of approved  
37 requests for each code;

38 (ii) With the highest percentage of approved prior authorization  
39 requests during the previous plan year, including the total number of



1 prior authorization requests for each code and the percent of  
2 approved requests for each code; ~~((and))~~ and

3 (iii) With the highest percentage of prior authorization requests  
4 that were initially denied and then subsequently approved on appeal,  
5 including the total number of prior authorization requests for each  
6 code and the percent of requests that were initially denied and then  
7 subsequently approved for each code;

8 (g) Lists of the 10 prescription drugs:

9 (i) With the highest total number of prior authorization requests  
10 during the previous plan year, including the total number of prior  
11 authorization requests for each prescription drug and the percent of  
12 approved requests for each prescription drug;

13 (ii) With the highest percentage of approved prior authorization  
14 requests during the previous plan year, including the total number of  
15 prior authorization requests for each prescription drug and the  
16 percent of approved requests for each prescription drug; and

17 (iii) With the highest percentage of prior authorization requests  
18 that were initially denied and then subsequently approved on appeal,  
19 including the total number of prior authorization requests for each  
20 prescription drug and the percent of requests that were initially  
21 denied and then subsequently approved for each prescription drug; and

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

26 (i) Expedited decisions;

27 (ii) Standard decisions; and

28 (iii) Extenuating circumstances decisions.

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

34 ~~(3))~~ By January 1, 2021, and annually thereafter, the  
35 commissioner shall aggregate and deidentify the data collected under  
36 subsection (1) of this section into a standard report and may not  
37 identify the name of the carrier that submitted the data. ~~((The~~  
38 ~~initial report due on January 1, 2021, may omit data for which a~~  
39 ~~hardship determination is made by the commissioner under subsection~~  
40 ~~(2) of this section. Such data must be included in the report due on~~

1 ~~January 1, 2022.~~) The commissioner must make the report available to  
2 interested parties.

3 ~~((4))~~ (3) The commissioner may request additional information  
4 from carriers reporting data under this section.

5 ~~((5))~~ (4) The commissioner may adopt rules to implement this  
6 section. In adopting rules, the commissioner must consult  
7 stakeholders including carriers, health care practitioners, health  
8 care facilities, and patients.

9 ~~((6))~~ (5) For the purpose of this section, "prior  
10 authorization" means a mandatory process that a carrier or its  
11 designated or contracted representative requires a provider or  
12 facility to follow before a service is delivered, to determine if a  
13 service is a benefit and meets the requirements for medical  
14 necessity, clinical appropriateness, level of care, or effectiveness  
15 in relation to the applicable plan, including any term used by a  
16 carrier or its designated or contracted representative to describe  
17 this process.

18 NEW SECTION. **Sec. 5.** Section 4 of this act takes effect January  
19 1, 2024.

20 NEW SECTION. **Sec. 6.** If specific funding for the purposes of  
21 this act, referencing this act by bill or chapter number, is not  
22 provided by June 30, 2023, in the omnibus appropriations act, this  
23 act is null and void."

**E2SHB 1357** - S COMM AMD

By Committee on Health & Long Term Care

**NOT CONSIDERED 04/11/2023**

24 On page 1, line 1 of the title, after "process;" strike the  
25 remainder of the title and insert "amending RCW 48.43.0161; adding a  
26 new section to chapter 48.43 RCW; adding a new section to chapter  
27 41.05 RCW; adding a new section to chapter 74.09 RCW; creating a new  
28 section; and providing an effective date."

EFFECT: Separately addresses requirements for the implementation  
of an application programming interface for prior authorization of  
health services and prescription drugs.

Requires carriers and plans to provide timeframes for submission of additional information on a prior authorization to the provider and enrollee.

Requires carriers and plans that cannot meet the API implementation deadline to provide justification to OIC or HCA by September 1, 2024.

Requires OIC to regularly update the legislature on the development and implementation of CMS prior authorization rules.

Exempts coverage provided under Medicare Parts C and D from the provisions of this act.

Exempts the prior authorization process for psychotropic drugs for children under Medicaid from the provisions of this act.

--- END ---