

E2SHB 1357 - S COMM AMD
By Committee on Ways & Means

ADOPTED 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
31 the provider or facility within one calendar day of submission of the
32 electronic prior authorization request.

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

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

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

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

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

1 color, gender, and underserved populations. The clinical review
2 criteria must be evaluated and updated, if necessary, at least
3 annually.

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

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

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

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

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

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

32 (b) Each carrier shall establish and maintain an interoperable
33 electronic process or application programming interface that
34 automates the process for in-network providers to determine whether a
35 prior authorization is required for a covered prescription drug. The
36 application programming interface must support the exchange of prior
37 authorization requests and determinations for prescription drugs,
38 including information on covered alternative prescription drugs,
39 beginning January 1, 2027, and must:

1 (i) Allow providers to identify prior authorization information
2 and documentation requirements;

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

10 (iii) Indicate that a prior authorization denial or authorization
11 of a drug other than the one included in the original prior
12 authorization request is an adverse benefit determination and is
13 subject to the carrier's grievance and appeal process under RCW
14 48.43.535.

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

21 (d)(i) If a carrier determines that it will not be able to
22 satisfy the requirements of (a) of this subsection by January 1,
23 2025, the carrier shall submit a narrative justification to the
24 commissioner on or before September 1, 2024, describing:

25 (A) The reasons that the carrier cannot reasonably satisfy the
26 requirements;

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

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

30 (D) A timeline and implementation plan to achieve compliance with
31 the requirements.

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

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

1 (e) By September 13, 2023, and at least every six months
2 thereafter until September 13, 2026, the commissioner shall provide
3 an update to the health care policy committees of the legislature on
4 the development of rules and implementation guidance from the federal
5 centers for medicare and medicaid services regarding the standards
6 for development of application programming interfaces and
7 interoperable electronic processes related to prior authorization
8 functions. The updates should include recommendations, as
9 appropriate, on whether the status of the federal rule development
10 aligns with the provisions of this act. The commissioner also shall
11 report on any actions by the federal centers for medicare and
12 medicaid services to exercise enforcement discretion related to the
13 implementation and maintenance of an application programming
14 interface for prior authorization functions. The commissioner shall
15 consult with the health care authority, carriers, providers, and
16 consumers on the development of these updates and any
17 recommendations.

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

20 (4) For the purposes of this section:

21 (a) "Expedited prior authorization request" means a request by a
22 provider or facility for approval of a health care service or
23 prescription drug where:

24 (i) The passage of time:

25 (A) Could seriously jeopardize the life or health of the
26 enrollee;

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

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

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

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

1 NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05

2 RCW to read as follows:

3 (1) A health plan offered to public employees, retirees, and
4 their covered dependents under this chapter issued or renewed on or
5 after January 1, 2024, shall comply with the following standards
6 related to prior authorization for health care services and
7 prescription drugs:

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

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

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

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

39 (i) For nonelectronic standard prior authorization requests, the
40 health plan shall make a decision and notify the provider or facility

1 of the results of the decision within five calendar days of
2 submission of a nonelectronic prior authorization request by the
3 provider or facility that contains the necessary information to make
4 a determination. If insufficient information has been provided to the
5 health plan to make a decision, the health plan shall request any
6 additional information from the provider or facility within five
7 calendar days of submission of the nonelectronic prior authorization
8 request.

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

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

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

39 (2) (a) Each health plan offered to public employees, retirees,
40 and their covered dependents under this chapter shall build and

1 maintain a prior authorization application programming interface that
2 automates the process for in-network providers to determine whether a
3 prior authorization is required for health care services, identify
4 prior authorization information and documentation requirements, and
5 facilitate the exchange of prior authorization requests and
6 determinations from its electronic health records or practice
7 management system. The application programming interface must support
8 the exchange of prior authorization requests and determinations for
9 health care services beginning January 1, 2025, and must:

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

13 (ii) Automate the process to determine whether a prior
14 authorization is required for durable medical equipment or a health
15 care service;

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

18 (iv) Support an automated approach using nonproprietary open
19 workflows to compile and exchange the necessary data elements to
20 populate the prior authorization requirements that are compliant with
21 the federal health insurance portability and accountability act of
22 1996 or have an exception from the federal centers for medicare and
23 medicaid services; and

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

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

38 (i) Allow providers to identify prior authorization information
39 and documentation requirements;

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

8 (iii) Indicate that a prior authorization denial or authorization
9 of a drug other than the one included in the original prior
10 authorization request is an adverse benefit determination and is
11 subject to the health plan's grievance and appeal process under RCW
12 48.43.535.

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

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

23 (A) The reasons that the health plan cannot reasonably satisfy
24 the requirements;

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

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

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

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

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

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

40 (4) For the purposes of this section:

1 (a) "Expedited prior authorization request" means a request by a
2 provider or facility for approval of a health care service or
3 prescription drug where:

4 (i) The passage of time:

5 (A) Could seriously jeopardize the life or health of the
6 enrollee;

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

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

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

15 (b) "Standard prior authorization request" means a request by a
16 provider or facility for approval of a health care service or
17 prescription drug where the request is made in advance of the
18 enrollee obtaining a health care service that is not required to be
19 expedited.

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

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

25 (1) Beginning January 1, 2024, the authority shall require each
26 managed care organization to comply with the following standards
27 related to prior authorization for health care services and
28 prescription drugs:

29 (a) The managed care organization shall meet the following time
30 frames for prior authorization determinations and notifications to a
31 participating provider or facility that submits the prior
32 authorization request through an electronic prior authorization
33 process, as designated by each managed care organization:

34 (i) For electronic standard prior authorization requests, the
35 managed care organization shall make a decision and notify the
36 provider or facility of the results of the decision within three
37 calendar days, excluding holidays, of submission of an electronic
38 prior authorization request by the provider or facility that contains
39 the necessary information to make a determination. If insufficient

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

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

16 (b) The managed care organization shall meet the following time
17 frames for prior authorization determinations and notifications to a
18 participating provider or facility that submits the prior
19 authorization request through a process other than an electronic
20 prior authorization process described in subsection (2) of this
21 section:

22 (i) For nonelectronic standard prior authorization requests, the
23 managed care organization shall make a decision and notify the
24 provider or facility of the results of the decision within five
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 five calendar days
31 of submission of the nonelectronic prior authorization request.

32 (ii) For nonelectronic expedited prior authorization requests,
33 the managed care organization shall make a decision and notify the
34 provider or facility of the results of the decision within two
35 calendar days of submission of a nonelectronic prior authorization
36 request by the provider or facility that contains the necessary
37 information to make a determination. If insufficient information has
38 been provided to the managed care organization to make a decision,
39 the managed care organization shall request any additional

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

3 (c) In any instance in which a managed care organization has
4 determined that a provider or facility has not provided sufficient
5 information for making a determination under (a) and (b) of this
6 subsection, a managed care organization may establish a specific
7 reasonable time frame for submission of the additional information.
8 This time frame must be communicated to the provider and enrollee
9 with a managed care organization's request for additional
10 information.

11 (d) The prior authorization requirements of the managed care
12 organization must be described in detail and written in easily
13 understandable language. The managed care organization shall make its
14 most current prior authorization requirements and restrictions,
15 including the written clinical review criteria, available to
16 providers and facilities in an electronic format upon request. The
17 prior authorization requirements must be based on peer-reviewed
18 clinical review criteria. The clinical review criteria must be
19 evidence-based criteria and must accommodate new and emerging
20 information related to the appropriateness of clinical criteria with
21 respect to black and indigenous people, other people of color,
22 gender, and underserved populations. The clinical review criteria
23 must be evaluated and updated, if necessary, at least annually.

24 (2)(a) Each managed care organization shall build and maintain a
25 prior authorization application programming interface that automates
26 the process for in-network providers to determine whether a prior
27 authorization is required for health care services, identify prior
28 authorization information and documentation requirements, and
29 facilitate the exchange of prior authorization requests and
30 determinations from its electronic health records or practice
31 management system. The application programming interface must support
32 the exchange of prior authorization requests and determinations for
33 health care services beginning January 1, 2025, and must:

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

37 (ii) Automate the process to determine whether a prior
38 authorization is required for durable medical equipment or a health
39 care service;

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

3 (iv) Support an automated approach using nonproprietary open
4 workflows to compile and exchange the necessary data elements to
5 populate the prior authorization requirements that are compliant with
6 the federal health insurance portability and accountability act of
7 1996 or have an exception from the federal centers for medicare and
8 medicaid services; and

9 (v) Indicate that a prior authorization denial or authorization
10 of a service less intensive than that included in the original
11 request is an adverse benefit determination and is subject to the
12 managed care organization's grievance and appeal process under RCW
13 48.43.535.

14 (b) Each managed care organization shall establish and maintain
15 an interoperable electronic process or application programming
16 interface that automates the process for in-network providers to
17 determine whether a prior authorization is required for a covered
18 prescription drug. The application programming interface must support
19 the exchange of prior authorization requests and determinations for
20 prescription drugs, including information on covered alternative
21 prescription drugs, beginning January 1, 2027, and must:

22 (i) Allow providers to identify prior authorization information
23 and documentation requirements;

24 (ii) Facilitate the exchange of prior authorization requests and
25 determinations from its electronic health records or practice
26 management system, and may include the necessary data elements to
27 populate the prior authorization requirements that are compliant with
28 the federal health insurance portability and accountability act of
29 1996 or have an exception from the federal centers for medicare and
30 medicaid services; and

31 (iii) Indicate that a prior authorization denial or authorization
32 of a drug other than the one included in the original prior
33 authorization request is an adverse benefit determination and is
34 subject to the managed care organization's grievance and appeal
35 process under RCW 48.43.535.

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

1 (d) (i) If a managed care organization determines that it will not
2 be able to satisfy the requirements of (a) of this subsection by
3 January 1, 2025, the managed care organization shall submit a
4 narrative justification to the authority on or before September 1,
5 2024, describing:

6 (A) The reasons that the managed care organization cannot
7 reasonably satisfy the requirements;

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

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

11 (D) A timeline and implementation plan to achieve compliance with
12 the requirements.

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

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

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

23 (4) For the purposes of this section:

24 (a) "Expedited prior authorization request" means a request by a
25 provider or facility for approval of a health care service or
26 prescription drug where:

27 (i) The passage of time:

28 (A) Could seriously jeopardize the life or health of the
29 enrollee;

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

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

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

38 (b) "Standard prior authorization request" means a request by a
39 provider or facility for approval of a health care service or
40 prescription drug where the request is made in advance of the

1 enrollee obtaining a health care service or prescription drug that is
2 not required to be expedited.

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

5 (1) (~~Except as provided in subsection (2) of this section, by~~)
6 By October 1, 2020, and annually thereafter, for individual and group
7 health plans issued by a carrier that has written at least one
8 percent of the total accident and health insurance premiums written
9 by all companies authorized to offer accident and health insurance in
10 Washington in the most recently available year, the carrier shall
11 report to the commissioner the following aggregated and deidentified
12 data related to the carrier's prior authorization practices and
13 experience for the prior plan year:

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

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

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

37 (iii) With the highest percentage of prior authorization requests
38 that were initially denied and then subsequently approved on appeal,
39 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 (c) Lists of the (~~ten~~) 10 inpatient mental health and substance
4 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 for each code;

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

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

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

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

33 (e) Lists of the (~~ten~~) 10 durable medical equipment 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 (f) Lists of the (~~(ten)~~) 10 diabetes supplies and equipment
9 codes:

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

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

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

23 (g) Lists of the 10 prescription drugs:

24 (i) With the highest total number of prior authorization requests
25 during the previous plan year, including the total number of prior
26 authorization requests for each prescription drug and the percent of
27 approved requests for each prescription drug;

28 (ii) With the highest percentage of approved prior authorization
29 requests during the previous plan year, including the total number of
30 prior authorization requests for each prescription drug and the
31 percent of approved requests for each prescription drug; and

32 (iii) With the highest percentage of prior authorization requests
33 that were initially denied and then subsequently approved on appeal,
34 including the total number of prior authorization requests for each
35 prescription drug and the percent of requests that were initially
36 denied and then subsequently approved for each prescription drug; and

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

- 1 (i) Expedited decisions;
- 2 (ii) Standard decisions; and
- 3 (iii) Extenuating circumstances decisions.

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

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

18 ~~((4))~~ (3) The commissioner may request additional information
19 from carriers reporting data under this section.

20 ~~((5))~~ (4) The commissioner may adopt rules to implement this
21 section. In adopting rules, the commissioner must consult
22 stakeholders including carriers, health care practitioners, health
23 care facilities, and patients.

24 ~~((6))~~ (5) For the purpose of this section, "prior
25 authorization" means a mandatory process that a carrier or its
26 designated or contracted representative requires a provider or
27 facility to follow before a service is delivered, to determine if a
28 service is a benefit and meets the requirements for medical
29 necessity, clinical appropriateness, level of care, or effectiveness
30 in relation to the applicable plan, including any term used by a
31 carrier or its designated or contracted representative to describe
32 this process.

33 NEW SECTION. **Sec. 5.** Section 4 of this act takes effect January
34 1, 2024.

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

ADOPTED 04/11/2023

1 On page 1, line 1 of the title, after "process;" strike the
2 remainder of the title and insert "amending RCW 48.43.0161; adding a
3 new section to chapter 48.43 RCW; adding a new section to chapter
4 41.05 RCW; adding a new section to chapter 74.09 RCW; creating a new
5 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.

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