HOUSE BILL REPORT
E2SHB 1357

As Passed Legislature

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

Brief Description: Modernizing the prior authorization process.

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

Brief History:

Committee Activity:

Health Care & Wellness: 1/25/23, 2/15/23 [DPS];
Appropriations: 2/23/23, 2/24/23 [DP2S(w/o sub HCW)].

Floor Activity:

Passed House: 3/4/23, 96-0.
Senate Amended.
Passed Senate: 4/11/23, 49-0.
House Concurred.
Passed House: 4/18/23, 97-0.
Passed Legislature.

Brief Summary of Engrossed Second Substitute Bill

- Establishes requirements for the prior authorization process for private health insurance, Public Employee Benefit Board and School Employee Benefit Board health programs, and Medicaid programs related to time frames for decisions, electronic authorization standards, and communication requirements.
- Expands the reporting requirements of health carriers related to prior authorization information to include prescription drug data.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 11 members: Representatives Riccelli, Chair; Bateman, Vice Chair; Schmick, Ranking Minority Member; Bronoske, Davis, Macri, Orwall, Simmons, Stonier, Thai and Tharinger.

Minority Report: Without recommendation. Signed by 5 members: Representatives Barnard, Graham, Harris, Maycumber and Mosbrucker.

Staff: Christopher Blake (786-7392).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Health Care & Wellness. Signed by 30 members: Representatives Ormsby, Chair; Bergquist, Vice Chair; Gregerson, Vice Chair; Macri, Vice Chair; Stokesbary, Ranking Minority Member; Chambers, Assistant Ranking Minority Member; Corry, Assistant Ranking Minority Member; Berg, Chandler, Chopp, Connors, Couture, Davis, Dye, Fitzgibbon, Harris, Lekanoff, Pollet, Riccelli, Rude, Ryu, Sandlin, Schmick, Senn, Simmons, Slatter, Springer, Steele, Stonier and Tharinger.

Staff: Meghan Morris (786-7119).

Background:

Prior authorization is the requirement that a health care provider seek approval of a drug, procedure, or test before receiving reimbursement from a health carrier. Health carriers may impose different prior authorization standards and criteria for a covered service among tiers of contracting providers.

The Office of the Insurance Commissioner maintains rules regarding prior authorization practices for health carriers in the private health insurance market. Under the rules, health carriers must have a documented prior authorization program description and use evidence-based clinical review criteria. Health carriers must also maintain an online prior authorization process. In addition, health carriers must comply with specified time frames for making a prior authorization determination and for notifying a provider. The time frames are five calendar days for a standard prior authorization request and two calendar days for an expedited request.

The Health Care Authority requires prior authorization for medical assistance programs as specified in administrative rules, billing instructions, and memoranda for certain health care services, including treatment, equipment, related supplies, and drugs. For managed health care systems, standards are specified in contract and require that standard authorizations for health care determinations be made and notices of decisions sent within five calendar days

and within two calendar days for expedited authorization decisions.

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

Summary of Engrossed Second Substitute Bill:

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

Timing of Review.
Beginning January 1, 2024, time frames are established for health carriers, health plans, and managed care organizations to make prior authorization determinations and notify a participating health care provider or health care facility. The time frames are established for both standard prior authorization requests and expedited prior authorization requests and differ depending on whether the request was made through an electronic prior authorization process or through a nonelectronic prior authorization process.

An expedited prior authorization request is a request by a health care provider or health care facility for approval of a health care service or prescription drug where the passage of time could either seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function or subject the enrollee to severe pain that cannot be adequately managed without the requested health care service. The term also applies to approval for a prescription drug where the enrollee is undergoing a current course of treatment using a nonformulary drug. For an expedited prior authorization request that is submitted through:

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

two calendar days of submission of a prior authorization request. If additional information is needed to make a determination, the health carrier, health plan, or managed care organization must request it within one calendar day of submission of the request through a nonelectronic prior authorization process.

A standard prior authorization request is a request by a health care provider or health care facility for advance approval of a health care service or prescription drug that does not include a condition requiring the request to be expedited. For a standard prior authorization request that is submitted through:

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

Health carriers, health plans, and managed care organizations may establish specific reasonable time frames for a health care provider or health care facility to submit additional information when needed to make a prior authorization decision.

Communication of Criteria.
Health carriers, health plans, and managed care organizations must describe their prior authorization requirements in detailed, easily understandable language. Health carriers, health plans, and managed care organizations must make the most current prior authorization requirements and restrictions available upon request in an electronic format. The prior authorization requirements must be based on peer-reviewed, evidence-based clinical review criteria which is evaluated and updated at least annually. In addition, the clinical review criteria must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous people, other people of color, gender, and underserved populations.

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

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

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

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

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

Null and Void.
The provisions of the bill are null and void if they are not specifically funded and referred to in the operating budget.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill contains multiple effective dates. Please see the bill. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) Formularies and prior authorizations serve a purpose for managing health care costs, but they can also be an unnecessary system that drives up health care costs, delays care, and increases hurdles to access. This bill is about standardizing and modernizing the prior authorization process. This bill will establish timelines for prior authorization decisions and standardize processes across health carriers which will result in less burden and better outcomes for patients. This bill streamlines prior authorization and brings transparency to the process. Prior authorization causes an overwhelming administrative burden that can drive health care providers out of business. This bill will create greater transparency between the carrier, the providers, and the patients. The inefficient prior authorization process results in patients having their treatment delayed, finances impacted, and quality of life affected. When dealing with a disease like cancer where there are procedures occurring on very tight timelines, a delay can mean that a patient is missing a chemotherapy appointment.

Prior authorization used to only be applied to outlier services, but is now applied to routine practices which institutionalizes delay and inefficiencies in health care delivery. This bill seeks to reduce administrative burdens by removing those rarely denied, but still required prior authorizations that create a bottleneck. Prior authorizations that are required, but rarely denied, delay access to important medication for chronic illness.

It is important to have a real peer-to-peer review because it isn't appropriate for a physician in one specialty to have a review by another specialty that knows nothing about the specialty at issue. Naturopaths should be included in the list of providers identified in the bill because, as primary care providers, they face similar barriers when submitting prior authorization requests.

(Opposed) Prior authorization is a key step to assuring that patients receive needed, safe, quality care. Patient safety may be compromised by the bill's exceptionally fast turnaround times and its authorization to the Insurance Commissioner to waive prior authorization altogether. This bill will likely result in a post-claim review process that will not be popular with some providers and patients. This bill drastically and unnecessarily cuts the amount of time to complete a prior authorization review and the times will be very difficult for health plans to meet and would likely result in an increase in denials. This bill requires a specialty-matched peer review process that will be expensive and not be a good use of limited health care staff. When Texas considered this type of legislation, it was estimated to cost nearly $1 billion.

While prior authorization programs should be made more efficient, that can be done by moving to an electronic platform. This bill does not mention the availability of technology to improve the prior authorization process. Health care providers have not been using the electronic prior authorization systems offered by health carriers. The bill's prohibition on prior authorization for procedures based on approval rates is concerning because there should be a review for quality and safety elements.

Staff Summary of Public Testimony (Appropriations):

(In Support) Prior authorization happens when a provider recommends a service for a patient that needs to be approved by the patient's insurance. Today, prior authorization often happens through fax machines. The focus of the bill is to modernize the prior authorization system and integrate electronic processes.

Delays with prior authorization lead to delays in care, creating a systematic issue. The fiscal analysis does not include the health care savings incurred by avoiding delays in care. It is impossible to put a dollar amount on the lives that will be saved with this bill.

Prior authorizations are supposed to eliminate unnecessary tests and treatments, except so many have high approval ratings already, so it just adds red tape. Reducing red tape will help providers with unnecessary paperwork and burnout.

(Opposed) None.

(Other) Technology can play a role in prior authorization and promote safe, evidence-based, affordable care. Increasing the adoption of electronic prior authorization is a major opportunity for improving prior authorization turnaround times. This bill will be an enormously complex technology lift for carriers as they need to build and maintain integrated prior authorization systems for prescriptions, which were excluded from pending federal standards and policy.

Persons Testifying (Health Care & Wellness): (In support) Representative Tarra Simmons, prime sponsor; Angela Ross, Washington Association of Naturopathic Physicians; Jenny Arnold, Washington State Pharmacy Association; Sean Graham, Washington State Medical Association; Matt Helder, American Cancer Society Cancer Action Network; Robin Sparks; and Teresa Girolami, King County Medical Society.

(Opposed) Jennifer Ziegler, Association of Washington Health Care Plans; Chris Berlin, Kaiser Permanente of Washington; Heidi Kriz, Regence; and Chris Bandoli, America's Health Insurance Plans.

Persons Testifying (Appropriations): (In support) Representative Tarra Simmons, prime sponsor; Sean Graham, Washington State Medical Assocation; and Ruchi Kapoor, American College of Cardiology.

(Other) Peggi Lewis Fu, Association of Washington Healthcare Plans.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): Nancy Belcher; Katina Rue; Garrett Jeffery; Carrie Horwitch; Christopher Chen, Health Care Authority; and Anna Taylor, MultiCare Connected Care.

Persons Signed In To Testify But Not Testifying (Appropriations): None.