
ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1357

State of Washington

68th Legislature

2023 Regular Session

By House Appropriations (originally sponsored by Representatives Simmons, Schmick, Stonier, Cortes, Reed, Bateman, Harris, Alvarado, Pollet, and Caldier)

READ FIRST TIME 02/24/23.

1 AN ACT Relating to modernizing the prior authorization process;
2 amending RCW 48.43.0161; adding a new section to chapter 48.43 RCW;
3 adding a new section to chapter 41.05 RCW; adding a new section to
4 chapter 74.09 RCW; creating a new section; and providing an effective
5 date.

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

7 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43
8 RCW to read as follows:

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

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

18 (i) For electronic standard prior authorization requests, the
19 carrier shall make a decision and notify the provider or facility of
20 the results of the decision within three calendar days, excluding
21 holidays, of submission of an electronic prior authorization request

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

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

16 (b) The carrier shall meet the following time frames for prior
17 authorization determinations and notifications to a participating
18 provider or facility that submits the prior authorization request
19 through a process other than an electronic prior authorization
20 process:

21 (i) For nonelectronic standard prior authorization requests, the
22 carrier shall make a decision and notify the provider or facility of
23 the results of the decision within five calendar days of submission
24 of a nonelectronic prior authorization request by the provider or
25 facility that contains the necessary information to make a
26 determination. If insufficient information has been provided to the
27 carrier to make a decision, the carrier shall request any additional
28 information from the provider or facility within five calendar days
29 of submission of the nonelectronic prior authorization request.

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

39 (c) In any instance in which a carrier has determined that a
40 provider or facility has not provided sufficient information for

1 making a determination under (a) and (b) of this subsection, a
2 carrier may establish a specific reasonable time frame for submission
3 of the additional information. This time frame must be communicated
4 to the provider or enrollee with a carrier's request for additional
5 information.

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

19 (2)(a) Each carrier shall build and maintain a prior
20 authorization application programming interface that automates the
21 process for in-network providers to determine whether a prior
22 authorization is required, identify prior authorization information
23 and documentation requirements, and facilitate the exchange of prior
24 authorization requests and determinations from its electronic health
25 records or practice management system. The application programming
26 interface must:

27 (i) Use fast health care interoperability resources;
28 (ii) Automate the process to determine whether a prior
29 authorization is required for durable medical equipment, a health
30 care service, or a prescription drug;

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

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

39 (v) Indicate that a prior authorization denial or authorization
40 of a service less intensive than that included in the original

1 request is an adverse benefit determination and is subject to the
2 carrier's grievance and appeal process under RCW 48.43.535.

3 (b) (i) Beginning January 1, 2025, the application programming
4 interface must support the exchange of prior authorization requests
5 and determinations for health care services.

6 (ii) Beginning January 1, 2027, the application programming
7 interface must support the exchange of prior authorization requests
8 and determinations for prescription drugs, including information on
9 covered alternative prescription drugs in the event of denials.

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

16 (d) (i) If a carrier determines that it will not be able to
17 satisfy the requirements of (a) of this subsection by January 1,
18 2025, the carrier shall submit a narrative justification to the
19 commissioner describing:

20 (A) The reasons that the carrier cannot reasonably satisfy the
21 requirements;

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

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

25 (D) A timeline and implementation plan to achieve compliance with
26 the requirements.

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

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

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

37 (4) For the purposes of this section:

38 (a) "Expedited prior authorization request" means a request by a
39 provider or facility for approval of a health care service or
40 prescription drug where:

1 (i) The passage of time:

2 (A) Could seriously jeopardize the life or health of the
3 enrollee;

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

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

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

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

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

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

24 (a) The health plan shall meet the following time frames for
25 prior authorization determinations and notifications to a
26 participating provider or facility that submits the prior
27 authorization request through an electronic prior authorization
28 process:

29 (i) For electronic standard prior authorization requests, the
30 health plan shall make a decision and notify the provider or facility
31 of the results of the decision within three calendar days, excluding
32 holidays, of submission of an electronic prior authorization request
33 by the provider or facility that contains the necessary information
34 to make a determination. If insufficient information has been
35 provided to the health plan to make a decision, the health plan shall
36 request any additional information from the provider or facility
37 within one calendar day of submission of the electronic prior
38 authorization request.

1 (ii) For electronic expedited prior authorization requests, the
2 health plan shall make a decision and notify the provider or facility
3 of the results of the decision within one calendar day of submission
4 of an electronic prior authorization request by the provider or
5 facility that contains the necessary information to make a
6 determination. If insufficient information has been provided to the
7 health plan to make a decision, the health plan shall request any
8 additional information from the provider or facility within one
9 calendar day of submission of the electronic prior authorization
10 request.

11 (b) The health plan shall meet the following time frames for
12 prior authorization determinations and notifications to a
13 participating provider or facility that submits the prior
14 authorization request through a process other than an electronic
15 prior authorization process described in subsection (2) of this
16 section:

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

27 (ii) For nonelectronic expedited prior authorization requests,
28 the health plan shall make a decision and notify the provider or
29 facility of the results of the decision within two calendar days of
30 submission of a nonelectronic prior authorization request by the
31 provider or facility that contains the necessary information to make
32 a determination. If insufficient information has been provided to the
33 health plan to make a decision, the health plan shall request any
34 additional information from the provider or facility within one
35 calendar day of submission of the nonelectronic prior authorization
36 request.

37 (c) In any instance in which the health plan has determined that
38 a provider or facility has not provided sufficient information for
39 making a determination under (a) and (b) of this subsection, the
40 health plan may establish a specific reasonable time frame for

1 submission of the additional information. This time frame must be
2 communicated to the provider or enrollee with the health plan's
3 request for additional information.

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

17 (2) (a) Each health plan offered to public employees, retirees,
18 and their covered dependents under this chapter shall build and
19 maintain a prior authorization application programming interface that
20 automates the process for in-network providers to determine whether a
21 prior authorization is required, identify prior authorization
22 information and documentation requirements, and facilitate the
23 exchange of prior authorization requests and determinations from its
24 electronic health records or practice management system. The
25 application programming interface must:

26 (i) Use fast health care interoperability resources;

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

30 (iii) Allow providers to query the health plan's prior
31 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

1 request is an adverse benefit determination and is subject to the
2 health plan's grievance and appeal process under RCW 48.43.535.

3 (b) (i) Beginning January 1, 2025, the application programming
4 interface must support the exchange of prior authorization requests
5 and determinations for health care services.

6 (ii) Beginning January 1, 2027, the application programming
7 interface must support the exchange of prior authorization requests
8 and determinations for prescription drugs, including information on
9 covered alternative prescription drugs in the event of denials.

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

16 (d) (i) If the health plan determines that it will not be able to
17 satisfy the requirements of (a) of this subsection by January 1,
18 2025, the health plan shall submit a narrative justification to the
19 authority describing:

20 (A) The reasons that the health plan cannot reasonably satisfy
21 the requirements;

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

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

25 (D) A timeline and implementation plan to achieve compliance with
26 the requirements.

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

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

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

37 (4) For the purposes of this section:

38 (a) "Expedited prior authorization request" means a request by a
39 provider or facility for approval of a health care service or
40 prescription drug where:

- 1 (i) The passage of time:
- 2 (A) Could seriously jeopardize the life or health of the
3 enrollee;
- 4 (B) Could seriously jeopardize the enrollee's ability to regain
5 maximum function; or
- 6 (C) In the opinion of a provider or facility with knowledge of
7 the enrollee's medical condition, would subject the enrollee to
8 severe pain that cannot be adequately managed without the health care
9 service or prescription drug that is the subject of the request; or
- 10 (ii) The enrollee is undergoing a current course of treatment
11 using a nonformulary drug.
- 12 (b) "Standard prior authorization request" means a request by a
13 provider or facility for approval of a health care service or
14 prescription drug where the request is made in advance of the
15 enrollee obtaining a health care service that is not required to be
16 expedited.

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

19 (1) Beginning January 1, 2024, the authority shall require each
20 managed care organization to comply with the following standards
21 related to prior authorization for health care services and
22 prescription drugs:

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

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

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

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

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

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

37 (c) In any instance in which a managed care organization has
38 determined that a provider or facility has not provided sufficient
39 information for making a determination under (a) and (b) of this
40 subsection, a managed care organization may establish a specific

1 reasonable time frame for submission of the additional information.
2 This time frame must be communicated to the provider or enrollee with
3 a managed care organization's request for additional information.

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

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

25 (i) Use fast health care interoperability resources;

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

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

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

37 (v) Indicate that a prior authorization denial or authorization
38 of a service less intensive than that included in the original
39 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) (i) Beginning January 1, 2025, the application programming
4 interface must support the exchange of prior authorization requests
5 and determinations for health care services.

6 (ii) Beginning January 1, 2027, the application programming
7 interface must support the exchange of prior authorization requests
8 and determinations for prescription drugs, including information on
9 covered alternative prescription drugs in the event of denials.

10 (c) If federal rules related to standards for using an
11 application programming interface to communicate prior authorization
12 status to providers are not finalized by September 13, 2023, the
13 requirements of (b) (i) of this subsection may not be enforced until
14 January 1, 2026.

15 (d) (i) If a managed care organization determines that it will not
16 be able to satisfy the requirements of (a) of this subsection by
17 January 1, 2025, the managed care organization shall submit a
18 narrative justification to the authority describing:

19 (A) The reasons that the managed care organization cannot
20 reasonably satisfy the requirements;

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

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

24 (D) A timeline and implementation plan to achieve compliance with
25 the requirements.

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

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

34 (3) Nothing in this section applies to prior authorization
35 determinations made pursuant to RCW 71.24.618.

36 (4) For the purposes of this section:

37 (a) "Expedited prior authorization request" means a request by a
38 provider or facility for approval of a health care service or
39 prescription drug where:

40 (i) The passage of time:

1 (A) Could seriously jeopardize the life or health of the
2 enrollee;

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

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

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

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

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

18 (1) (~~Except as provided in subsection (2) of this section, by~~)
19 By October 1, 2020, and annually thereafter, for individual and group
20 health plans issued by a carrier that has written at least one
21 percent of the total accident and health insurance premiums written
22 by all companies authorized to offer accident and health insurance in
23 Washington in the most recently available year, the carrier shall
24 report to the commissioner the following aggregated and deidentified
25 data related to the carrier's prior authorization practices and
26 experience for the prior plan year:

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

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

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

36 (iii) With the highest percentage of prior authorization requests
37 that were initially denied and then subsequently approved on appeal,
38 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 (b) Lists of the (~~ten~~) 10 outpatient medical or surgical codes:

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

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

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

17 (c) Lists of the (~~ten~~) 10 inpatient mental health and substance
18 use disorder service 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 (d) Lists of the (~~ten~~) 10 outpatient mental health and
33 substance use disorder service 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;

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

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 code and the percent of approved
12 requests for each code;

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 code and the percent of
16 approved requests for each code; (~~(and)~~) 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 code and the percent of requests that were initially denied and then
21 subsequently approved for each code;

22 (f) Lists of the (~~ten~~) 10 diabetes supplies and equipment
23 codes:

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 code and the percent of approved
27 requests for each code;

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 code and the percent of
31 approved requests for each code; (~~(and)~~) 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 code and the percent of requests that were initially denied and then
36 subsequently approved for each code;

37 (g) Lists of the 10 prescription drugs:

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

1 authorization requests for each prescription drug and the percent of
2 approved requests for each prescription drug;

3 (ii) With the highest percentage of approved prior authorization
4 requests during the previous plan year, including the total number of
5 prior authorization requests for each prescription drug and the
6 percent of approved requests for each prescription drug; and

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

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

16 (i) Expedited decisions;

17 (ii) Standard decisions; and

18 (iii) Extenuating circumstances decisions.

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

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

33 ~~((4))~~ (3) The commissioner may request additional information
34 from carriers reporting data under this section.

35 ~~((5))~~ (4) The commissioner may adopt rules to implement this
36 section. In adopting rules, the commissioner must consult
37 stakeholders including carriers, health care practitioners, health
38 care facilities, and patients.

39 ~~((6))~~ (5) For the purpose of this section, "prior
40 authorization" means a mandatory process that a carrier or its

1 designated or contracted representative requires a provider or
2 facility to follow before a service is delivered, to determine if a
3 service is a benefit and meets the requirements for medical
4 necessity, clinical appropriateness, level of care, or effectiveness
5 in relation to the applicable plan, including any term used by a
6 carrier or its designated or contracted representative to describe
7 this process.

8 NEW SECTION. **Sec. 5.** Section 4 of this act takes effect January
9 1, 2024.

10 NEW SECTION. **Sec. 6.** If specific funding for the purposes of
11 this act, referencing this act by bill or chapter number, is not
12 provided by June 30, 2023, in the omnibus appropriations act, this
13 act is null and void.

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