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**HOUSE BILL 1357**

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**State of Washington**

**68th Legislature**

**2023 Regular Session**

**By** Representatives Simmons, Schmick, Stonier, Cortes, Reed, Bateman, Harris, Alvarado, Pollet, and Caldier

Read first time 01/16/23. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to modernizing the prior authorization process;  
2 amending RCW 48.43.0161 and 48.43.545; adding a new section to  
3 chapter 48.43 RCW; adding a new section to chapter 41.05 RCW; and  
4 adding a new section to chapter 74.09 RCW.

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

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

8 (1) Each carrier offering a health plan issued or renewed on or  
9 after January 1, 2024, shall comply with the following standards  
10 related to prior authorization:

11 (a) The carrier shall meet the following time frames for prior  
12 authorization determinations and notifications to a participating  
13 provider or facility:

14 (i) For standard prior authorization requests, the carrier shall  
15 make a decision and notify the provider or facility of the results of  
16 the decision within 48 hours of submission of the prior authorization  
17 request by the provider or facility. If insufficient information has  
18 been provided to the carrier to make a decision, the carrier shall  
19 request any additional information from the provider or facility in a  
20 timely manner to allow the carrier to comply with the 48-hour  
21 notification requirement.

1 (ii) For expedited prior authorization requests, the carrier  
2 shall make a decision and notify the provider or facility of the  
3 results of the decision within 24 hours of submission of the prior  
4 authorization request by the provider or facility. If insufficient  
5 information has been provided to the carrier to make a decision, the  
6 carrier shall request any additional information from the provider or  
7 facility in a timely manner to allow the carrier to comply with the  
8 24-hour notification requirement.

9 (b) (i) The initial review of information submitted in support of  
10 a request for prior authorization must be conducted and approved by a  
11 licensed health care professional.

12 (ii) For prior authorization requests made by a physician,  
13 osteopathic physician, physician assistant, or advanced registered  
14 nurse practitioner, only a physician or osteopathic physician may  
15 issue a denial of the prior authorization request.

16 (iii) In the case of a denied prior authorization, a carrier  
17 shall make available to the requesting provider a peer-to-peer review  
18 discussion. The peer reviewer provided by the carrier must be  
19 licensed in the same or similar medical specialty as the requesting  
20 provider and must have authority to modify or overturn the prior  
21 authorization decision.

22 (c) The carrier's prior authorization requirements must be  
23 described in detail and written in easily understandable language.  
24 The carrier shall make its most current prior authorization  
25 requirements and restrictions, including the written clinical review  
26 criteria, available to providers and facilities upon request, as well  
27 as readily accessible and conspicuously posted on its website for  
28 enrollees, providers, and facilities. The prior authorization  
29 requirements must be based on peer-reviewed clinical review criteria.  
30 The clinical review criteria must be evidence-based criteria. The  
31 clinical review criteria must be evaluated and updated, if necessary,  
32 at least annually.

33 (2) By January 1, 2024, carriers shall make available an  
34 electronic prior authorization request transaction process using an  
35 internet webpage, internet webpage portal, or similar electronic,  
36 internet, or web-based system.

37 (3) Nothing in this section applies to prior authorization  
38 determinations made pursuant to RCW 48.43.400 through 48.43.420 or  
39 48.43.761.

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 where the  
3 passage of time could seriously jeopardize the life or health of the  
4 enrollee, seriously jeopardize the enrollee's ability to regain  
5 maximum function, or, in the opinion of a provider or facility with  
6 knowledge of the enrollee's medical condition, would subject the  
7 enrollee to severe pain that cannot be adequately managed without the  
8 health care service that is the subject of the request.

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

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

15 (1) A health plan offered to public employees and their covered  
16 dependents under this chapter issued or renewed on or after January  
17 1, 2024, shall comply with the following standards related to prior  
18 authorization:

19 (a) The carrier offering the health plan shall meet the following  
20 time frames for prior authorization determinations and notifications  
21 to a participating provider or facility:

22 (i) For standard prior authorization requests, the carrier shall  
23 make a decision and notify the provider or facility of the results of  
24 the decision within 48 hours of submission of the prior authorization  
25 request by the provider or facility. If insufficient information has  
26 been provided to the carrier to make a decision, the carrier shall  
27 request any additional information from the provider or facility in a  
28 timely manner to allow the carrier to comply with the 48-hour  
29 notification requirement.

30 (ii) For expedited prior authorization requests, the carrier  
31 shall make a decision and notify the provider or facility of the  
32 results of the decision within 24 hours of submission of the prior  
33 authorization request by the provider or facility. If insufficient  
34 information has been provided to the carrier to make a decision, the  
35 carrier shall request any additional information from the provider or  
36 facility in a timely manner to allow the carrier to comply with the  
37 24-hour notification requirement.

1 (b) (i) The initial review of information submitted in support of  
2 a request for prior authorization must be conducted and approved by a  
3 licensed health care professional.

4 (ii) For prior authorization requests made by a physician,  
5 osteopathic physician, physician assistant, or advanced registered  
6 nurse practitioner, only a physician or osteopathic physician may  
7 issue a denial of the prior authorization request.

8 (iii) In the case of a denied prior authorization, a carrier  
9 shall make available to the requesting provider a peer-to-peer review  
10 discussion. The peer reviewer provided by the carrier must be  
11 licensed in the same or similar medical specialty as the requesting  
12 provider and must have authority to modify or overturn the prior  
13 authorization decision.

14 (c) The prior authorization requirements of the carrier offering  
15 the health plan must be described in detail and written in easily  
16 understandable language. The carrier shall make its most current  
17 prior authorization requirements and restrictions, including the  
18 written clinical review criteria, available to providers and  
19 facilities upon request, as well as readily accessible and  
20 conspicuously posted on its website for enrollees, providers, and  
21 facilities. The prior authorization requirements must be based on  
22 peer-reviewed clinical review criteria. The clinical review criteria  
23 must be evidence-based criteria. The clinical review criteria must be  
24 evaluated and updated, if necessary, at least annually.

25 (2) By January 1, 2024, carriers shall make available an  
26 electronic prior authorization request transaction process using an  
27 internet webpage, internet webpage portal, or similar electronic,  
28 internet, or web-based system.

29 (3) The authority shall prohibit health plans from requiring  
30 prior authorization to the same extent that the insurance  
31 commissioner has established such prohibitions pursuant to rules  
32 adopted under RCW 48.43.0161(5)(b).

33 (4) Nothing in this section applies to prior authorization  
34 determinations made pursuant to RCW 41.05.526.

35 (5) For the purposes of this section:

36 (a) "Expedited prior authorization request" means a request by a  
37 provider or facility for approval of a health care service where the  
38 passage of time could seriously jeopardize the life or health of the  
39 enrollee, seriously jeopardize the enrollee's ability to regain  
40 maximum function, or, in the opinion of a provider or facility with

1 knowledge of the enrollee's medical condition, would subject the  
2 enrollee to severe pain that cannot be adequately managed without the  
3 health care service that is the subject of the request.

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

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

10 (1) Beginning January 1, 2024, the authority shall require all  
11 managed health care systems, including managed care organizations, to  
12 comply with the following standards related to prior authorization:

13 (a) The managed health care system shall meet the following time  
14 frames for prior authorization determinations and notifications to a  
15 participating provider or facility:

16 (i) For standard prior authorization requests, the managed health  
17 care system shall make a decision and notify the provider or facility  
18 of the results of the decision within 48 hours of submission of the  
19 prior authorization request by the provider or facility. If  
20 insufficient information has been provided to the managed health care  
21 system to make a decision, the managed health care system shall  
22 request any additional information from the provider or facility in a  
23 timely manner to allow the managed health care system to comply with  
24 the 48-hour notification requirement.

25 (ii) For expedited prior authorization requests, the managed  
26 health care system shall make a decision and notify the provider or  
27 facility of the results of the decision within 24 hours of submission  
28 of the prior authorization request by the provider or facility. If  
29 insufficient information has been provided to the managed health care  
30 system to make a decision, the managed health care system shall  
31 request any additional information from the provider or facility in a  
32 timely manner to allow the managed health care system to comply with  
33 the 24-hour notification requirement.

34 (b) (i) The initial review of information submitted in support of  
35 a request for prior authorization must be conducted and approved by a  
36 licensed health care professional.

37 (ii) For prior authorization requests made by a physician,  
38 osteopathic physician, physician assistant, or advanced registered

1 nurse practitioner, only a physician or osteopathic physician may  
2 issue a denial of the prior authorization request.

3 (iii) In the case of a denied prior authorization, a managed  
4 health care system shall make available to the requesting provider a  
5 peer-to-peer review discussion. The peer reviewer provided by the  
6 managed health care system must be licensed in the same or similar  
7 medical specialty as the requesting provider and must have authority  
8 to modify or overturn the prior authorization decision.

9 (c) The prior authorization requirements of the managed health  
10 care system must be described in detail and written in easily  
11 understandable language. The managed health care system shall make  
12 its most current prior authorization requirements and restrictions,  
13 including the written clinical review criteria, available to  
14 providers and facilities upon request, as well as readily accessible  
15 and conspicuously posted on its website for enrollees, providers, and  
16 facilities. The prior authorization requirements must be based on  
17 peer-reviewed clinical review criteria. The clinical review criteria  
18 must be evidence-based criteria. The clinical review criteria must be  
19 evaluated and updated, if necessary, at least annually.

20 (2) By January 1, 2024, managed health care systems, including  
21 managed care organizations, shall make available an electronic prior  
22 authorization request transaction process using an internet webpage,  
23 internet webpage portal, or similar electronic, internet, or web-  
24 based system.

25 (3) The authority shall prohibit managed health care systems,  
26 including managed care organizations, from requiring prior  
27 authorization to the same extent that the insurance commissioner has  
28 established such prohibitions pursuant to rules adopted under RCW  
29 48.43.0161(5)(b).

30 (4) Nothing in this section applies to prior authorization  
31 determinations made pursuant to RCW 71.24.618.

32 (5) For the purposes of this section:

33 (a) "Expedited prior authorization request" means a request by a  
34 provider or facility for approval of a health care service where the  
35 passage of time could seriously jeopardize the life or health of the  
36 enrollee, seriously jeopardize the enrollee's ability to regain  
37 maximum function, or, in the opinion of a provider or facility with  
38 knowledge of the enrollee's medical condition, would subject the  
39 enrollee to severe pain that cannot be adequately managed without the  
40 health care service that is the subject of the request.

1 (b) "Standard prior authorization request" means a request by a  
2 provider or facility for approval of a health care service where the  
3 request is made in advance of the enrollee obtaining a health care  
4 service that is not required to be expedited.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

29 (i) Expedited decisions;

30 (ii) Standard decisions; and

31 (iii) Extenuating circumstances decisions.

32 (2) For the October 1, 2020, reporting deadline, a carrier is not  
33 required to report data pursuant to subsection (1)(a)(iii), (b)(iii),  
34 (c)(iii), (d)(iii), (e)(iii), or (f)(iii) of this section until April  
35 1, 2021, if the commissioner determines that doing so constitutes a  
36 hardship.

37 (3) By January 1, 2021, and annually thereafter, the commissioner  
38 shall aggregate and deidentify the data collected under subsection  
39 (1) of this section into a standard report and may not identify the  
40 name of the carrier that submitted the data. The initial report due

1 on January 1, 2021, may omit data for which a hardship determination  
2 is made by the commissioner under subsection (2) of this section.  
3 Such data must be included in the report due on January 1, 2022. The  
4 commissioner must make the report available to interested parties.

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

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

11 (b) The commissioner shall adopt rules to prohibit carriers from  
12 requiring prior authorization for any code covered by the reporting  
13 requirements of subsection (1) of this section if the commissioner  
14 has determined that the data in the most recent report demonstrates  
15 that the code has a prior authorization approval rate higher than 95  
16 percent. For codes where prior authorization has been prohibited by  
17 rule, if the commissioner determines after three years that  
18 utilization of the code has changed significantly, the commissioner  
19 may initiate rule making to reinstate eligibility of the code for  
20 prior authorization.

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

29 **Sec. 5.** RCW 48.43.545 and 2000 c 5 s 17 are each amended to read  
30 as follows:

31 (1)(a) A health carrier shall adhere to the accepted standard of  
32 care for health care providers under chapter 7.70 RCW when arranging  
33 for the provision of medically necessary health care services to its  
34 enrollees. A health carrier shall be liable for any and all harm  
35 proximately caused by its failure to follow that standard of care  
36 when the failure resulted in the denial, delay, or modification of  
37 the health care service recommended for, or furnished to, an  
38 enrollee.

1 (b) A health carrier is also liable for damages under (a) of this  
2 subsection for harm to an enrollee proximately caused by health care  
3 treatment decisions that result from a failure to follow the accepted  
4 standard of care made by its:

5 (i) Employees;

6 (ii) Agents; or

7 (iii) Ostensible agents who are acting on its behalf and over  
8 whom it has the right to exercise influence or control or has  
9 actually exercised influence or control.

10 (2) The provisions of this section may not be waived, shifted, or  
11 modified by contract or agreement and responsibility for the  
12 provisions shall be a duty that cannot be delegated. Any effort to  
13 waive, modify, delegate, or shift liability for a breach of the duty  
14 established by this section, through a contract for indemnification  
15 or otherwise, is invalid.

16 (3) This section does not create any new cause of action, or  
17 eliminate any presently existing cause of action, with respect to  
18 health care providers and health care facilities that are included in  
19 and subject to the provisions of chapter 7.70 RCW.

20 (4) It is a defense to any action or liability asserted under  
21 this section against a health carrier that:

22 (a) The health care service in question is not a benefit provided  
23 under the plan or the service is subject to limitations under the  
24 plan that have been exhausted;

25 (b) Neither the health carrier, nor any employee, agent, or  
26 ostensible agent for whose conduct the health carrier is liable under  
27 subsection (1)(b) of this section, controlled, influenced, or  
28 participated in the health care decision; or

29 (c) The health carrier did not deny or unreasonably delay payment  
30 for treatment prescribed or recommended by a participating health  
31 care provider for the enrollee.

32 (5) This section does not create any liability on the part of an  
33 employer, an employer group purchasing organization that purchases  
34 coverage or assumes risk on behalf of its employers, or a  
35 governmental agency that purchases coverage on behalf of individuals  
36 and families. The governmental entity established to offer and  
37 provide health insurance to public employees, public retirees, and  
38 their covered dependents under RCW 41.05.140 is subject to liability  
39 under this section.

1 (6) Nothing in any law of this state prohibiting a health carrier  
2 from practicing medicine or being licensed to practice medicine may  
3 be asserted as a defense by the health carrier in an action brought  
4 against it under this section.

5 ~~(7) ((a) A person may not maintain a cause of action under this  
6 section against a health carrier unless:~~

7 ~~(i) The affected enrollee has suffered substantial harm. As used  
8 in this subsection, "substantial harm" means loss of life, loss or  
9 significant impairment of limb, bodily or cognitive function,  
10 significant disfigurement, or severe or chronic physical pain; and~~

11 ~~(ii) The affected enrollee or the enrollee's representative has  
12 exercised the opportunity established in RCW 48.43.535 to seek  
13 independent review of the health care treatment decision.~~

14 ~~(b) This subsection (7) does not prohibit an enrollee from  
15 pursuing other appropriate remedies, including injunctive relief, a  
16 declaratory judgment, or other relief available under law, if its  
17 requirements place the enrollee's health in serious jeopardy.~~

18 ~~(8))~~ In an action against a health carrier, a finding that a  
19 health care provider is an employee, agent, or ostensible agent of  
20 such a health carrier shall not be based solely on proof that the  
21 person's name appears in a listing of approved physicians or health  
22 care providers made available to enrollees under a health plan.

23 ~~((9))~~ (8) Any action under this section shall be commenced  
24 within three years of the ~~((completion of the independent review  
25 process.~~

26 ~~(10))~~ denial, delay, or modification of the health care service.

27 (9) This section does not apply to workers' compensation  
28 insurance under Title 51 RCW.

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