

CERTIFICATION OF ENROLLMENT

**ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1357**

Chapter 382, Laws of 2023

68th Legislature  
2023 Regular Session

HEALTH PLANS—PRIOR AUTHORIZATION

EFFECTIVE DATE: July 23, 2023—Except for section 4, which takes effect January 1, 2024.

Passed by the House April 18, 2023  
Yeas 97 Nays 0

LAURIE JINKINS

**Speaker of the House of  
Representatives**

Passed by the Senate April 11, 2023  
Yeas 49 Nays 0

DENNY HECK

**President of the Senate**

Approved May 9, 2023 2:14 PM

JAY INSLEE

**Governor of the State of Washington**

CERTIFICATE

I, Bernard Dean, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1357** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BERNARD DEAN

**Chief Clerk**

FILED

May 10, 2023

**Secretary of State  
State of Washington**

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**ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1357**

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AS AMENDED BY THE SENATE

Passed Legislature - 2023 Regular Session

**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 and 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 for health care services, identify prior  
23 authorization information and documentation requirements, and  
24 facilitate the exchange of prior authorization requests and  
25 determinations from its electronic health records or practice  
26 management system. The application programming interface must support  
27 the exchange of prior authorization requests and determinations for  
28 health care services beginning January 1, 2025, and must:

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

32 (ii) Automate the process to determine whether a prior  
33 authorization is required for durable medical equipment or a health  
34 care service;

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

37 (iv) Support an automated approach using nonproprietary open  
38 workflows to compile and exchange the necessary data elements to  
39 populate the prior authorization requirements that are compliant with  
40 the federal health insurance portability and accountability act of

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

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

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

15 (i) Allow providers to identify prior authorization information  
16 and documentation requirements;

17 (ii) Facilitate the exchange of prior authorization requests and  
18 determinations from its electronic health records or practice  
19 management system, and may include 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 (iii) Indicate that a prior authorization denial or authorization  
25 of a drug other than the one included in the original prior  
26 authorization request is an adverse benefit determination and is  
27 subject to the carrier's grievance and appeal process under RCW  
28 48.43.535.

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

35 (d) (i) If a carrier determines that it will not be able to  
36 satisfy the requirements of (a) of this subsection by January 1,  
37 2025, the carrier shall submit a narrative justification to the  
38 commissioner on or before September 1, 2024, describing:

39 (A) The reasons that the carrier cannot reasonably satisfy the  
40 requirements;

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

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

4 (D) A timeline and implementation plan to achieve compliance with  
5 the requirements.

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

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

14 (e) By September 13, 2023, and at least every six months  
15 thereafter until September 13, 2026, the commissioner shall provide  
16 an update to the health care policy committees of the legislature on  
17 the development of rules and implementation guidance from the federal  
18 centers for medicare and medicaid services regarding the standards  
19 for development of application programming interfaces and  
20 interoperable electronic processes related to prior authorization  
21 functions. The updates should include recommendations, as  
22 appropriate, on whether the status of the federal rule development  
23 aligns with the provisions of this act. The commissioner also shall  
24 report on any actions by the federal centers for medicare and  
25 medicaid services to exercise enforcement discretion related to the  
26 implementation and maintenance of an application programming  
27 interface for prior authorization functions. The commissioner shall  
28 consult with the health care authority, carriers, providers, and  
29 consumers on the development of these updates and any  
30 recommendations.

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

33 (4) For the purposes of this section:

34 (a) "Expedited prior authorization request" means a request by a  
35 provider or facility for approval of a health care service or  
36 prescription drug where:

37 (i) The passage of time:

38 (A) Could seriously jeopardize the life or health of the  
39 enrollee;

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

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

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

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

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

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

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

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

36 (ii) For electronic expedited prior authorization requests, the  
37 health plan shall make a decision and notify the provider or facility  
38 of the results of the decision within one calendar day of submission  
39 of an electronic prior authorization request by the provider or

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

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

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

23 (ii) For nonelectronic expedited prior authorization requests,  
24 the health plan shall make a decision and notify the provider or  
25 facility of the results of the decision within two calendar days of  
26 submission of a nonelectronic prior authorization request by the  
27 provider or facility that contains the necessary information to make  
28 a 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 nonelectronic prior authorization  
32 request.

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



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

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

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

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

31 (iii) Allow providers to query the health plan's prior  
32 authorization 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 health plan's grievance and appeal process under RCW 48.43.535.

3 (b) Each health plan offered to public employees, retirees, and  
4 their covered dependents under this chapter shall establish and  
5 maintain an interoperable electronic process or application  
6 programming interface that automates the process for in-network  
7 providers to determine whether a prior authorization is required for  
8 a covered prescription drug. The application programming interface  
9 must support the exchange of prior authorization requests and  
10 determinations for prescription drugs, including information on  
11 covered alternative prescription drugs, beginning January 1, 2027,  
12 and must:

13 (i) Allow providers to identify prior authorization information  
14 and documentation requirements;

15 (ii) Facilitate the exchange of prior authorization requests and  
16 determinations from its electronic health records or practice  
17 management system, and may include the necessary data elements to  
18 populate the prior authorization requirements that are compliant with  
19 the federal health insurance portability and accountability act of  
20 1996 or have an exception from the federal centers for medicare and  
21 medicaid services; and

22 (iii) Indicate that a prior authorization denial or authorization  
23 of a drug other than the one included in the original prior  
24 authorization request is an adverse benefit determination and is  
25 subject to the health plan's grievance and appeal process under RCW  
26 48.43.535.

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

33 (d) (i) If the health plan determines that it will not be able to  
34 satisfy the requirements of (a) of this subsection by January 1,  
35 2025, the health plan shall submit a narrative justification to the  
36 authority on or before September 1, 2024, describing:

37 (A) The reasons that the health plan cannot reasonably satisfy  
38 the requirements;

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

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

3 (D) A timeline and implementation plan to achieve compliance with  
4 the requirements.

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

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

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

15 (4) For the purposes of this section:

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

19 (i) The passage of time:

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

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

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

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

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

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

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

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

5 (a) The managed care organization shall meet the following time  
6 frames for prior authorization determinations and notifications to a  
7 participating provider or facility that submits the prior  
8 authorization request through an electronic prior authorization  
9 process, as designated by each managed care organization:

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

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

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

37 (i) For nonelectronic standard prior authorization requests, the  
38 managed care organization shall make a decision and notify the  
39 provider or facility of the results of the decision within five  
40 calendar days of submission of a nonelectronic prior authorization

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

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

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

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

38 (2)(a) Each managed care organization shall build and maintain a  
39 prior authorization application programming interface that automates  
40 the process for in-network providers to determine whether a prior

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

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

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

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

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

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

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

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

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

1 the federal health insurance portability and accountability act of  
2 1996 or have an exception from the federal centers for medicare and  
3 medicaid services; and

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

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

14 (d) (i) If a managed care organization determines that it will not  
15 be able to satisfy the requirements of (a) of this subsection by  
16 January 1, 2025, the managed care organization shall submit a  
17 narrative justification to the authority on or before September 1,  
18 2024, 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 or 74.09.490.

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.

Passed by the House April 18, 2023.  
Passed by the Senate April 11, 2023.  
Approved by the Governor May 9, 2023.  
Filed in Office of Secretary of State May 10, 2023.

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