**2SHB 1432** - H AMD TO H AMD (H-1867.1/25) **380**
By Representative Schmick

**NOT ADOPTED 03/11/2025**

On page 22, after line 27, insert the following:

**"Sec. 10.** RCW 41.05.017 and 2024 c 251 s 5 and 2024 c 242 s 10 are each reenacted and amended to read as follows:

Each health plan that provides medical insurance offered under this chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, are subject to the provisions of RCW 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545, 48.43.550, 70.02.110, 70.02.900, 48.43.190, 48.43.083, 48.43.0128, 48.43.780, 48.43.435, 48.43.815, 48.200.020 through 48.200.280, 48.200.300 through 48.200.320, 48.43.440, section 2 of this act, and chapter 48.49 RCW.

**Sec. 11.** RCW 41.05.074 and 2019 c 308 s 20 are each amended to read as follows:

(1) A health plan offered to public employees and their covered dependents under this chapter that imposes different prior authorization standards and criteria for a covered service among tiers of contracting providers of the same licensed profession in the same health plan shall inform an enrollee which tier an individual provider or group of providers is in by posting the information on its website in a manner accessible to both enrollees and providers.

(2) The health plan may not require prior authorization for an evaluation and management visit or an initial treatment visit with a contracting provider in a new episode of chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, outpatient mental health care office visits, outpatient substance use disorder care office visits, or speech and hearing therapies. Notwithstanding RCW 48.43.515(5) this section may not be interpreted to limit the ability of a health plan to require a referral or prescription for the therapies listed in this section. Quantitative treatment limitations and nonquantitative treatment

limitations, including any referral and prescription requirements, for mental health or substance use disorder care shall comply with the requirements of the mental health parity and addiction equity act, state law, and any implementing regulations.

(3) The health care authority shall post on its website and provide upon the request of a covered person or contracting provider any prior authorization standards, criteria, or information the health plan uses for medical necessity decisions.

(4) A health care provider with whom the administrator of the health plan consults regarding a decision to deny, limit, or terminate a person's covered health care services must hold a license, certification, or registration, in good standing and must be in the same or related health field as the health care provider being reviewed or of a specialty whose practice entails the same or similar covered health care service.

(5) The health plan may not require a provider to provide a discount from usual and customary rates for health care services not covered under the health plan, policy, or other agreement, to which the provider is a party.

(6) For purposes of this section:

(a) "New episode of care" means treatment for a new or recurrent condition for which the enrollee has not been treated by the provider within the previous ninety days and is not currently undergoing any active treatment.

(b) "Contracting provider" does not include providers employed within an integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW.

**Sec. 12.** RCW 41.05.845 and 2023 c 382 s 2 are each amended to read as follows:

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

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

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

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

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

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

(ii) For nonelectronic expedited prior authorization requests, the health plan shall make a decision and notify the provider or facility of the results of the decision within two calendar days of submission of a nonelectronic prior authorization request by the

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

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

(d) The prior authorization requirements of the health plan must be described in detail and written in easily understandable language. The health plan shall make its most current prior authorization requirements and restrictions, including the written clinical review criteria, available to providers and facilities in an electronic format upon request. The prior authorization requirements must be based on peer-reviewed clinical review criteria. The clinical review criteria must be evidence-based criteria and must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous people, other people of color, gender, and underserved populations. The clinical review criteria must be evaluated and updated, if necessary, at least annually. Clinical review criteria used for purposes of reviewing and decided upon prior authorization requests related to mental health and substance use disorder services, as defined in section 2 of this act, must meet the requirements of section 2 of this act.

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

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

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

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

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

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

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

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

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

(iii) Indicate that a prior authorization denial or authorization of a drug other than the one included in the original prior authorization request is an adverse benefit determination and is

subject to the health plan's grievance and appeal process under RCW 48.43.535.

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

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

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

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

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

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

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

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

(3) A health plan offered to public employees, retirees, and their dependents shall approve coverage of the mental health and substance use disorder services that are the subject of the prior authorization request if the health plan does not respond to the prior authorization request within the time frames required in this section.

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

((~~(4)~~)) (5) For the purposes of this section:

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

(i) The passage of time:

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

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

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

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

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

((~~(5)~~)) (6) This section shall not apply to coverage provided under the medicare part C or part D programs set forth in Title XVIII of the social security act of 1965, as amended."

Renumber the remaining sections consecutively and correct any internal references accordingly.

On page 23, line 4, after "through" strike "9" and insert "12"

Correct the title.

EFFECT: Applies the following provisions to all plans offered to public and school employees and their dependents:

• Establishes definitions of "mental health and substance use disorder (SUD) services," "medically necessary," "clinical review criteria," "utilization review," and other terms for the purposes of the below provisions;

• Prohibits a health carrier from limiting benefits or coverage for medically necessary mental health or SUD services on the basis that those services should or could be covered by a public entitlement program;

• Prohibits utilization review and clinical review criteria from deviating from generally accepted standards of mental health and SUD care;

• Requires health plans that provide any benefits for a mental health condition or an SUD in any classification of benefits, to provide meaningful benefits for that mental health condition or SUD in every classification in which medical or surgical benefits are provided;

• Applies the requirements related to the Mental Health Parity and Addiction Equity Act issued on September 23, 2024;

• Requires health plans conducting utilization reviews relating to service intensity or level of care placement, continued stay, or

transfer or discharge to apply relevant age-appropriate patient placement criteria from nonprofit professional associations and authorize placement consistent with that criteria;

• Establishes penalties for violations of the above provisions;

• Prohibits the health plan from requiring utilization management or review, or prior authorization for an initial evaluation and management visit, and up to six consecutive office visits in a new episode of care for outpatient mental health care and outpatient SUD care; and

• Requires health plans to approve coverage of the mental health and SUD services that are the subject of the prior authorization request if the health plan does not respond to the prior authorization request within the time frames required in this section.

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