Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1706

Brief Description: Aligning the implementation of application programming interfaces for prior authorization with federal guidelines.

Sponsors: Representative Simmons.

Brief Summary of Bill

- Aligns technical requirements for prior authorization application programming interfaces (APIs) with federal requirements.
- Establishes that requirements regarding prior authorization APIs may not be enforced until related federal rules take effect.

Hearing Date: 2/11/25

Staff: Emily Poole (786-7106).

Background:

Prior Authorization.
Prior authorization is the requirement that a health care provider seek approval of a drug, procedure, or test before receiving reimbursement from a health carrier, health plan, or managed care organization. Requested drugs, procedures, or tests may be evaluated based on medical necessity, clinical appropriateness, level of care, and effectiveness. Health plans offered by health carriers, health plans offered to public or school employees, retirees, and their dependents, and medical assistance coverage offered through managed care organizations are subject to certain requirements regarding the prior authorization process.

Health carriers, health plans, and managed care organizations must build and maintain a prior authorization application programming interface (API) that automates the processes for

---

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

determining the necessity for a prior authorization for health care services, identifying information and documentation requirements, and facilitating the exchange of prior authorization requests and determinations. Beginning January 1, 2025, the API must:

- use Health Level 7 (HL7) Fast Health Care Interoperability Resources (FHIR);
- automate the process to determine whether a prior authorization is required;
- allow providers to query prior authorization documentation requirements;
- support an automated approach to compile and exchange the necessary data elements to populate the prior authorization requirements; and
- 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 carrier's, health plan's, or managed care organization's grievance and appeal process.

Health carriers, health plans, and managed care organizations are also required to establish an interoperable electronic process or API that automates the process for in-network providers to determine whether a prior authorization is required for a covered prescription drug.

If federal rules related to standards for using an API to communicate prior authorization status to providers are not finalized by the Centers for Medicare and Medicaid Services (CMS) by September 13, 2023, the requirements relating to APIs may not be enforced until January 1, 2026. If a carrier, health plan, or managed care organization determines that it will not be able to satisfy the requirements relating to APIs by January 1, 2025, the carrier, health plan, or managed care organization must submit a justification to the Office of the Insurance Commissioner or to the Health Care Authority, as applicable, by September 1, 2024.

Federal Rules.
In 2020 the CMS published the Interoperability and Patient Access final rule, which required impacted payers to implement a HL7 FHIR Patient Access API. Building on the 2020 rule, the CMS published the Interoperability and Prior Authorization final rule (Prior Authorization Rule), effective April 8, 2024.

The Prior Authorization Rule requires impacted payers to add information about prior authorizations (excluding those for drugs) to the data available via the patient access API. The Prior Authorization Rule also requires impacted payers to implement and maintain a Provider Access API, a Payer-to-Payer API, and a Prior Authorization API.

The Prior Authorization API must be populated with a list of covered items and services, able to identify documentation requirements for prior authorization approval, and able to support a prior authorization request and response. The Prior Authorization API must also communicate whether the payer approves the prior authorization request, denies the request, or requests more information. This requirement must be implemented beginning January 1, 2027.

The Prior Authorization Rule also includes required standards and implementation specifications for APIs.

Summary of Bill:

Technical requirements regarding the functionality of prior authorization APIs are replaced with the requirement that a carrier, health plan, or managed care organization is required to establish and maintain a prior authorization API that is consistent with final rules issued by the CMS. The implementation of the API must align with federal effective dates, including enforcement delays and suspensions, issued by the CMS.

The requirements regarding APIs that automate the process for in-network providers to determine whether a prior authorization is required for a covered prescription drug are applied to other interoperable electronic processes.

Requirements regarding prior authorization APIs may not be enforced until final rules published by the federal government take effect.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.