

ESSB 6404 - H AMD 2179

By Representative Cody

ADOPTED 03/10/2020

1 Strike everything after the enacting clause and insert the
2 following:

3 "NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43
4 RCW to read as follows:

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

14 (a) Lists of the ten inpatient medical or surgical codes:

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

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

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

28 (b) Lists of the ten outpatient medical or surgical codes:

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

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 (c) Lists of the ten inpatient mental health and substance use
11 disorder service 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;

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 (d) Lists of the ten outpatient mental health and substance use
26 disorder service codes:

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

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

35 (iii) With the highest percentage of prior authorization requests
36 that were initially denied and then subsequently approved on appeal,
37 including the total number of prior authorization requests for each
38 code and the percent of requests that were initially denied and then
39 subsequently approved;

40 (e) Lists of the ten durable medical equipment codes:

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

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

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

14 (f) Lists of the ten diabetes supplies and equipment codes:

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

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

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

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

32 (i) Expedited decisions;

33 (ii) Standard decisions; and

34 (iii) Extenuating circumstances decisions.

35 (2) For the October 1, 2020, reporting deadline, a carrier is not
36 required to report data pursuant to subsection (1)(a)(iii), (b)(iii),
37 (c)(iii), (d)(iii), (e)(iii), or (f)(iii) of this section until April
38 1, 2021, if the commissioner determines that doing so constitutes a
39 hardship.

1 (3) By January 1, 2021, and annually thereafter, the commissioner
2 shall aggregate and deidentify the data collected under subsection
3 (1) of this section into a standard report and may not identify the
4 name of the carrier that submitted the data. The initial report due
5 on January 1, 2021, may omit data for which a hardship determination
6 is made by the commissioner under subsection (2) of this section.
7 Such data must be included in the report due on January 1, 2022. The
8 commissioner must make the report available to interested parties.

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

11 (5) The commissioner may adopt rules to implement this section.
12 In adopting rules, the commissioner must consult stakeholders
13 including carriers, health care practitioners, health care
14 facilities, and patients.

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

23 Correct the title.

EFFECT: Removes the Prior Authorization Work Group and related provisions. Requires carriers to submit to the Insurance Commissioner the ten diabetes supplies and equipment codes and the ten durable medical equipment codes for the previous plan year that had the highest number of total authorization requests, had the highest prior authorization, and had the highest number of prior authorization requests that were initially denied and subsequently approved, and the average response times for each code. Allows a carrier to delay reporting of the codes with the highest percentage of prior authorization requests that were initially denied and subsequently approved for reporting year 2020 until April 2021, if the Commissioner determines reporting by the October 1, 2020, deadline would constitute a hardship.

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