ESSB 6404 - H COMM AMD
By Committee on Health Care & Wellness

ADOPTED AND ENGROSSED 3/5/20

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) By April 1, 2021, and annually thereafter, for individual and
6 group health plans issued by a carrier that has written at least one
7 percent of the total accident and health insurance premiums written
8 by all companies authorized to offer accident and health insurance in
9 Washington in the most recently available year, the carrier shall
10 report to the commissioner the following aggregated and deidentified
11 data related to the carrier's prior authorization practices and
12 experience for the prior plan year:
13 (a) Lists of the ten inpatient medical or surgical codes:
14 (i) With the highest total number of prior authorization requests
15 during the previous plan year, including the total number of prior
16 authorization requests for each code and the percent of approved
17 requests for each code;
18 (ii) With the highest percentage of approved prior authorization
19 requests during the previous plan year, including the total number of
20 prior authorization requests for each code and the percent of
21 approved requests for each code; and
22 (iii) With the highest percentage of prior authorization requests
23 that were initially denied and then subsequently approved on appeal,
24 including the total number of prior authorization requests for each
25 code and the percent of requests that were initially denied and then
26 subsequently approved for each code;
27 (b) Lists of the ten outpatient 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

prior authorization requests for each code and the percent of approved requests for each code; and

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

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

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

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

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

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

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

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

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

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

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior

authorization requests for each code and the percent of approved requests for each code;

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

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

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

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

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

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

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

(i) Expedited decisions;

(ii) Standard decisions; and

(iii) Extenuating circumstances decisions.

(2) By July 1, 2021, and annually thereafter, the commissioner shall aggregate and deidentify the data collected under subsection (1) of this section into a standard report and may not identify the name of the carrier that submitted the data. The commissioner must make the report available to interested parties.

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

1 (4) The commissioner may adopt rules to implement this section.
2 In adopting rules, the commissioner must consult stakeholders
3 including carriers, health care practitioners, health care
4 facilities, and patients.
5 (5) For the purpose of this section, "prior authorization" means
6 a mandatory process that a carrier or its designated or contracted
7 representative requires a provider or facility to follow before a
8 service is delivered, to determine if a service is a benefit and
9 meets the requirements for medical necessity, clinical
10 appropriateness, level of care, or effectiveness in relation to the
11 applicable plan, including any term used by a carrier or its
12 designated or contracted representative to describe this process."

13 Correct the title.

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