<u>ESSB 6404</u> - H COMM AMD
By Committee on Health Care & Wellness

ADOPTED AS AMENDED 03/05/2020

1 Strike everything after the enacting clause and insert the
2 following:
3 "<u>NEW SECTION.</u> **Sec. 1.** A new section is added to chapter 48.43
4 RCW to read as follows:
5 (1) By October 1, 2020, and annually thereafter, for individual
6 and group health plans issued by a carrier that has written at least
7 one percent of the total accident and health insurance premiums
8 written by all companies authorized to offer accident and health
9 insurance in Washington in the most recently available year, the
10 carrier shall report to the commissioner the following aggregated
11 and deidentified data related to the carrier's prior authorization
12 practices and 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
15 requests during the previous plan year, including the total number
16 of prior authorization requests for each code and the percent of
17 approved 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
20 of 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
23 requests that were initially denied and then subsequently approved
24 on appeal, including the total number of prior authorization
25 requests for each code and the percent of requests that were
26 initially denied and then subsequently approved for each code;
27 (b) Lists of the ten outpatient medical or surgical codes:

1 (i) With the highest total number of prior authorization
2 requests during the previous plan year, including the total number
3 of prior authorization requests for each code and the percent of
4 approved 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
7 of prior authorization requests for each code and the percent of
8 approved requests for each code; and
9 (iii) With the highest percentage of prior authorization
10 requests that were initially denied and then subsequently approved
11 on appeal, including the total number of prior authorization
12 requests for each code and the percent of requests that were
13 initially denied and then subsequently approved for each code;
14 (c) Lists of the ten inpatient mental health and substance use
15 disorder service codes:
16 (i) With the highest total number of prior authorization
17 requests during the previous plan year, including the total number
18 of prior authorization requests for each code and the percent of
19 approved requests for each code;
20 (ii) With the highest percentage of approved prior authorization
21 requests during the previous plan year, including the total number
22 of prior authorization requests for each code and the percent of
23 approved requests for each code;
24 (iii) With the highest percentage of prior authorization
25 requests that were initially denied and then subsequently approved
26 on appeal, including the total number of prior authorization
27 requests for each code and the percent of requests that were
28 initially denied and then subsequently approved for each code;
29 (d) Lists of the ten outpatient mental health and substance use
30 disorder service codes:
31 (i) With the highest total number of prior authorization
32 requests during the previous plan year, including the total number
33 of prior authorization requests for each code and the percent of
34 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; and

(e) The average determination response time in hours for prior authorization requests to the carrier with respect to each code reported under (a) through (d) 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 January 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.

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

(5) For the purpose of this section, "prior authorization" means a mandatory process that a carrier or its designated or contracted representative requires a provider or facility to follow before a service is delivered, to determine if a service is a benefit and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness in relation to the

1 applicable plan, including any term used by a carrier or its
2 designated or contracted representative to describe this process."
3

Correct the title.

EFFECT: Removes the Prior Authorization Work Group and related provisions.

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