FINAL BILL REPORT
ESSB 6404

C 316 L 20
Synopsis as Enacted

Brief Description: Adopting prior authorization and appropriate use criteria in patient care.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Frockt, O'Ban, Dhingra, Becker, Kuderer, Rivers, Lovelett, Wellman, Pedersen, Nguyen, Darneille, Hasegawa, McCoy, Wilson, C., Das, Conway and Saldaña).

Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means
House Committee on Health Care & Wellness

Background: Prior Authorization. Prior authorization is a requirement that a health care provider obtain approval from a patient's insurance plan to prescribe a specific medication or treatment. Health carriers may impose different prior authorization standards and criteria for a covered service among tiers of contracting providers.

In 2018, the Legislature prohibited health carriers from requiring prior authorization for initial evaluation and management visits, and up to six consecutive treatment visits in a new episode of care of chiropractic, physical therapy, occupational therapy, east Asian medicine, massage therapy, and speech and hearing therapies that meet the standards of medical necessity and are subject to quantitative treatment limits of the health plan.

Dr. Robert Bree Collaborative. The Dr. Robert Bree Collaborative (Collaborative) is an organization funded by the Health Care Authority (HCA) which convenes public and private stakeholders to improve the quality, health outcomes, and cost effectiveness of health care in Washington State. The Collaborative identifies health care services that have substantial variations in practice patterns or high use trends and investigates evidence-based practices that will improve quality and reduce variation in the use of the services. Members of the Collaborative are appointed by the Governor. The Collaborative has published reports on topics such as accountable payment models, addiction and dependence treatment, cardiovascular health, obstetrics, potentially avoidable hospital readmissions, and pediatric psychotropic use.

All state purchased health care programs must implement evidence-based best practice guidelines or protocols developed by the Collaborative after the HCA administrator, in consultation with participating agencies, has affirmatively reviewed and endorsed the

---

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

recommendations. Beginning in 2021, qualified health plans contracted by HCA to be offered on the individual market, will be required to incorporate recommendations of the Collaborative.

Summary: By October 1, 2020 and annually thereafter, for health plans issued by a carrier, a carrier must report the following deidentified and aggregated data to the insurance commissioner for the 2019 plan year:

- lists of the ten inpatient and lists of the ten outpatient medical or surgical codes, lists of ten inpatient and lists of ten outpatient mental health and substance use disorder codes**,** lists of the ten diabetes supplies and equipment codes, and lists of the ten durable medical equipment codes:
    - with the highest total number of prior authorization requests during the previous plan year, including the total number of requests and percent of approved requests for each code;
    - with the highest percentage of approved prior authorization requests during the previous plan year, including the total number of requests and percent of approved requests for each code;
    - with the highest percentage or prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of requests and the percent of requests initially denied and then subsequently approved for each code; and
- the average determination response time in hours for prior authorization requests to the plan with respect to each covered service included in the lists for each of the following categories:
    - expedited decisions;
    - standard decisions; and
    - extenuating circumstances decisions.

A carrier may delay reporting for 2020, the codes with the highest percentage of prior authorization requests that were initially denied and subsequently approved until April 1, 2021, if the commissioner determines the reporting of these codes would constitute a hardship.

By January 1, 2021, and annually thereafter, the commissioner must develop standardized reports of the data and make the reports available upon request to interested parties.

The commissioner may omit data for which a hardship determination is made in its 2021 report.

The commissioner may request additional data from carriers, in support of the prior authorization work group.

Votes on Final Passage:

Senate	48	0	
House	97	0	(House amended)
			(Senate refused to concur/asked House to recede)
House	97	0	(House receded/amended)
Senate	46	0	(Senate concurred)

Effective: June 11, 2020