

**2SHB 1357 - H AMD 266**

By Representatives Simmons, Schmick

**ADOPTED 03/04/2023**

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) Each carrier offering a health plan issued or renewed on or  
6 after January 1, 2024, shall comply with the following standards  
7 related to prior authorization for health care services and  
8 prescription drugs:

9 (a) The carrier shall meet the following time frames for prior  
10 authorization determinations and notifications to a participating  
11 provider or facility that submits the prior authorization request  
12 through an electronic prior authorization process, as designated by  
13 each carrier:

14 (i) For electronic standard prior authorization requests, the  
15 carrier shall make a decision and notify the provider or facility of  
16 the results of the decision within three calendar days, excluding  
17 holidays, of submission of an electronic prior authorization request  
18 by the provider or facility that contains the necessary information  
19 to make a determination. If insufficient information has been  
20 provided to the carrier to make a decision, the carrier shall request  
21 any additional information from the provider or facility within one  
22 calendar day of submission of the electronic prior authorization  
23 request.

24 (ii) For electronic expedited prior authorization requests, the  
25 carrier shall make a decision and notify the provider or facility of  
26 the results of the decision within one calendar day of submission of  
27 an electronic prior authorization request by the provider or facility  
28 that contains the necessary information to make a determination. If  
29 insufficient information has been provided to the carrier to make a  
30 decision, the carrier shall request any additional information from  
31 the provider or facility within one calendar day of submission of the  
32 electronic prior authorization request.

1 (b) The carrier shall meet the following time frames for prior  
2 authorization determinations and notifications to a participating  
3 provider or facility that submits the prior authorization request  
4 through a process other than an electronic prior authorization  
5 process:

6 (i) For nonelectronic standard prior authorization requests, the  
7 carrier shall make a decision and notify the provider or facility of  
8 the results of the decision within five calendar days of submission  
9 of a nonelectronic prior authorization request by the provider or  
10 facility that contains the necessary information to make a  
11 determination. If insufficient information has been provided to the  
12 carrier to make a decision, the carrier shall request any additional  
13 information from the provider or facility within five calendar days  
14 of submission of the nonelectronic prior authorization request.

15 (ii) For nonelectronic expedited prior authorization requests,  
16 the carrier shall make a decision and notify the provider or facility  
17 of the results of the decision within two calendar days of submission  
18 of a nonelectronic prior authorization request by the provider or  
19 facility that contains the necessary information to make a  
20 determination. If insufficient information has been provided to the  
21 carrier to make a decision, the carrier shall request any additional  
22 information from the provider or facility within one calendar day of  
23 submission of the nonelectronic prior authorization request.

24 (c) In any instance in which a carrier has determined that a  
25 provider or facility has not provided sufficient information for  
26 making a determination under (a) and (b) of this subsection, a  
27 carrier may establish a specific reasonable time frame for submission  
28 of the additional information. This time frame must be communicated  
29 to the provider or enrollee with a carrier's request for additional  
30 information.

31 (d) The carrier's prior authorization requirements must be  
32 described in detail and written in easily understandable language.  
33 The carrier shall make its most current prior authorization  
34 requirements and restrictions, including the written clinical review  
35 criteria, available to providers and facilities in an electronic  
36 format upon request. The prior authorization requirements must be  
37 based on peer-reviewed clinical review criteria. The clinical review  
38 criteria must be evidence-based criteria and must accommodate new and  
39 emerging information related to the appropriateness of clinical  
40 criteria with respect to black and indigenous people, other people of

1 color, gender, and underserved populations. The clinical review  
2 criteria must be evaluated and updated, if necessary, at least  
3 annually.

4 (2)(a) Each carrier shall build and maintain a prior  
5 authorization application programming interface that automates the  
6 process for in-network providers to determine whether a prior  
7 authorization is required, identify prior authorization information  
8 and documentation requirements, and facilitate the exchange of prior  
9 authorization requests and determinations from its electronic health  
10 records or practice management system. The application programming  
11 interface must:

12 (i) Use fast health care interoperability resources;

13 (ii) Automate the process to determine whether a prior  
14 authorization is required for durable medical equipment, a health  
15 care service, or a prescription drug;

16 (iii) Allow providers to query the carrier's prior authorization  
17 documentation requirements;

18 (iv) Support an automated approach using nonproprietary open  
19 workflows to compile and exchange the necessary data elements to  
20 populate the prior authorization requirements that are compliant with  
21 the federal health insurance portability and accountability act of  
22 1996 or have an exception from the federal centers for medicare and  
23 medicaid services; and

24 (v) Indicate that a prior authorization denial or authorization  
25 of a service less intensive than that included in the original  
26 request is an adverse benefit determination and is subject to the  
27 carrier's grievance and appeal process under RCW 48.43.535.

28 (b)(i) Beginning January 1, 2025, the application programming  
29 interface must support the exchange of prior authorization requests  
30 and determinations for health care services.

31 (ii) Beginning January 1, 2027, the application programming  
32 interface must support the exchange of prior authorization requests  
33 and determinations for prescription drugs, including information on  
34 covered alternative prescription drugs in the event of denials.

35 (c) If federal rules related to standards for using an  
36 application programming interface to communicate prior authorization  
37 status to providers are not finalized by the federal centers for  
38 medicare and medicaid services by September 13, 2023, the  
39 requirements of (b)(i) of this subsection may not be enforced until  
40 January 1, 2026.

1 (d) (i) If a carrier determines that it will not be able to  
2 satisfy the requirements of (a) of this subsection by January 1,  
3 2025, the carrier shall submit a narrative justification to the  
4 commissioner describing:

5 (A) The reasons that the carrier cannot reasonably satisfy the  
6 requirements;

7 (B) The impact of noncompliance upon providers and enrollees;

8 (C) The current or proposed means of providing health information  
9 to the providers; and

10 (D) A timeline and implementation plan to achieve compliance with  
11 the requirements.

12 (ii) The commissioner may grant a one-year delay in enforcement  
13 of the requirements of (a) of this subsection (2) if the commissioner  
14 determines that the carrier has made a good faith effort to comply  
15 with the requirements.

16 (iii) This subsection (2)(d) shall not apply if the delay in  
17 enforcement in (c) of this subsection takes effect because the  
18 federal centers for medicare and medicaid services did not finalize  
19 the applicable regulations by September 13, 2023.

20 (3) Nothing in this section applies to prior authorization  
21 determinations made pursuant to RCW 48.43.761.

22 (4) For the purposes of this section:

23 (a) "Expedited prior authorization request" means a request by a  
24 provider or facility for approval of a health care service or  
25 prescription drug where:

26 (i) The passage of time:

27 (A) Could seriously jeopardize the life or health of the  
28 enrollee;

29 (B) Could seriously jeopardize the enrollee's ability to regain  
30 maximum function; or

31 (C) In the opinion of a provider or facility with knowledge of  
32 the enrollee's medical condition, would subject the enrollee to  
33 severe pain that cannot be adequately managed without the health care  
34 service or prescription drug that is the subject of the request; or

35 (ii) The enrollee is undergoing a current course of treatment  
36 using a nonformulary drug.

37 (b) "Standard prior authorization request" means a request by a  
38 provider or facility for approval of a health care service or  
39 prescription drug where the request is made in advance of the

1 enrollee obtaining a health care service or prescription drug that is  
2 not required to be expedited.

3 NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05  
4 RCW to read as follows:

5 (1) A health plan offered to public employees, retirees, and  
6 their covered dependents under this chapter issued or renewed on or  
7 after January 1, 2024, shall comply with the following standards  
8 related to prior authorization for health care services and  
9 prescription drugs:

10 (a) The health plan shall meet the following time frames for  
11 prior authorization determinations and notifications to a  
12 participating provider or facility that submits the prior  
13 authorization request through an electronic prior authorization  
14 process:

15 (i) For electronic standard prior authorization requests, the  
16 health plan shall make a decision and notify the provider or facility  
17 of the results of the decision within three calendar days, excluding  
18 holidays, of submission of an electronic prior authorization request  
19 by the provider or facility that contains the necessary information  
20 to make a determination. If insufficient information has been  
21 provided to the health plan to make a decision, the health plan shall  
22 request any additional information from the provider or facility  
23 within one calendar day of submission of the electronic prior  
24 authorization request.

25 (ii) For electronic expedited prior authorization requests, the  
26 health plan shall make a decision and notify the provider or facility  
27 of the results of the decision within one calendar day of submission  
28 of an electronic prior authorization request by the provider or  
29 facility that contains the necessary information to make a  
30 determination. If insufficient information has been provided to the  
31 health plan to make a decision, the health plan shall request any  
32 additional information from the provider or facility within one  
33 calendar day of submission of the electronic prior authorization  
34 request.

35 (b) The health plan shall meet the following time frames for  
36 prior authorization determinations and notifications to a  
37 participating provider or facility that submits the prior  
38 authorization request through a process other than an electronic

1 prior authorization process described in subsection (2) of this  
2 section:

3 (i) For nonelectronic standard prior authorization requests, the  
4 health plan shall make a decision and notify the provider or facility  
5 of the results of the decision within five calendar days of  
6 submission of a nonelectronic prior authorization request by the  
7 provider or facility that contains the necessary information to make  
8 a determination. If insufficient information has been provided to the  
9 health plan to make a decision, the health plan shall request any  
10 additional information from the provider or facility within five  
11 calendar days of submission of the nonelectronic prior authorization  
12 request.

13 (ii) For nonelectronic expedited prior authorization requests,  
14 the health plan shall make a decision and notify the provider or  
15 facility of the results of the decision within two calendar days of  
16 submission of a nonelectronic prior authorization request by the  
17 provider or facility that contains the necessary information to make  
18 a determination. If insufficient information has been provided to the  
19 health plan to make a decision, the health plan shall request any  
20 additional information from the provider or facility within one  
21 calendar day of submission of the nonelectronic prior authorization  
22 request.

23 (c) In any instance in which the health plan has determined that  
24 a provider or facility has not provided sufficient information for  
25 making a determination under (a) and (b) of this subsection, the  
26 health plan may establish a specific reasonable time frame for  
27 submission of the additional information. This time frame must be  
28 communicated to the provider or enrollee with the health plan's  
29 request for additional information.

30 (d) The prior authorization requirements of the health plan must  
31 be described in detail and written in easily understandable language.  
32 The health plan shall make its most current prior authorization  
33 requirements and restrictions, including the written clinical review  
34 criteria, available to providers and facilities in an electronic  
35 format upon request. The prior authorization requirements must be  
36 based on peer-reviewed clinical review criteria. The clinical review  
37 criteria must be evidence-based criteria and must accommodate new and  
38 emerging information related to the appropriateness of clinical  
39 criteria with respect to black and indigenous people, other people of  
40 color, gender, and underserved populations. The clinical review

1 criteria must be evaluated and updated, if necessary, at least  
2 annually.

3 (2) (a) Each health plan offered to public employees, retirees,  
4 and their covered dependents under this chapter shall build and  
5 maintain a prior authorization application programming interface that  
6 automates the process for in-network providers to determine whether a  
7 prior authorization is required, identify prior authorization  
8 information and documentation requirements, and facilitate the  
9 exchange of prior authorization requests and determinations from its  
10 electronic health records or practice management system. The  
11 application programming interface must:

12 (i) Use fast health care interoperability resources;

13 (ii) Automate the process to determine whether a prior  
14 authorization is required for durable medical equipment, a health  
15 care service, or a prescription drug;

16 (iii) Allow providers to query the health plan's prior  
17 authorization documentation requirements;

18 (iv) Support an automated approach using nonproprietary open  
19 workflows to compile and exchange the necessary data elements to  
20 populate the prior authorization requirements that are compliant with  
21 the federal health insurance portability and accountability act of  
22 1996 or have an exception from the federal centers for medicare and  
23 medicaid services; and

24 (v) Indicate that a prior authorization denial or authorization  
25 of a service less intensive than that included in the original  
26 request is an adverse benefit determination and is subject to the  
27 health plan's grievance and appeal process under RCW 48.43.535.

28 (b) (i) Beginning January 1, 2025, the application programming  
29 interface must support the exchange of prior authorization requests  
30 and determinations for health care services.

31 (ii) Beginning January 1, 2027, the application programming  
32 interface must support the exchange of prior authorization requests  
33 and determinations for prescription drugs, including information on  
34 covered alternative prescription drugs in the event of denials.

35 (c) If federal rules related to standards for using an  
36 application programming interface to communicate prior authorization  
37 status to providers are not finalized by the federal centers for  
38 medicare and medicaid services by September 13, 2023, the  
39 requirements of (b) (i) of this subsection may not be enforced until  
40 January 1, 2026.

1 (d) (i) If the health plan determines that it will not be able to  
2 satisfy the requirements of (a) of this subsection by January 1,  
3 2025, the health plan shall submit a narrative justification to the  
4 authority describing:

5 (A) The reasons that the health plan cannot reasonably satisfy  
6 the requirements;

7 (B) The impact of noncompliance upon providers and enrollees;

8 (C) The current or proposed means of providing health information  
9 to the providers; and

10 (D) A timeline and implementation plan to achieve compliance with  
11 the requirements.

12 (ii) The authority may grant a one-year delay in enforcement of  
13 the requirements of (a) of this subsection (2) if the authority  
14 determines that the health plan has made a good faith effort to  
15 comply with the requirements.

16 (iii) This subsection (2)(d) shall not apply if the delay in  
17 enforcement in (c) of this subsection takes effect because the  
18 federal centers for medicare and medicaid services did not finalize  
19 the applicable regulations by September 13, 2023.

20 (3) Nothing in this section applies to prior authorization  
21 determinations made pursuant to RCW 41.05.526.

22 (4) For the purposes of this section:

23 (a) "Expedited prior authorization request" means a request by a  
24 provider or facility for approval of a health care service or  
25 prescription drug where:

26 (i) The passage of time:

27 (A) Could seriously jeopardize the life or health of the  
28 enrollee;

29 (B) Could seriously jeopardize the enrollee's ability to regain  
30 maximum function; or

31 (C) In the opinion of a provider or facility with knowledge of  
32 the enrollee's medical condition, would subject the enrollee to  
33 severe pain that cannot be adequately managed without the health care  
34 service or prescription drug that is the subject of the request; or

35 (ii) The enrollee is undergoing a current course of treatment  
36 using a nonformulary drug.

37 (b) "Standard prior authorization request" means a request by a  
38 provider or facility for approval of a health care service or  
39 prescription drug where the request is made in advance of the



1 enrollee obtaining a health care service that is not required to be  
2 expedited.

3 NEW SECTION. **Sec. 3.** A new section is added to chapter 74.09  
4 RCW to read as follows:

5 (1) Beginning January 1, 2024, the authority shall require each  
6 managed care organization to comply with the following standards  
7 related to prior authorization for health care services and  
8 prescription drugs:

9 (a) The managed care organization shall meet the following time  
10 frames for prior authorization determinations and notifications to a  
11 participating provider or facility that submits the prior  
12 authorization request through an electronic prior authorization  
13 process, as designated by each managed care organization:

14 (i) For electronic standard prior authorization requests, the  
15 managed care organization shall make a decision and notify the  
16 provider or facility of the results of the decision within three  
17 calendar days, excluding holidays, of submission of an electronic  
18 prior authorization request by the provider or facility that contains  
19 the necessary information to make a determination. If insufficient  
20 information has been provided to the managed care organization to  
21 make a decision, the managed care organization shall request any  
22 additional information from the provider or facility within one  
23 calendar day of submission of the electronic prior authorization  
24 request.

25 (ii) For electronic expedited prior authorization requests, the  
26 managed care organization shall make a decision and notify the  
27 provider or facility of the results of the decision within one  
28 calendar day of submission of an electronic prior authorization  
29 request by the provider or facility that contains the necessary  
30 information to make a determination. If insufficient information has  
31 been provided to the managed care organization to make a decision,  
32 the managed care organization shall request any additional  
33 information from the provider or facility within one calendar day of  
34 submission of the electronic prior authorization request.

35 (b) The managed care organization shall meet the following time  
36 frames for prior authorization determinations and notifications to a  
37 participating provider or facility that submits the prior  
38 authorization request through a process other than an electronic

1 prior authorization process described in subsection (2) of this  
2 section:

3 (i) For nonelectronic standard prior authorization requests, the  
4 managed care organization shall make a decision and notify the  
5 provider or facility of the results of the decision within five  
6 calendar days of submission of a nonelectronic prior authorization  
7 request by the provider or facility that contains the necessary  
8 information to make a determination. If insufficient information has  
9 been provided to the managed care organization to make a decision,  
10 the managed care organization shall request any additional  
11 information from the provider or facility within five calendar days  
12 of submission of the nonelectronic prior authorization request.

13 (ii) For nonelectronic expedited prior authorization requests,  
14 the managed care organization shall make a decision and notify the  
15 provider or facility of the results of the decision within two  
16 calendar days of submission of a nonelectronic prior authorization  
17 request by the provider or facility that contains the necessary  
18 information to make a determination. If insufficient information has  
19 been provided to the managed care organization to make a decision,  
20 the managed care organization shall request any additional  
21 information from the provider or facility within one calendar day of  
22 submission of the nonelectronic prior authorization request.

23 (c) In any instance in which a managed care organization has  
24 determined that a provider or facility has not provided sufficient  
25 information for making a determination under (a) and (b) of this  
26 subsection, a managed care organization may establish a specific  
27 reasonable time frame for submission of the additional information.  
28 This time frame must be communicated to the provider or enrollee with  
29 a managed care organization's request for additional information.

30 (d) The prior authorization requirements of the managed care  
31 organization must be described in detail and written in easily  
32 understandable language. The managed care organization shall make its  
33 most current prior authorization requirements and restrictions,  
34 including the written clinical review criteria, available to  
35 providers and facilities in an electronic format upon request. The  
36 prior authorization requirements must be based on peer-reviewed  
37 clinical review criteria. The clinical review criteria must be  
38 evidence-based criteria and must accommodate new and emerging  
39 information related to the appropriateness of clinical criteria with  
40 respect to black and indigenous people, other people of color,

1 gender, and underserved populations. The clinical review criteria  
2 must be evaluated and updated, if necessary, at least annually.

3 (2) (a) Each managed care organization shall build and maintain a  
4 prior authorization application programming interface that automates  
5 the process for in-network providers to determine whether a prior  
6 authorization is required, identify prior authorization information  
7 and documentation requirements, and facilitate the exchange of prior  
8 authorization requests and determinations from its electronic health  
9 records or practice management system. The application programming  
10 interface must:

11 (i) Use fast health care interoperability resources;

12 (ii) Automate the process to determine whether a prior  
13 authorization is required for durable medical equipment, a health  
14 care service, or a prescription drug;

15 (iii) Allow providers to query the managed care organization's  
16 prior authorization documentation requirements;

17 (iv) Support an automated approach using nonproprietary open  
18 workflows to compile and exchange the necessary data elements to  
19 populate the prior authorization requirements that are compliant with  
20 the federal health insurance portability and accountability act of  
21 1996 or have an exception from the federal centers for medicare and  
22 medicaid services; and

23 (v) Indicate that a prior authorization denial or authorization  
24 of a service less intensive than that included in the original  
25 request is an adverse benefit determination and is subject to the  
26 managed care organization's grievance and appeal process under RCW  
27 48.43.535.

28 (b) (i) Beginning January 1, 2025, the application programming  
29 interface must support the exchange of prior authorization requests  
30 and determinations for health care services.

31 (ii) Beginning January 1, 2027, the application programming  
32 interface must support the exchange of prior authorization requests  
33 and determinations for prescription drugs, including information on  
34 covered alternative prescription drugs in the event of denials.

35 (c) If federal rules related to standards for using an  
36 application programming interface to communicate prior authorization  
37 status to providers are not finalized by September 13, 2023, the  
38 requirements of (b) (i) of this subsection may not be enforced until  
39 January 1, 2026.

1 (d) (i) If a managed care organization determines that it will not  
2 be able to satisfy the requirements of (a) of this subsection by  
3 January 1, 2025, the managed care organization shall submit a  
4 narrative justification to the authority describing:

5 (A) The reasons that the managed care organization cannot  
6 reasonably satisfy the requirements;

7 (B) The impact of noncompliance upon providers and enrollees;

8 (C) The current or proposed means of providing health information  
9 to the providers; and

10 (D) A timeline and implementation plan to achieve compliance with  
11 the requirements.

12 (ii) The authority may grant a one-year delay in enforcement of  
13 the requirements of (a) of this subsection (2) if the authority  
14 determines that the managed care organization has made a good faith  
15 effort to comply with the requirements.

16 (iii) This subsection (2)(d) shall not apply if the delay in  
17 enforcement in (c) of this subsection takes effect because the  
18 federal centers for medicare and medicaid services did not finalize  
19 the applicable regulations by September 13, 2023.

20 (3) Nothing in this section applies to prior authorization  
21 determinations made pursuant to RCW 71.24.618.

22 (4) For the purposes of this section:

23 (a) "Expedited prior authorization request" means a request by a  
24 provider or facility for approval of a health care service or  
25 prescription drug where:

26 (i) The passage of time:

27 (A) Could seriously jeopardize the life or health of the  
28 enrollee;

29 (B) Could seriously jeopardize the enrollee's ability to regain  
30 maximum function; or

31 (C) In the opinion of a provider or facility with knowledge of  
32 the enrollee's medical condition, would subject the enrollee to  
33 severe pain that cannot be adequately managed without the health care  
34 service or prescription drug that is the subject of the request; or

35 (ii) The enrollee is undergoing a current course of treatment  
36 using a nonformulary drug.

37 (b) "Standard prior authorization request" means a request by a  
38 provider or facility for approval of a health care service or  
39 prescription drug where the request is made in advance of the

1 enrollee obtaining a health care service or prescription drug that is  
2 not required to be expedited.

3 **Sec. 4.** RCW 48.43.0161 and 2020 c 316 s 1 are each amended to  
4 read as follows:

5 (1) (~~Except as provided in subsection (2) of this section, by~~)  
6 By 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~~) 10 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~~) 10 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;

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

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

1 code and the percent of requests that were initially denied and then  
2 subsequently approved for each code;

3 (c) Lists of the (~~ten~~) 10 inpatient mental health and substance  
4 use disorder service codes:

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

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

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

18 (d) Lists of the (~~ten~~) 10 outpatient mental health and  
19 substance use disorder service codes:

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

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

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

33 (e) Lists of the (~~ten~~) 10 durable medical equipment codes:

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

38 (ii) With the highest percentage of approved prior authorization  
39 requests during the previous plan year, including the total number of

1 prior authorization requests for each code and the percent of  
2 approved requests for each code; (~~(and)~~) and

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

8 (f) Lists of the (~~ten~~) 10 diabetes supplies and equipment  
9 codes:

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

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

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

23 (g) Lists of the 10 prescription drugs:

24 (i) With the highest total number of prior authorization requests  
25 during the previous plan year, including the total number of prior  
26 authorization requests for each prescription drug and the percent of  
27 approved requests for each prescription drug;

28 (ii) With the highest percentage of approved prior authorization  
29 requests during the previous plan year, including the total number of  
30 prior authorization requests for each prescription drug and the  
31 percent of approved requests for each prescription drug; and

32 (iii) With the highest percentage of prior authorization requests  
33 that were initially denied and then subsequently approved on appeal,  
34 including the total number of prior authorization requests for each  
35 prescription drug and the percent of requests that were initially  
36 denied and then subsequently approved for each prescription drug; and

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

- 1 (i) Expedited decisions;
- 2 (ii) Standard decisions; and
- 3 (iii) Extenuating circumstances decisions.

4 (2) ~~((For the October 1, 2020, reporting deadline, a carrier is~~  
5 ~~not required to report data pursuant to subsection (1)(a)(iii),~~  
6 ~~(b)(iii), (c)(iii), (d)(iii), (e)(iii), or (f)(iii) of this section~~  
7 ~~until April 1, 2021, if the commissioner determines that doing so~~  
8 ~~constitutes a hardship.~~

9 ~~(3))~~ By January 1, 2021, and annually thereafter, the  
10 commissioner shall aggregate and deidentify the data collected under  
11 subsection (1) of this section into a standard report and may not  
12 identify the name of the carrier that submitted the data. ~~((The~~  
13 ~~initial report due on January 1, 2021, may omit data for which a~~  
14 ~~hardship determination is made by the commissioner under subsection~~  
15 ~~(2) of this section. Such data must be included in the report due on~~  
16 ~~January 1, 2022.))~~ The commissioner must make the report available to  
17 interested parties.

18 ~~((4))~~ (3) The commissioner may request additional information  
19 from carriers reporting data under this section.

20 ~~((5))~~ (4) The commissioner may adopt rules to implement this  
21 section. In adopting rules, the commissioner must consult  
22 stakeholders including carriers, health care practitioners, health  
23 care facilities, and patients.

24 ~~((6))~~ (5) For the purpose of this section, "prior  
25 authorization" means a mandatory process that a carrier or its  
26 designated or contracted representative requires a provider or  
27 facility to follow before a service is delivered, to determine if a  
28 service is a benefit and meets the requirements for medical  
29 necessity, clinical appropriateness, level of care, or effectiveness  
30 in relation to the applicable plan, including any term used by a  
31 carrier or its designated or contracted representative to describe  
32 this process.

33 NEW SECTION. **Sec. 5.** Section 4 of this act takes effect January  
34 1, 2024.

35 NEW SECTION. **Sec. 6.** If specific funding for the purposes of  
36 this act, referencing this act by bill or chapter number, is not



1 provided by June 30, 2023, in the omnibus appropriations act, this  
2 act is null and void."

3 Correct the title.

EFFECT: Requires that an implementation plan be submitted when a health carrier, health plan, or managed care organization requests an extension for implementing its prior authorization application programming interface. Removes the requirement that the electronic prior authorization process be a "standardized" process in order for the prior authorization timelines to apply.

Restores existing law related to prescription drug utilization management requirements and clarifies that the changes to prescription drug standards only apply to prior authorization timelines, but not exception requests.

Adds retirees to the prior authorization provisions related to public employees. Changes references to "carriers" to "health plans" in the prior authorization provisions related to public employees.

Changes references to "managed health care systems" to "managed care organizations" in the prior authorization provisions related to medical assistance programs. Conforms the reference to federal rules in the provisions related to managed care organizations to be similar to the references in the provisions related to health carriers and health plans.

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