
SECOND SUBSTITUTE HOUSE BILL 1357

State of Washington

68th Legislature

2023 Regular Session

By House Appropriations (originally sponsored by Representatives Simmons, Schmick, Stonier, Cortes, Reed, Bateman, Harris, Alvarado, Pollet, and Caldier)

READ FIRST TIME 02/24/23.

1 AN ACT Relating to modernizing the prior authorization process;
2 amending RCW 48.43.420, 48.43.0161, and 48.43.400; adding a new
3 section to chapter 48.43 RCW; adding a new section to chapter 41.05
4 RCW; adding a new section to chapter 74.09 RCW; creating a new
5 section; repealing RCW 48.43.410; and providing an effective date.

6 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

7 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43
8 RCW to read as follows:

9 (1) Each carrier offering a health plan issued or renewed on or
10 after January 1, 2024, shall comply with the following standards
11 related to prior authorization:

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

17 (i) For electronic standard prior authorization requests, the
18 carrier shall make a decision and notify the provider or facility of
19 the results of the decision within three calendar days, excluding
20 holidays, of submission of an electronic prior authorization request
21 by the provider or facility that contains the necessary information

1 to make a determination. If insufficient information has been
2 provided to the carrier to make a decision, the carrier shall request
3 any additional information from the provider or facility within one
4 calendar day of submission of the electronic prior authorization
5 request.

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

15 (b) The carrier shall meet the following time frames for prior
16 authorization determinations and notifications to a participating
17 provider or facility that submits the prior authorization request
18 through a process other than an electronic standardized prior
19 authorization process described in subsection (2) of this section:

20 (i) For nonelectronic standard prior authorization requests, the
21 carrier shall make a decision and notify the provider or facility of
22 the results of the decision within five calendar days of submission
23 of a nonelectronic prior authorization request by the provider or
24 facility that contains the necessary information to make a
25 determination. If insufficient information has been provided to the
26 carrier to make a decision, the carrier shall request any additional
27 information from the provider or facility within five calendar days
28 of submission of the nonelectronic prior authorization request.

29 (ii) For nonelectronic expedited prior authorization requests,
30 the carrier shall make a decision and notify the provider or facility
31 of the results of the decision within two calendar days of submission
32 of a nonelectronic prior authorization request by the provider or
33 facility that contains the necessary information to make a
34 determination. If insufficient information has been provided to the
35 carrier to make a decision, the carrier shall request any additional
36 information from the provider or facility within one calendar day of
37 submission of the nonelectronic prior authorization request.

38 (c) In any instance in which a carrier has determined that a
39 provider or facility has not provided sufficient information for
40 making a determination under (a) and (b) of this subsection, a

1 carrier may establish a specific reasonable time frame for submission
2 of the additional information. This time frame must be communicated
3 to the provider or enrollee with a carrier's request for additional
4 information.

5 (d) The carrier's prior authorization requirements must be
6 described in detail and written in easily understandable language.
7 The carrier shall make its most current prior authorization
8 requirements and restrictions, including the written clinical review
9 criteria, available to providers and facilities in an electronic
10 format upon request. The prior authorization requirements must be
11 based on peer-reviewed clinical review criteria. The clinical review
12 criteria must be evidence-based criteria and must accommodate new and
13 emerging information related to the appropriateness of clinical
14 criteria with respect to black and indigenous people, other people of
15 color, gender, and underserved populations. The clinical review
16 criteria must be evaluated and updated, if necessary, at least
17 annually.

18 (2) (a) Each carrier shall build and maintain a prior
19 authorization application programming interface that automates the
20 process for in-network providers to determine whether a prior
21 authorization is required, identify prior authorization information
22 and documentation requirements, and facilitate the exchange of prior
23 authorization requests and determinations from its electronic health
24 records or practice management system. The application programming
25 interface must:

26 (i) Use fast health care interoperability resources;

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

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

32 (iv) Support an automated approach using nonproprietary open
33 workflows to compile and exchange the necessary data elements to
34 populate the prior authorization requirements that are compliant with
35 the federal health insurance portability and accountability act of
36 1996 or have an exception from the federal centers for medicare and
37 medicaid services; and

38 (v) Indicate that a prior authorization denial or authorization
39 of a service less intensive than that included in the original

1 request is an adverse benefit determination and is subject to the
2 carrier's grievance and appeal process under RCW 48.43.535.

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

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

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

16 (d) (i) If a carrier determines that it will not be able to
17 satisfy the requirements of (a) of this subsection by January 1,
18 2025, the carrier shall submit a narrative justification to the
19 commissioner describing:

20 (A) The reasons that the carrier cannot reasonably satisfy the
21 requirements;

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

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

25 (D) A timeline to achieve compliance with the requirements.

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

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

34 (3) Nothing in this section applies to prior authorization
35 determinations made pursuant to RCW 48.43.400 through 48.43.420 or
36 48.43.761.

37 (4) For the purposes of this section:

38 (a) "Expedited prior authorization request" means a request by a
39 provider or facility for approval of a health care service or

1 prescription drug, including exception requests addressed in RCW
2 48.43.420, where:

3 (i) The passage of time:

4 (A) Could seriously jeopardize the life or health of the
5 enrollee;

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

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

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

14 (b) "Standard prior authorization request" means a request by a
15 provider or facility for approval of a health care service or
16 prescription drug where the request is made in advance of the
17 enrollee obtaining a health care service or prescription drug that is
18 not required to be expedited. The term includes exception requests
19 referenced in RCW 48.43.420.

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

22 (1) A health plan offered to public employees and their covered
23 dependents under this chapter issued or renewed on or after January
24 1, 2024, shall comply with the following standards related to prior
25 authorization:

26 (a) The carrier offering the health plan shall meet the following
27 time frames for prior authorization determinations and notifications
28 to a participating provider or facility that submits the prior
29 authorization request through an electronic standardized prior
30 authorization process:

31 (i) For electronic standard prior authorization requests, the
32 carrier shall make a decision and notify the provider or facility of
33 the results of the decision within three calendar days, excluding
34 holidays, of submission of an electronic prior authorization request
35 by the provider or facility that contains the necessary information
36 to make a determination. If insufficient information has been
37 provided to the carrier to make a decision, the carrier shall request
38 any additional information from the provider or facility within one

1 calendar day of submission of the electronic prior authorization
2 request.

3 (ii) For electronic expedited prior authorization requests, the
4 carrier shall make a decision and notify the provider or facility of
5 the results of the decision within one calendar day of submission of
6 an electronic prior authorization request by the provider or facility
7 that contains the necessary information to make a determination. If
8 insufficient information has been provided to the carrier to make a
9 decision, the carrier shall request any additional information from
10 the provider or facility within one calendar day of submission of the
11 electronic prior authorization request.

12 (b) The carrier shall meet the following time frames for prior
13 authorization determinations and notifications to a participating
14 provider or facility that submits the prior authorization request
15 through a process other than an electronic standardized prior
16 authorization process described in subsection (2) of this section:

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

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

35 (c) In any instance in which a carrier has determined that a
36 provider or facility has not provided sufficient information for
37 making a determination under (a) and (b) of this subsection, a
38 carrier may establish a specific reasonable time frame for submission
39 of the additional information. This time frame must be communicated

1 to the provider or enrollee with a carrier's request for additional
2 information.

3 (d) The prior authorization requirements of the carrier offering
4 the health plan must be described in detail and written in easily
5 understandable language. The carrier shall make its most current
6 prior authorization requirements and restrictions, including the
7 written clinical review criteria, available to providers and
8 facilities in an electronic format upon request. The prior
9 authorization requirements must be based on peer-reviewed clinical
10 review criteria. The clinical review criteria must be evidence-based
11 criteria and must accommodate new and emerging information related to
12 the appropriateness of clinical criteria with respect to black and
13 indigenous people, other people of color, gender, and underserved
14 populations. The clinical review criteria must be evaluated and
15 updated, if necessary, at least annually.

16 (2)(a) Each carrier shall build and maintain a prior
17 authorization application programming interface that automates the
18 process for in-network providers to determine whether a prior
19 authorization is required, identify prior authorization information
20 and documentation requirements, and facilitate the exchange of prior
21 authorization requests and determinations from its electronic health
22 records or practice management system. The application programming
23 interface must:

24 (i) Use fast health care interoperability resources;

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

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

30 (iv) Support an automated approach using nonproprietary open
31 workflows to compile and exchange the necessary data elements to
32 populate the prior authorization requirements that are compliant with
33 the federal health insurance portability and accountability act of
34 1996 or have an exception from the federal centers for medicare and
35 medicaid services; and

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

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

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

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

14 (d) (i) If a carrier determines that it will not be able to
15 satisfy the requirements of (a) of this subsection by January 1,
16 2025, the carrier shall submit a narrative justification to the
17 commissioner describing:

18 (A) The reasons that the carrier cannot reasonably satisfy the
19 requirements;

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

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

23 (D) A timeline to achieve compliance with the requirements.

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

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

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

34 (4) For the purposes of this section:

35 (a) "Expedited prior authorization request" means a request by a
36 provider or facility for approval of a health care service or
37 prescription drug, including exception requests addressed in RCW
38 48.43.420, where:

39 (i) The passage of time:

1 (A) Could seriously jeopardize the life or health of the
2 enrollee;

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

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

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

11 (b) "Standard prior authorization request" means a request by a
12 provider or facility for approval of a health care service or
13 prescription drug where the request is made in advance of the
14 enrollee obtaining a health care service that is not required to be
15 expedited. The term includes exception requests referenced in RCW
16 48.43.420.

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

19 (1) Beginning January 1, 2024, the authority shall require all
20 managed health care systems, including managed care organizations, to
21 comply with the following standards related to prior authorization:

22 (a) The managed health care system shall meet the following time
23 frames for prior authorization determinations and notifications to a
24 participating provider or facility that submits the prior
25 authorization request through an electronic standardized prior
26 authorization process, as designated by each managed health care
27 system:

28 (i) For electronic standard prior authorization requests, the
29 managed health care system shall make a decision and notify the
30 provider or facility of the results of the decision within three
31 calendar days, excluding holidays, of submission of an electronic
32 prior authorization request by the provider or facility that contains
33 the necessary information to make a determination. If insufficient
34 information has been provided to the managed health care system to
35 make a decision, the managed health care system shall request any
36 additional information from the provider or facility within one
37 calendar day of submission of the electronic prior authorization
38 request.

1 (ii) For electronic expedited prior authorization requests, the
2 managed health care system shall make a decision and notify the
3 provider or facility of the results of the decision within one
4 calendar day of submission of an electronic prior authorization
5 request by the provider or facility that contains the necessary
6 information to make a determination. If insufficient information has
7 been provided to the managed health care system to make a decision,
8 the managed health care system shall request any additional
9 information from the provider or facility within one calendar day of
10 submission of the electronic prior authorization request.

11 (b) The managed health care system shall meet the following time
12 frames for prior authorization determinations and notifications to a
13 participating provider or facility that submits the prior
14 authorization request through a process other than an electronic
15 standardized prior authorization process described in subsection (2)
16 of this section:

17 (i) For nonelectronic standard prior authorization requests, the
18 managed health care system shall make a decision and notify the
19 provider or facility of the results of the decision within five
20 calendar days of submission of a nonelectronic prior authorization
21 request by the provider or facility that contains the necessary
22 information to make a determination. If insufficient information has
23 been provided to the managed health care system to make a decision,
24 the managed health care system shall request any additional
25 information from the provider or facility within five calendar days
26 of submission of the nonelectronic prior authorization request.

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

37 (c) In any instance in which a managed health care system has
38 determined that a provider or facility has not provided sufficient
39 information for making a determination under (a) and (b) of this
40 subsection, a managed health care system may establish a specific

1 reasonable time frame for submission of the additional information.
2 This time frame must be communicated to the provider or enrollee with
3 a managed health care system's request for additional information.

4 (d) The prior authorization requirements of the managed health
5 care system must be described in detail and written in easily
6 understandable language. The managed health care system shall make
7 its most current prior authorization requirements and restrictions,
8 including the written clinical review criteria, available to
9 providers and facilities in an electronic format upon request. The
10 prior authorization requirements must be based on peer-reviewed
11 clinical review criteria. The clinical review criteria must be
12 evidence-based criteria and must accommodate new and emerging
13 information related to the appropriateness of clinical criteria with
14 respect to black and indigenous people, other people of color,
15 gender, and underserved populations. The clinical review criteria
16 must be evaluated and updated, if necessary, at least annually.

17 (2)(a) Each managed health care system, including managed care
18 organizations, shall build and maintain a prior authorization
19 application programming interface that automates the process for in-
20 network providers to determine whether a prior authorization is
21 required, identify prior authorization information and documentation
22 requirements, and facilitate the exchange of prior authorization
23 requests and determinations from its electronic health records or
24 practice management system. The application programming interface
25 must:

26 (i) Use fast health care interoperability resources;

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

30 (iii) Allow providers to query the managed health care system's
31 prior authorization documentation requirements;

32 (iv) Support an automated approach using nonproprietary open
33 workflows to compile and exchange the necessary data elements to
34 populate the prior authorization requirements that are compliant with
35 the federal health insurance portability and accountability act of
36 1996 or have an exception from the federal centers for medicare and
37 medicaid services; and

38 (v) Indicate that a prior authorization denial or authorization
39 of a service less intensive than that included in the original
40 request is an adverse benefit determination and is subject to the

1 managed health care system's grievance and appeal process under RCW
2 48.43.535.

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

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

10 (c) If the federal rules to adopt 45 C.F.R. Sec. 156.223 are not
11 finalized by September 13, 2023, the requirements of (b) (i) of this
12 subsection may not be enforced until January 1, 2026.

13 (d) (i) If a managed health care system determines that it will
14 not be able to satisfy the requirements of (a) of this subsection by
15 January 1, 2025, the managed health care system shall submit a
16 narrative justification to the authority describing:

17 (A) The reasons that the managed health care system cannot
18 reasonably satisfy the requirements;

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

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

22 (D) A timeline to achieve compliance with the requirements.

23 (ii) The authority may grant a one-year delay in enforcement of
24 the requirements of (a) of this subsection (2) if the authority
25 determines that the managed health care system has made a good faith
26 effort to comply with the requirements.

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

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

33 (4) For the purposes of this section:

34 (a) "Expedited prior authorization request" means a request by a
35 provider or facility for approval of a health care service or
36 prescription drug where:

37 (i) The passage of time:

38 (A) Could seriously jeopardize the life or health of the
39 enrollee;

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

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

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

9 (b) "Standard prior authorization request" means a request by a
10 provider or facility for approval of a health care service or
11 prescription drug where the request is made in advance of the
12 enrollee obtaining a health care service or prescription drug that is
13 not required to be expedited.

14 **Sec. 4.** RCW 48.43.420 and 2019 c 171 s 3 are each amended to
15 read as follows:

16 For health plans delivered, issued for delivery, or renewed on or
17 after January 1, 2021:

18 (1) When coverage of a prescription drug for the treatment of any
19 medical condition is subject to prescription drug utilization
20 management, the patient and prescribing practitioner must have access
21 to a clear, readily accessible, and convenient process to request an
22 exception through which the prescription drug utilization management
23 can be overridden in favor of coverage of a prescription drug
24 prescribed by a treating health care provider. A health carrier or
25 prescription drug utilization management entity may use its existing
26 medical exceptions process to satisfy this requirement. The process
27 must be easily accessible on the health carrier and prescription drug
28 utilization management entity's website. Approval criteria must be
29 clearly posted on the health carrier and prescription drug
30 utilization management entity's website. This information must be in
31 plain language and understandable to providers and patients.

32 (2) Health carriers must disclose all rules and criteria related
33 to the prescription drug utilization management process to all
34 participating providers, including the specific information and
35 documentation that must be submitted by a health care provider or
36 patient to be considered a complete exception request.

37 (3) An exception request must be granted if the health carrier or
38 prescription drug utilization management entity determines that the

1 evidence submitted by the provider or patient is sufficient to
2 establish that:

3 (a) The required prescription drug is contraindicated or will
4 likely cause a clinically predictable adverse reaction by the
5 patient;

6 (b) The required prescription drug is expected to be ineffective
7 based on the known clinical characteristics of the patient and the
8 known characteristics of the prescription drug regimen;

9 (c) The patient has tried the required prescription drug or
10 another prescription drug in the same pharmacologic class or a drug
11 with the same mechanism of action while under his or her current or a
12 previous health plan, and such prescription drug was discontinued due
13 to lack of efficacy or effectiveness, diminished effect, or an
14 adverse event;

15 (d) The patient is currently experiencing a positive therapeutic
16 outcome on a prescription drug recommended by the patient's provider
17 for the medical condition under consideration while on his or her
18 current or immediately preceding health plan, and changing to the
19 required prescription drug may cause clinically predictable adverse
20 reactions, or physical or mental harm to, the patient; or

21 (e) The required prescription drug is not in the best interest of
22 the patient, based on documentation of medical appropriateness,
23 because the patient's use of the prescription drug is expected to:

24 (i) Create a barrier to the patient's adherence to or compliance
25 with the patient's plan of care;

26 (ii) Negatively impact a comorbid condition of the patient;

27 (iii) Cause a clinically predictable negative drug
28 interaction; or

29 (iv) Decrease the patient's ability to achieve or maintain
30 reasonable functional ability in performing daily activities.

31 (4) Upon the granting of an exception, the health carrier or
32 prescription drug utilization management entity shall authorize
33 coverage for the prescription drug prescribed by the patient's
34 treating health care provider.

35 (5) (a) (~~For nonurgent exception requests, the~~) The health
36 carrier or prescription drug utilization management entity must(÷

37 ~~(i) Within three business days notify the treating health care~~
38 ~~provider that additional information, as disclosed under subsection~~
39 ~~(2) of this section, is required in order to approve or deny the~~

1 ~~exception request, if the information provided is not sufficient to~~
2 ~~approve or deny the request; and~~

3 ~~(ii) Within three business days of receipt of sufficient~~
4 ~~information from the treating health care provider as disclosed under~~
5 ~~subsection (2) of this section,)) meet the time frames for decisions~~
6 ~~and notification to health care providers and for requests for~~
7 ~~additional information as established in section 1 of this act. The~~
8 ~~health carrier or prescription drug utilization management entity~~
9 ~~must approve a request if the information provided meets at least one~~
10 ~~of the conditions referenced in subsection (3) of this section or if~~
11 ~~deemed medically appropriate, or deny a request if the requested~~
12 ~~service does not meet at least one of the conditions referenced in~~
13 ~~subsection (3) of this section.~~

14 (b) ~~((For urgent exception requests, the health carrier or~~
15 ~~prescription drug utilization management entity must:~~

16 ~~(i) Within one business day notify the treating health care~~
17 ~~provider that additional information, as disclosed under subsection~~
18 ~~(2) of this section, is required in order to approve or deny the~~
19 ~~exception request, if the information provided is not sufficient to~~
20 ~~approve or deny the request; and~~

21 ~~(ii) Within one business day of receipt of sufficient information~~
22 ~~from the treating health care provider as disclosed under subsection~~
23 ~~(2) of this section, approve a request if the information provided~~
24 ~~meets at least one of the conditions referenced in subsection (3) of~~
25 ~~this section or if deemed medically appropriate, or deny a request if~~
26 ~~the requested service does not meet at least one of the conditions~~
27 ~~referenced in subsection (3) of this section.~~

28 ~~(e)) If a response by a health carrier or prescription drug~~
29 ~~utilization management entity is not received within the time frames~~
30 ~~established under this section, the exception request is deemed~~
31 ~~granted.~~

32 ~~((d) For purposes of this subsection, exception requests are~~
33 ~~considered urgent when an enrollee is experiencing a health condition~~
34 ~~that may seriously jeopardize the enrollee's life, health, or ability~~
35 ~~to regain maximum function, or when an enrollee is undergoing a~~
36 ~~current course of treatment using a nonformulary drug.))~~

37 (6) Health carriers must cover an emergency supply fill if a
38 treating health care provider determines an emergency fill is
39 necessary to keep the patient stable while the exception request is

1 being processed. This exception shall not be used to solely justify
2 any further exemption.

3 (7) When responding to a prescription drug utilization management
4 exception request, a health carrier or prescription drug utilization
5 management entity shall clearly state in their response if the
6 exception request was approved or denied. The health carrier must use
7 clinical review criteria as referenced in (~~RCW 48.43.410~~) section 1
8 of this act for the basis of any denial. Any denial must be based
9 upon and include the specific clinical review criteria relied upon
10 for the denial and include information regarding how to appeal denial
11 of the exception request. If the exception request from a treating
12 health care provider is denied for administrative reasons, or for not
13 including all the necessary information, the health carrier or
14 prescription drug utilization management entity must inform the
15 provider what additional information is needed and the deadline for
16 its submission.

17 (8) The health carrier or prescription drug utilization
18 management entity must permit a stabilized patient to remain on a
19 drug during an exception request process.

20 (9) A health carrier must provide sixty days' notice to providers
21 and patients for any new policies or procedures applicable to
22 prescription drug utilization management protocols. New health
23 carrier policies or procedures may not be applied retroactively.

24 (10) This section (~~does~~) and sections 1 and 3 of this act do
25 not prevent:

26 (a) A health carrier or prescription drug utilization management
27 entity from requiring a patient to try an AB-rated generic equivalent
28 or a biological product that is an interchangeable biological product
29 prior to providing coverage for the equivalent branded prescription
30 drug;

31 (b) A health carrier or prescription drug utilization management
32 entity from denying an exception for a drug that has been removed
33 from the market due to safety concerns from the federal food and drug
34 administration; or

35 (c) A health care provider from prescribing a prescription drug
36 that is determined to be medically appropriate.

37 **Sec. 5.** RCW 48.43.0161 and 2020 c 316 s 1 are each amended to
38 read as follows:

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

10 (a) Lists of the (~~ten~~) 10 inpatient medical or surgical codes:

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

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

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

24 (b) Lists of the (~~ten~~) 10 outpatient medical or surgical codes:

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

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

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

38 (c) Lists of the (~~ten~~) 10 inpatient mental health and substance
39 use disorder service 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; (~~(+and+)~~) and

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

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

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

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

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

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

38 (iii) With the highest percentage of prior authorization requests
39 that were initially denied and then subsequently approved on appeal,
40 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 (f) Lists of the (~~ten~~) 10 diabetes supplies and equipment
4 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 (g) Lists of the 10 prescription drugs:

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

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

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

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

36 (i) Expedited decisions;

37 (ii) Standard decisions; and

38 (iii) Extenuating circumstances decisions.

39 (2) For the October 1, 2020, reporting deadline, a carrier is not
40 required to report data pursuant to subsection (1)(a)(iii), (b)(iii),

1 (c)(iii), (d)(iii), (e)(iii), or (f)(iii) of this section until April
2 1, 2021, if the commissioner determines that doing so constitutes a
3 hardship.

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

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

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

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

27 **Sec. 6.** RCW 48.43.400 and 2019 c 171 s 1 are each amended to
28 read as follows:

29 The definitions in this section apply throughout this section and
30 RCW (~~48.43.410 and~~) 48.43.420 unless the context clearly requires
31 otherwise.

32 (1) "Clinical practice guidelines" means a systemically developed
33 statement to assist decision making by health care providers and
34 patients about appropriate health care for specific clinical
35 circumstances and conditions.

36 (2) "Clinical review criteria" means the written screening
37 procedures, decision rules, medical protocols, and clinical practice
38 guidelines used by a health carrier or prescription drug utilization
39 management entity as an element in the evaluation of medical

1 necessity and appropriateness of requested prescription drugs under a
2 health plan.

3 (3) "Emergency fill" means a limited dispensed amount of
4 medication that allows time for the processing of prescription drug
5 utilization management.

6 (4) "Medically appropriate" means prescription drugs that under
7 the applicable standard of care are appropriate: (a) To improve or
8 preserve health, life, or function; (b) to slow the deterioration of
9 health, life, or function; or (c) for the early screening,
10 prevention, evaluation, diagnosis, or treatment of a disease,
11 condition, illness, or injury.

12 (5) "Prescription drug utilization management" means a set of
13 formal techniques used by a health carrier or prescription drug
14 utilization management entity, that are designed to monitor the use
15 of or evaluate the medical necessity, appropriateness, efficacy, or
16 efficiency of prescription drugs including, but not limited to, prior
17 authorization and step therapy protocols.

18 (6) "Prescription drug utilization management entity" means an
19 entity affiliated with, under contract with, or acting on behalf of a
20 health carrier to perform prescription drug utilization management.

21 (7) "Prior authorization" means a mandatory process that a
22 carrier or prescription drug utilization management entity requires a
23 provider or facility to follow to determine if a service is a benefit
24 and meets the requirements for medical necessity, clinical
25 appropriateness, level of care, or effectiveness in relation to the
26 applicable plan.

27 (8) "Step therapy protocol" means a protocol or program that
28 establishes the specific sequence in which prescription drugs for a
29 specified medical condition will be covered by a health carrier.

30 NEW SECTION. **Sec. 7.** Sections 4, 5, and 6 of this act take
31 effect January 1, 2024.

32 NEW SECTION. **Sec. 8.** RCW 48.43.410 (Prescription drug
33 utilization management—Clinical review criteria—Requirement to be
34 evidence-based and updated regularly) and 2019 c 171 s 2 are each
35 repealed.

36 NEW SECTION. **Sec. 9.** If specific funding for the purposes of
37 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.

--- **END** ---