H-1454.1

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Use fast health care interoperability resources;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) For the purposes of this section:

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

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

(i) The passage of time:

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

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

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

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

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

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

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

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

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

calendar day of submission of the electronic prior authorization request.

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

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

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

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

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

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

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

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

(i) Use fast health care interoperability resources;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) For the purposes of this section:

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

(i) The passage of time:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Use fast health care interoperability resources;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) For the purposes of this section:

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

(i) The passage of time:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) Lists of the 10 prescription drugs:

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

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

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

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

(i) Expedited decisions;

(ii) Standard decisions; and

(iii) Extenuating circumstances decisions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 9.** If specific funding for the purposes of this act, referencing this act by bill or chapter number, is not

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

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