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HOUSE BILL 1357

State of Washington 68th Legislature 2023 Regular Session

By Representatives Simmons, Schmick, Stonier, Cortes, Reed, Bateman, Harris, Alvarado, Pollet, and Caldier

Read first time 01/16/23. Referred to Committee on Health Care & Wellness.

AN ACT Relating to modernizing the prior authorization process; amending RCW 48.43.0161 and 48.43.545; adding a new section to chapter 48.43 RCW; adding a new section to chapter 41.05 RCW; and adding a new section to chapter 74.09 RCW.

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:

(i) For standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within 48 hours of submission of the prior authorization request by the provider or facility. 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 in a timely manner to allow the carrier to comply with the 48-hour notification requirement.

(ii) For expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within 24 hours of submission of the prior authorization request by the provider or facility. 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 in a timely manner to allow the carrier to comply with the 24-hour notification requirement.

(b)(i) The initial review of information submitted in support of a request for prior authorization must be conducted and approved by a licensed health care professional.

(ii) For prior authorization requests made by a physician, osteopathic physician, physician assistant, or advanced registered nurse practitioner, only a physician or osteopathic physician may issue a denial of the prior authorization request.

(iii) In the case of a denied prior authorization, a carrier shall make available to the requesting provider a peer-to-peer review discussion. The peer reviewer provided by the carrier must be licensed in the same or similar medical specialty as the requesting provider and must have authority to modify or overturn the prior authorization decision.

(c) 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 upon request, as well as readily accessible and conspicuously posted on its website for enrollees, providers, and facilities. The prior authorization requirements must be based on peer-reviewed clinical review criteria. The clinical review criteria must be evidence-based criteria. The clinical review criteria must be evaluated and updated, if necessary, at least annually.

(2) By January 1, 2024, carriers shall make available an electronic prior authorization request transaction process using an internet webpage, internet webpage portal, or similar electronic, internet, or web-based system.

(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 where the passage of time could seriously jeopardize the life or health of the enrollee, seriously jeopardize the enrollee's ability to regain maximum function, or, 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 that is the subject of the request.

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

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:

(i) For standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within 48 hours of submission of the prior authorization request by the provider or facility. 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 in a timely manner to allow the carrier to comply with the 48-hour notification requirement.

(ii) For expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within 24 hours of submission of the prior authorization request by the provider or facility. 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 in a timely manner to allow the carrier to comply with the 24-hour notification requirement.

(b)(i) The initial review of information submitted in support of a request for prior authorization must be conducted and approved by a licensed health care professional.

(ii) For prior authorization requests made by a physician, osteopathic physician, physician assistant, or advanced registered nurse practitioner, only a physician or osteopathic physician may issue a denial of the prior authorization request.

(iii) In the case of a denied prior authorization, a carrier shall make available to the requesting provider a peer-to-peer review discussion. The peer reviewer provided by the carrier must be licensed in the same or similar medical specialty as the requesting provider and must have authority to modify or overturn the prior authorization decision.

(c) 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 upon request, as well as readily accessible and conspicuously posted on its website for enrollees, providers, and facilities. The prior authorization requirements must be based on peer-reviewed clinical review criteria. The clinical review criteria must be evidence-based criteria. The clinical review criteria must be evaluated and updated, if necessary, at least annually.

(2) By January 1, 2024, carriers shall make available an electronic prior authorization request transaction process using an internet webpage, internet webpage portal, or similar electronic, internet, or web-based system.

(3) The authority shall prohibit health plans from requiring prior authorization to the same extent that the insurance commissioner has established such prohibitions pursuant to rules adopted under RCW 48.43.0161(5)(b).

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

(5) 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 where the passage of time could seriously jeopardize the life or health of the enrollee, seriously jeopardize the enrollee's ability to regain maximum function, or, 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 that is the subject of the request.

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

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:

(i) For 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 48 hours of submission of the prior authorization request by the provider or facility. 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 in a timely manner to allow the managed health care system to comply with the 48-hour notification requirement.

(ii) For 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 24 hours of submission of the prior authorization request by the provider or facility. 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 in a timely manner to allow the managed health care system to comply with the 24-hour notification requirement.

(b)(i) The initial review of information submitted in support of a request for prior authorization must be conducted and approved by a licensed health care professional.

(ii) For prior authorization requests made by a physician, osteopathic physician, physician assistant, or advanced registered

nurse practitioner, only a physician or osteopathic physician may issue a denial of the prior authorization request.

(iii) In the case of a denied prior authorization, a managed health care system shall make available to the requesting provider a peer-to-peer review discussion. The peer reviewer provided by the managed health care system must be licensed in the same or similar medical specialty as the requesting provider and must have authority to modify or overturn the prior authorization decision.

(c) 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 upon request, as well as readily accessible and conspicuously posted on its website for enrollees, providers, and facilities. The prior authorization requirements must be based on peer-reviewed clinical review criteria. The clinical review criteria must be evidence-based criteria. The clinical review criteria must be evaluated and updated, if necessary, at least annually.

(2) By January 1, 2024, managed health care systems, including managed care organizations, shall make available an electronic prior authorization request transaction process using an internet webpage, internet webpage portal, or similar electronic, internet, or web-based system.

(3) The authority shall prohibit managed health care systems, including managed care organizations, from requiring prior authorization to the same extent that the insurance commissioner has established such prohibitions pursuant to rules adopted under RCW 48.43.0161(5)(b).

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

(5) 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 where the passage of time could seriously jeopardize the life or health of the enrollee, seriously jeopardize the enrollee's ability to regain maximum function, or, 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 that is the subject of the request.

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

Sec. 4. 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) 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)(a) 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.

(b) The commissioner shall adopt rules to prohibit carriers from requiring prior authorization for any code covered by the reporting requirements of subsection (1) of this section if the commissioner has determined that the data in the most recent report demonstrates that the code has a prior authorization approval rate higher than 95 percent. For codes where prior authorization has been prohibited by rule, if the commissioner determines after three years that utilization of the code has changed significantly, the commissioner may initiate rule making to reinstate eligibility of the code for prior authorization.

(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. 5. RCW 48.43.545 and 2000 c 5 s 17 are each amended to read as follows:

(1)(a) A health carrier shall adhere to the accepted standard of care for health care providers under chapter 7.70 RCW when arranging for the provision of medically necessary health care services to its enrollees. A health carrier shall be liable for any and all harm proximately caused by its failure to follow that standard of care when the failure resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, an enrollee.

(b) A health carrier is also liable for damages under (a) of this subsection for harm to an enrollee proximately caused by health care treatment decisions that result from a failure to follow the accepted standard of care made by its:

(i) Employees;

(ii) Agents; or

(iii) Ostensible agents who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control.

(2) The provisions of this section may not be waived, shifted, or modified by contract or agreement and responsibility for the provisions shall be a duty that cannot be delegated. Any effort to waive, modify, delegate, or shift liability for a breach of the duty established by this section, through a contract for indemnification or otherwise, is invalid.

(3) This section does not create any new cause of action, or eliminate any presently existing cause of action, with respect to health care providers and health care facilities that are included in and subject to the provisions of chapter 7.70 RCW.

(4) It is a defense to any action or liability asserted under this section against a health carrier that:

(a) The health care service in question is not a benefit provided under the plan or the service is subject to limitations under the plan that have been exhausted;

(b) Neither the health carrier, nor any employee, agent, or ostensible agent for whose conduct the health carrier is liable under subsection (1)(b) of this section, controlled, influenced, or participated in the health care decision; or

(c) The health carrier did not deny or unreasonably delay payment for treatment prescribed or recommended by a participating health care provider for the enrollee.

(5) This section does not create any liability on the part of an employer, an employer group purchasing organization that purchases coverage or assumes risk on behalf of its employers, or a governmental agency that purchases coverage on behalf of individuals and families. The governmental entity established to offer and provide health insurance to public employees, public retirees, and their covered dependents under RCW 41.05.140 is subject to liability under this section.

(6) Nothing in any law of this state prohibiting a health carrier from practicing medicine or being licensed to practice medicine may be asserted as a defense by the health carrier in an action brought against it under this section.

(7)((~~(a) A person may not maintain a cause of action under this section against a health carrier unless:~~

~~(i) The affected enrollee has suffered substantial harm. As used in this subsection, "substantial harm" means loss of life, loss or significant impairment of limb, bodily or cognitive function, significant disfigurement, or severe or chronic physical pain; and~~

~~(ii) The affected enrollee or the enrollee's representative has exercised the opportunity established in RCW 48.43.535 to seek independent review of the health care treatment decision.~~

~~(b) This subsection (7) does not prohibit an enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or other relief available under law, if its requirements place the enrollee's health in serious jeopardy.~~

~~(8)~~)) In an action against a health carrier, a finding that a health care provider is an employee, agent, or ostensible agent of such a health carrier shall not be based solely on proof that the person's name appears in a listing of approved physicians or health care providers made available to enrollees under a health plan.

((~~(9)~~)) (8) Any action under this section shall be commenced within three years of the ((~~completion of the independent review process.~~

~~(10)~~)) denial, delay, or modification of the health care service.

(9) This section does not apply to workers' compensation insurance under Title 51 RCW.

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