
ENGROSSED SUBSTITUTE SENATE BILL 6404

AS AMENDED BY THE HOUSE

Passed Legislature - 2020 Regular Session

State of Washington 66th Legislature 2020 Regular Session

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

READ FIRST TIME 02/06/20.

1 AN ACT Relating to reducing barriers to patient care through
2 appropriate use of prior authorization and adoption of appropriate
3 use criteria; and adding a new section to chapter 48.43 RCW.

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

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

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

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

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

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

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

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

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

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

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

39 (d) Lists of the ten outpatient mental health and substance use
40 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;

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;

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

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

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

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

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

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

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

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

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

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

- 7 (i) Expedited decisions;
- 8 (ii) Standard decisions; and
- 9 (iii) Extenuating circumstances decisions.

10 (2) For the October 1, 2020, reporting deadline, a carrier is not
11 required to report data pursuant to subsection (1)(a)(iii), (b)(iii),
12 (c)(iii), (d)(iii), (e)(iii), or (f)(iii) of this section until April
13 1, 2021, if the commissioner determines that doing so constitutes a
14 hardship.

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

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

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

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

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