S-0158.3

SENATE BILL 5267

State of Washington 63rd Legislature 2013 Regular Session

By Senators Becker, Keiser, Conway, Ericksen, Bailey, Dammeier, Frockt, and Schlicher

Read first time 01/24/13. Referred to Committee on Health Care .

AN ACT Relating to improving patient health care through a more efficient and standardized prior authorization process for health care services; adding a new section to chapter 48.165 RCW; and creating a new section.

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

NEW SECTION. **Sec. 1.** The legislature finds that some health insurers require hundreds of different paper forms for prior authorization for health care services, creating administrative waste and inefficiency in the health care delivery system. According to recent studies, insurer administrative tasks cost billions of dollars annually, and limit patients' timely access to lifesaving treatments and medications. The legislature is committed to patient protection, access to health care services, and eliminating administrative waste. Thus, it is the intent of the legislature that the process for the prior authorization of health care services should be standardized by requiring all payors to utilize one form which shall be available in paper, online, and electronic formats.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.165 RCW to read as follows:

(1) A payor or any entity acting for a payor under contract, when requiring prior authorization for a health care service or benefit, must use and accept only the prior authorization forms or data fields designated for the specific types of services and benefits developed under subsection (4) of this section.

(2) A payor or any entity acting for a payor under contract must respond to a request for prior authorization within two business days after receiving a completed prior authorization request from a health care provider on a form or data fields developed under subsection (4) of this section.

(3) If a payor or any entity acting for a payor under contract fails to use or accept the required prior authorization form or data fields after six months from the date of release, or fails to respond within two business days to a request for prior authorization after receiving a completed prior authorization request from a health care provider on a form or data field developed under subsection (4) of this section, the prior authorization request shall be deemed accepted.

(4) The office of the insurance commissioner must develop and implement uniform prior authorization forms or data fields for different health care services and benefits.

(a) The forms and data fields must apply to health care services and benefits including, but not limited to:

(i) Provider office visits;

(ii) Prescription drug benefits;

(iii) Imaging and other diagnostic testing; and

(iv) Laboratory testing;

(b) All forms and data fields must be developed in consultation with health care providers licensed under chapter 18.71, 18.57, or 18.64 RCW who are board certified in the specialty to which the forms or data fields apply and have been actively practicing in that specialty for a minimum of five years; and

(c) All forms and data fields must be developed and released by the office of the insurance commissioner by July 1, 2014.

(5) The prior authorization forms developed under subsection (4) of this section must:

(a) Not exceed two pages;

(b) Be made electronically available; and

(c) Be capable of being electronically accepted by the payor after being completed.

(6) The office of the insurance commissioner, in developing the forms and data fields, must:

(a) Seek input from interested stakeholders and seek to use forms and data fields that have been mutually agreed upon by payors and providers;

(b) Ensure that the forms are consistent with existing prior authorization forms established by the federal centers for medicare and medicaid services; and

(c) Consider other national standards pertaining to electronic prior authorization.

(7) All payors and any entities acting for a payor under contract must use the uniform forms or data fields designated by the office of the insurance commissioner for the specific type of service, and every payor or any entity acting for a payor under contract must accept the form as sufficient to request prior authorization for the health care service or benefit by January 1, 2015.

(8) Nothing in this section:

(a) Prohibits a payor or any entity acting for a payor under contract from using a prior authorization methodology that uses an internet web page, internet web page portal, or similar electronic, internet, and web-based system in lieu of a paper form, provided that it is consistent with the paper form, developed pursuant to subsection (4) of this section; and

(b) Limits a health plan from requiring prior authorization for services.

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