Multiple Agency Fiscal Note Summary

Bill Number: 1357 HB	**Title:** Prior authorization/health

Estimated Cash Receipts

Agency Name	2023-25			2025-27			2027-29		
	GF-State	NGF-Outlook	Total	GF-State	NGF-Outlook	Total	GF-State	NGF-Outlook	Total
Washington State Health Care Authority	0	0	732,000	0	0	732,000	0	0	732,000
Washington State Health Care Authority	In addition to the estimate above,there are additional indeterminate costs and/or savings. Please see individual fiscal note.								
Total $	**0**	**0**	**732,000**	**0**	**0**	**732,000**	**0**	**0**	**732,000**

Estimated Operating Expenditures

Agency Name	2023-25				2025-27				2027-29			
	FTEs	GF-State	NGF-Outlook	Total	FTEs	GF-State	NGF-Outlook	Total	FTEs	GF-State	NGF-Outlook	Total
Washington State Health Care Authority	3.9	904,000	904,000	1,636,000	3.9	904,000	904,000	1,636,000	3.9	904,000	904,000	1,636,000
Washington State Health Care Authority	In addition to the estimate above,there are additional indeterminate costs and/or savings. Please see individual fiscal note.											
Office of Insurance Commissioner	1.3	0	0	445,448	1.0	0	0	409,918	1.0	0	0	409,918
Total $	**5.2**	**904,000**	**904,000**	**2,081,448**	**4.9**	**904,000**	**904,000**	**2,045,918**	**4.9**	**904,000**	**904,000**	**2,045,918**

Estimated Capital Budget Expenditures

Agency Name	2023-25			2025-27			2027-29		
	FTEs	Bonds	Total	FTEs	Bonds	Total	FTEs	Bonds	Total
Washington State Health Care Authority	.0	0	0	.0	0	0	.0	0	0
Office of Insurance Commissioner	.0	0	0	.0	0	0	.0	0	0
Total $	**0.0**	**0**	**0**	**0.0**	**0**	**0**	**0.0**	**0**	**0**

Estimated Capital Budget Breakout

Prepared by: Jason Brown, OFM	Phone: (360) 742-7277	Date Published: Revised

Individual State Agency Fiscal Note

Revised

Bill Number: 1357 HB	Title: Prior authorization/health	Agency: 107-Washington State Health Care Authority

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

ACCOUNT		FY 2024	FY 2025	2023-25	2025-27	2027-29
General Fund-Federal	001-2	366,000	366,000	732,000	732,000	732,000
Total $		366,000	366,000	732,000	732,000	732,000

In addition to the estimates above, there are additional indeterminate costs and/or savings. Please see discussion.

Estimated Operating Expenditures from:

		FY 2024	FY 2025	2023-25	2025-27	2027-29
FTE Staff Years		3.9	3.9	3.9	3.9	3.9
Account						
General Fund-State	001-1	452,000	452,000	904,000	904,000	904,000
General Fund-Federal	001-2	366,000	366,000	732,000	732,000	732,000
Total $		818,000	818,000	1,636,000	1,636,000	1,636,000

In addition to the estimates above, there are additional indeterminate costs and/or savings. Please see discussion.

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☐ Requires new rule making, complete Part V.

Legislative Contact:	Chris Blake	Phone: 360-786-7392	Date: 01/18/2023
Agency Preparation:	Lena Johnson	Phone: 360-725-5295	Date: 02/02/2023
Agency Approval:	Cliff Hicks	Phone: 360-725-0875	Date: 02/02/2023
OFM Review:	Jason Brown	Phone: (360) 742-7277	Date: 02/02/2023

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Significant provisions of the bill and any related workload or policy assumptions that have revenue or expenditure impact on the responding agency by section number.

Please see attached narrative.

II. B - Cash receipts Impact

Cash receipts impact of the legislation on the responding agency with the cash receipts provisions identified by section number and when appropriate, the detail of the revenue sources. Description of the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explanation of how workload assumptions translate into estimates. Distinguished between one time and ongoing functions.

II. C - Expenditures

Agency expenditures necessary to implement this legislation (or savings resulting from this legislation), with the provisions of the legislation that result in the expenditures (or savings) identified by section number. Description of the factual basis of the assumptions and the method by which the expenditure impact is derived. Explanation of how workload assumptions translate into cost estimates. Distinguished between one time and ongoing functions.

Part III: Expenditure Detail

III. A - Operating Budget Expenditures

Account	Account Title	Type	FY 2024	FY 2025	2023-25	2025-27	2027-29
001-1	General Fund	State	452,000	452,000	904,000	904,000	904,000
001-2	General Fund	Federal	366,000	366,000	732,000	732,000	732,000
		Total $	818,000	818,000	1,636,000	1,636,000	1,636,000

In addition to the estimates above, there are additional indeterminate costs and/or savings. Please see discussion.

III. B - Expenditures by Object Or Purpose

	FY 2024	FY 2025	2023-25	2025-27	2027-29
FTE Staff Years	3.9	3.9	3.9	3.9	3.9
A-Salaries and Wages	345,000	345,000	690,000	690,000	690,000
B-Employee Benefits	108,000	108,000	216,000	216,000	216,000
C-Professional Service Contracts	242,000	242,000	484,000	484,000	484,000
E-Goods and Other Services	6,000	6,000	12,000	12,000	12,000
G-Travel					
J-Capital Outlays					
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services					
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements	117,000	117,000	234,000	234,000	234,000
9-					
Total $	818,000	818,000	1,636,000	1,636,000	1,636,000

In addition to the estimates above, there are additional indeterminate costs and/or savings. Please see discussion.

III. C - Operating FTE Detail: *List FTEs by classification and corresponding annual compensation. Totals need to agree with total FTEs in Part I and Part IIIA*

Job Classification	Salary	FY 2024	FY 2025	2023-25	2025-27	2027-29
FISCAL ANALYST 3	65,000	0.9	0.9	0.9	0.9	0.9
MEDICAL ASSISTANCE PROGRA SPECIALIST 3	8,300	1.0	1.0	1.0	1.0	1.0
OCCUPATIONAL NURSE CONSULTANT	131,000	2.0	2.0	2.0	2.0	2.0
Total FTEs		3.9	3.9	3.9	3.9	3.9

III. D - Expenditures By Program (optional)

Program	FY 2024	FY 2025	2023-25	2025-27	2027-29
200 - HCA - OTHER (200)	818,000	818,000	1,636,000	1,636,000	1,636,000
Total $	818,000	818,000	1,636,000	1,636,000	1,636,000

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout

Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.

NONE

IV. D - Capital FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.*

NONE

Part V: New Rule Making Required

Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.

Part II: Narrative Explanation

AN ACT Relating to modernizing the prior authorization (PA) 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.

II. A - Brief Description of What the Measure Does That Has Fiscal Impact

HB 1357 adds new sections to chapter 48.43 RCW, 41.05 RCW, and 74.09 RCW that require the Washington State Health Care Authority (HCA) to require that commercial carriers, Uniform Medical Plan (UMP), and Medicaid managed care organizations (MCO's) comply with shorter PA turnaround times, provide certain notifications, and perform specific PA processes.

Employee and Retiree Benefits (ERB):

Section 1 of this bill adds a new section to RCW 48.43 (Insurance Reform) that requires commercial health plans issued on or after January 1, 2024, to follow updated prior authorization standards. Specifically, this bill requires carriers to make a PA determination and notify a provider or facility of the results within 48 hours of submission for a standard PA request and within 24 hours for an expedited request.

Further, this bill requires that an initial PA review must be conducted by a licensed health care professional, and only a medical doctor (MD) or Doctor of Osteopathic Medicine (DO) may deny a PA request made by an MD, DO, physician assistant, or advanced registered nurse practitioner (ARNP). Health carriers must also offer peer-to-peer review of denied PA decisions, and requirements must be described in detail based on peer-reviewed, evidence-based clinical criteria and easily accessible to providers and enrollees.

Carriers must also make an electronic PA request process available by January 1, 2024.

Section 2 of this bill adds a new section to RCW 41.05 (State Health Care Authority), which applies the same requirements under Section 1 to the UMP offered to employees and their covered dependents in the Public Employees Benefits Board Program (PEBB) and School Employees Benefits Board Program (SEBB).

Section 4 of this bill amends 48.43.0161 (Prior authorization practices—Carrier annual reporting requirements—Commissioner's standardized report) expanding the Washington State Office of the Insurance Commissioner's (OIC) authority to prohibit use of prior authorizations by commercial health plans for any service with a 95% or higher approval rating.

Apple Health:

HB 1357 adds new sections to chapter 74.09 RCW that requires HCA to require that MCO's comply with shorter PA turnaround times, provide certain notifications, and perform specific PA processes. More specifically, the bill requires that:

- Initial PA reviews must be conducted and approved by licensed healthcare professionals.
- Only MDs and DOs may deny a PA request made by an MD, DO, physician assistant, or ARNP.
- A specialty-matched peer-to-peer review discussion must be made available to providers if a PA is denied.

- PA requirements must be written and published.
- PA requirements must be peer-reviewed, evidence based, and reviewed annually.
- An electronic PA transaction process must be provided by Jan 1, 2024.
- PA requirements are prohibited for any PA with a historical approval rate of 95% or more.

The Office of the Insurance Commissioner is directed to monitor utilization of codes that are prohibited from PA to determine if utilization of the code changes significantly and, if so, to reinstate the code's eligibility for PA.

Section 3 adds new sections to 74.09 RCW, applies the same requirements from Section 1 for carriers offering managed health care systems and expands PA prohibitions, specifically exempts PAs for substance use disorder (SUD) treatment services under RCW 71.24.618.

II. B - Cash Receipts Impact

Fiscal impacts associated with adding a new section to chapter 74.09 RCW would be eligible for Federal Financial Participation (FFP). HCA estimates an average FFP of 45 percent.

II. B - Estimated Cash Receipts to:

ACCOUNT		FY-2024	FY-2025	FY-2026	FY-2027	FY-2028	FY-2029	2023-25	2025-27	2027-29
General Fund-Medicaid	001-C	366,000	366,000	366,000	366,000	366,000	366,000	**732,000**	**732,000**	**732,000**
	Totals	**$ 366,000**	**$ 366,000**	**$ 366,000**	**$ 366,000**	**$ 366,000**	**$ 366,000**	**$ 732,000**	**$ 732,000**	**$ 732,000**

II. C – Expenditures

Employee and Retiree Benefits:

The fiscal impact is indeterminate.

This bill has an indeterminate fiscal impact on the PEBB and SEBB programs greater than $50,000 due to increased staffing costs for carriers to process prior authorization requests. This is likely to result in higher premiums charged to HCA by the fully insured carriers and higher administrative fees for UMP. These costs could be reflected in a potential increase to employee premiums and the state medical benefit contribution.

<u>Section 1</u> of this bill adds a new section to RCW 48.43, which governs fully insured carriers, that requires health plans to shorten the prior authorization timeline for standard requests from five days (existing Office of the Insurance Commissioner regulations) to 48 hours, and the timeline for expedited requests from 48 hours (existing Office of the Insurance Commissioner regulations) to 24 hours. This bill also outlines new prior authorization requirements for health plans, such as qualifications for providers that can perform reviews, access to prior authorization criteria for providers and enrollees, peer-to-peer review for any denied prior authorizations, and access to an electronic prior authorization request process by January 1, 2024. This section does not apply to prescription drug utilization management, including prior authorizations.

<u>Section 2</u> of this bill adds a new section that requires health plans issued under RCW 41.05 (State Health Care Authority) to apply the same requirements as section 1 of this bill. RCW 41.05 governs UMP, which are self-insured plans offered by the PEBB and SEBB programs. This bill would require the UMP third party administrators (TPAs) for medical and pharmacy benefits (Regence and Moda, respectively) to follow the new prior authorization standards and timeline. While Section 1 explicitly exempts prescription drug prior authorization determinations from complying with the enhanced

requirements and timeline, Section 2 does not include a reference to prescription drug utilization management and therefore HCA assumes the bill language applies to prescription drugs covered by UMP.

The condensed review period and enhanced requirements under the bill would increase carriers' costs associated with administration of prior authorizations. PEBB and SEBB carriers cite a need for additional staffing to process prior authorizations within the 24- and 48-hour timeframes imposed. This includes greater reliance on physicians, clinical pharmacists, and specialists in performing reviews, diverting these human resources from other clinical duties. For UMP pharmacy, our contracted PBM provided estimates that this bill is expected to increase spending by $3.2 to $6.8 million dollars. The increase is due to administrative staffing and increased drug expense. Administrative staffing components of the bill would require a faster turnaround time for all aspects of the prior authorization process, as well as more stringent credentialing requirements for who may evaluate an authorization. The type of staff (physician and osteopath) needed to comply are scarce resources, and there may be a need for outsourcing to professional contractors. The increased drug costs are based on the expectation that there would be increased use of the list of drugs that would be excluded from prior authorization due to a 95% PA approval history. It is unclear how much of those costs would result in direct funding rate impacts.

It is unknown how this will impact future rates for Regence and the fully insured carriers. These additional staffing costs may increase the premiums charged to the HCA by the fully insured carriers, and rates for UMP. This could result in an indeterminate increase to the state medical benefit contribution and employee contributions for health benefits.

There is no impact to the Medicare Advantage (MA) plans offered to Medicare eligible PEBB retirees because state laws are pre-empted by Federal laws for MA and Part D offerings.

Apple Health:

The fiscal impact is indeterminate.

This bill adds new sections to chapter 74.09 RCW that requires HCA to require that MCO's comply with shorter PA turnaround times, provide certain notifications, and perform specific PA processes. These changes are expected to result in significant fiscal impact for HCA. While HCA is able to estimate the agency's staffing and technology related costs, the magnitude of the potential costs that will be passed on to HCA through benefit contracts with the MCOs are unknown at this time but expected to be significant.

It is worth noting that the bill, as written, does not require operational changes in Apple Health fee-for-service (FFS). If the bill passes in its current form. it would create an inconsistency in standards, with longer PA turnaround time standards in FFS than in other program areas of HCA. This is inequitable to the clients served by FFS.

HCA staffing and technology related costs (magnitude known)

HCA requests $1,636,000 ($904,000 of GF-State) and 3.9 Full Time Equivalent (FTE) staff in the 2023-25 Biennium. Of these amounts, $918,000 is needed cover the cost of the 3.9 FTEs to implement the bill as written, $484,000 is needed to complete the 11 additional Health Technology Assessment program (HTA) annual searches, and $234,000 is needed for administrative costs.

The HTA is directed in RCW 70.14.100 to contract for health technology assessments that are reviewed by the Health Technology Clinical Committee (HTCC). The policies of the HTCC are commonly adopted by Medicaid and the expectation is that the policies are used by the MCOs. To comply with the bill, CQCT assumes that an annual update literature search will be required for policies promulgated by the HTCC and CQCT and used by the MCOs. Policies are not on an annual review cycle now and CQCT is not staffed to meet such a requirement. To meet the annual update requirement, CQCT will need additional staff. To meet the annual update requirement for HTCC determinations, the HTA program will use the technology assessment centers (TACs) as a resource to provide updated literature searches annually for a significant number of policies.

Staffing costs:

- 1.0 FTE Occupational Nurse Consultant (ONC) with background, training and/or experience with evidence-based medicine and policy or guideline development for clinical policy applications, OR 1.0 FTE Epidemiologist 2 or 3 or equivalent with experience as above, to monitor and track policy cadence for those requiring annual updates, to work with Rules and Publications to maintain policy publications, etc.
- 1.0 FTE Medical Assistance Program Specialist 3 (MAPS3) to monitor and track policy cadence for those requiring annual updates, to work with Rules and Publications to maintain policy publications, etc.
- 1.0 FTE Occupational Nurse Consultant (ONC) informaticist to share proper clinical implementation of interoperability or PA clinical data systems, alignment and clinical validity of electronic PA submission processes, and related information exchanges between MCOs and providers. This is needed to meet requirements for annual review and/or updating existing (not new) clinical policies.

HTA TAC costs:

- It is assumed that annual signal searches will increase from 4 per year to 15 per year. Cost for an additional 11 searches at an average cost of $22,000 per search = $242,000.

Managed Care contract costs (magnitude unknown)

HCA solicited feedback from each of the MCOs to understand prospective administrative costs to implement the bill. Four of five MCOs responded, with per-plan estimated costs ranging from $1 million to $6 million in increased expenditures per year. Total estimated increased expenditures per year for these four plans ranged from $11.8 million to $14.2 million. Any increase in administrative costs to the MCOs would lead to impacts to managed care rates established annually by the state.

Increased costs were associated with the needs to hire additional FTEs and in some instances transition FTEs to higher paying positions, associated with requirements for providers handling initial prior authorizations and for specialists to be involved in specialty-to-specialty peer review. Estimates may not capture the full costs of implementation.

The proposed policy change would increase the operational costs for the MCOs. This cost, in turn, is expected to be passed on to HCA by the MCOs in the form of higher contracted rates. While the amount of this impact is currently unknown, it is expected to be quite significant.

Washington currently requires five days non-urgent, and two days expedited turnaround times for PAs. PA is waived for emergent cases. Changing the requirements to 48 hours for non-urgent and 24 hours for expedited implies a major shift on the part of the MCOs. Additional staff qualifications as required by the bill would also contribute to the increased costs.

- The faster turnaround times will require additional resource and staffing investments on the part of the MCOs and their contracted providers.
- Prior to the availability of such additional resources, MCOs may need to deny claims at the 48- or 24-hour mark to comply with the required turnaround times, leading to an increase in appeals and associated costs.
- The turnaround time limits appear to be calendar and not business days. PA service would therefore need to be available 24/7, thereby significantly increasing costs for evening and weekend staffing needs.
- MCOs would have to hire licensed health care workers to perform the initial review. It is unclear what is meant by “initial review of information submitted.” Unlicensed staff are currently utilized to organize the PA submission for more efficient clinician review. Shifting this to licensed staff would decrease efficiency and increase costs.
- The requirement that, for PA 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 PA request will impact staff workflow, leading to increased delays and increased admin costs. Pharmacists and nurses would no longer able to deny many claims. They would need to work up a case and send it to a physician for final review and approval. This extra review will cause further delays in the PA review process, which would further lead to more denials, appeals, and admin costs.
- Requirement for specialty matched peer-to-peer review discussion would increase time to identify a qualifying physician and increase turnaround time, given the limited number of specialists who perform reviews.
- MCOs would likely need to hire physicians to review PAs, leading to increased costs.
- Inability to meet turn-around-times due to staffing, PA volume, or incomplete information from providers may result in a higher volume of denials and PA re-submissions, both delaying care for patients and potentially increasing overall PA volume.

Assumptions

- "Review” is a human review, not an automated processing of a PA request.
- “Electronic PA submission process” is any submission/process involving an electronic/digital medium exclusive of a human review, including automated processing, auto-adjudication, and PA related application programming interfaces.
- HCA would implement the required PA turnaround times in contracts, not in agency rules.
- The bill does not currently apply to Medicaid FFS, and it is unclear if it applies to pharmacy. If it applies to pharmacy additional staff and funding will be needed.
- The 48-hour/24-hour (expedited) PA response time applies to all services, for all eligibility categories, for MCOs.
- Under the bill, the determination of “expedited” is at the sole discretion of the provider. HCA assumes that requiring clinical justification for expedited processing would not be allowed. Such services would be provided immediately following the receipt of the PA. HCA will need to verify that this provision meets federal requirements to enable HCA to draw down federal match.
- The 48-hour/24-hour standard is based on calendar days and not business days.

- The criteria of "peer-reviewed evidence" will align with the current medical necessity rule allowing HCA to continue to draw down federal match.
- Pricing durable medical equipment would also require the 48-hour/24-hour turn around.
- The definition of "expedited" has the same definition as "urgent."
- HCA's CQCT division will need to maintain policies on an annual update schedule for select policies that are likely to require PA by MCOs.
- HTA program policies will require annual updates.
- A pharmacy technician is a licensed health care professional.

II. C - Operating Budget Expenditures

Account	Account Title	Type	FY-2024	FY-2025	FY-2026	FY-2027	FY-2028	FY-2029	2023-25	2025-27	2027-29
001-1	General Fund	State	452,000	452,000	452,000	452,000	452,000	452,000	904,000	904,000	904,000
001-C	General Fund	Medicaid	366,000	366,000	366,000	366,000	366,000	366,000	732,000	732,000	732,000
		Totals	$ 818,000	$ 818,000	$ 818,000	$ 818,000	$ 818,000	$ 818,000	$ 1,636,000	$ 1,636,000	$ 1,636,000

II. C - Expenditures by Object Or Purpose

		FY-2024	FY-2025	FY-2026	FY-2027	FY-2028	FY-2029	2023-25	2025-27	2027-29
FTE		3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9
A	Salaries and Wages	345,000	345,000	345,000	345,000	345,000	345,000	690,000	690,000	690,000
B	Employee Benefits	108,000	108,000	108,000	108,000	108,000	108,000	216,000	216,000	216,000
C	Professional Service Contracts	242,000	242,000	242,000	242,000	242,000	242,000	484,000	484,000	484,000
E	Goods and Other Services	6,000	6,000	6,000	6,000	6,000	6,000	12,000	12,000	12,000
T	Intra-Agency Reimbursements	117,000	117,000	117,000	117,000	117,000	117,000	234,000	234,000	234,000
	Totals	$ 818,000	$ 818,000	$ 818,000	$ 818,000	$ 818,000	$ 818,000	$ 1,636,000	$ 1,636,000	$ 1,636,000

II. C - Operating FTE Detail: List FTEs by classification and corresponding annual compensation.

Job title	Salary	FY-2024	FY-2025	FY-2026	FY-2027	FY-2028	FY-2029	2023-25	2025-27	2027-29
FISCAL ANALYST 3	65,000	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9
MEDICAL ASSISTANCE PROGRAM SPECIALIST 3	83,000	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
OCCUPATIONAL NURSE CONSULTANT	131,000	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
	Totals	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9

II. C - Expenditures By Program (optional)

Program		FY-2024	FY-2025	FY-2026	FY-2027	FY-2028	FY-2029	2023-25	2025-27	2027-29
200	200 - HCA - Other	818,000	818,000	818,000	818,000	818,000	818,000	1,636,000	1,636,000	1,636,000
	Totals	$ 818,000	$ 818,000	$ 818,000	$ 818,000	$ 818,000	$ 818,000	$ 1,636,000	$ 1,636,000	$ 1,636,000

Administrative costs are calculated at $39,000 per 1.0 FTE. This cost is included in Object T based on HCA's federally approved cost allocation plan and are capture and/or included as Fiscal Analyst 3 classification.

Part IV: Capital Budget Impact

None.

Part V: New Rule Making Require

None.

Individual State Agency Fiscal Note

Bill Number: 1357 HB	**Title:** Prior authorization/health	**Agency:** 160-Office of Insurance Commissioner

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

NONE

Estimated Operating Expenditures from:

	FY 2024	FY 2025	2023-25	2025-27	2027-29
FTE Staff Years	1.4	1.2	1.3	1.0	1.0
Account					
Insurance Commissioners Regulatory Account-State 138-1	211,580	233,868	445,448	409,918	409,918
Total $	211,580	233,868	445,448	409,918	409,918

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☒ Requires new rule making, complete Part V.

Legislative Contact:	Chris Blake	Phone: 360-786-7392	Date: 01/18/2023
Agency Preparation:	Jane Beyer	Phone: 360-725-7043	Date: 01/23/2023
Agency Approval:	Michael Wood	Phone: 360-725-7007	Date: 01/23/2023
OFM Review:	Jason Brown	Phone: (360) 742-7277	Date: 01/24/2023

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Significant provisions of the bill and any related workload or policy assumptions that have revenue or expenditure impact on the responding agency by section number.

Section 1 requires carriers offering a health plan issued or renewed on or after January 1, 2024, to comply with standards related to prior authorization. The standards relate to time limits for carriers to process standard and expedited prior authorization requests, the qualifications of health care professionals who can review and deny a prior authorization request, provider and consumer access to carriers' prior authorization requirements and required establishment of an electronic prior authorization request transaction process by carriers.

Section 4(5)(b) requires the Office of Insurance Commissioner (OIC) to adopt rules to prohibit carriers from applying prior authorization for any code covered by the reporting requirements of RCW 48.43.0161 if the OIC determines the data in the most recent report demonstrates that the code has a prior approval rate higher than 95%. This would include medical/surgical codes, mental/substance use disorder codes, and durable medical equipment codes. Section 4(5)(b) also authorizes the OIC to assess utilization of codes where a prior authorization prohibition has been adopted by rule. If the OIC determines after 3 years that utilization of the code has changed significantly, the OIC can initiate rulemaking to reinstate prior authorization for that code.

II. B - Cash receipts Impact

Cash receipts impact of the legislation on the responding agency with the cash receipts provisions identified by section number and when appropriate, the detail of the revenue sources. Description of the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explanation of how workload assumptions translate into estimates. Distinguished between one time and ongoing functions.

II. C - Expenditures

Agency expenditures necessary to implement this legislation (or savings resulting from this legislation), with the provisions of the legislation that result in the expenditures (or savings) identified by section number. Description of the factual basis of the assumptions and the method by which the expenditure impact is derived. Explanation of how workload assumptions translate into cost estimates. Distinguished between one time and ongoing functions.

Section 1 requires carriers offering a health plan issued or renewed on or after January 1, 2024, to comply with standards related to prior authorization. The standards relate to time limits for carriers to process standard and expedited prior authorization requests, the qualifications of health care professionals who can review and deny a prior authorization request, provider and consumer access to carriers' prior authorization requirements and required establishment of an electronic prior authorization request transaction process by carriers. Section 1 will require additional review of health plan form filings to ensure plans have updated the change in timeframes for determinations and notifications related to prior authorization. The Office of Insurance Commissioner (OIC) will require one-time costs, in FY2024, of 6 hours of a Functional Program Analyst 4 to update filing review standards, update checklist documents and filing instructions, train staff, and educate issuers. The OIC receives approximately 312 health plan form filings each year and assumes the new review standards will result in an additional 20 minutes of review per form filing in FY2024 and an additional 10 minutes of review per form filing in FY2025 and thereafter requiring 104 hours (312 form filings x 20 minutes) of a Functional Program Analyst 3 (FPA3) in FY2024 and 52 hours (312 form filings x 10 minutes) of a FPA3 in FY2025 and thereafter.

The changes to prior authorization processes in Section 1, such as cutting prior authorization review times by 50%, will also require additional market analysis and market conduct examinations of carriers. The OIC assumes it will need to conduct an additional 4 market conduct examinations (MCEs) in FY2025 reduced to one additional MCEs each year thereafter requiring 480 hours (4 MCEs x 120 hours) in FY2025 and 120 hours (1 MCEs x 120 hours) in FY2026 and thereafter of a Functional Program Analyst 3.

Section 1(1) will generate additional consumer inquiries, calls, and complaints regarding delayed prior authorization requests. Based on a review of the last 4 years of available consumer contact data, an average of 39 inquiries, 112 calls and 85 complaints relating to prior authorizations and denials are received each year. As a result of this bill, consumer contacts related to prior authorization are expected to increase by 20%. For purposes of this fiscal note, it is assumed that

informational cases will take 10 minutes per case and complaint cases will take 3.25 hours per case requiring a total of 60 hours (30 info cases x 10 minutes + 17 complaint cases x 3.25 hours) of a Functional Program Analyst 3 each year beginning in FY2024.

Section 4(5)(b) requires the Office of Insurance Commissioner (OIC) to adopt rules to prohibit carriers from applying prior authorization for any code covered by the reporting requirements of RCW 48.43.0161 if the OIC determines the data in the most recent report demonstrates that the code has a prior approval rate higher than 95%. This would include medical/surgical codes, mental/substance use disorder codes, and durable medical equipment codes. Section 4(5)(b) also authorizes the OIC to assess utilization of codes where a prior authorization prohibition has been adopted by rule. If the OIC determines after 3 years that utilization of the code has changed significantly, the OIC can initiate rulemaking to reinstate prior authorization for that code. For purposes of this fiscal note, OIC assumes annual rulemaking that will identify at least one code for which prior authorization is prohibited. Section 4 will require additional review of all provider contracts to ensure the modified review criteria has been met. Provider contracts will need to be updated annually identifying the codes the OIC has adopted in rule for which prior authorization will be prohibited. The OIC will require one-time costs, in FY2024, of 6 hours of a Functional Program Analyst 4 to update filing review standards, update checklist documents and filing instructions and train staff. The OIC receives approximately 7,350 provider contracts filings each year and the current review time is 4 hours per filing. The updated review criteria are expected to take an additional 5 minutes of review per filing requiring 613 hours (7,350 provider contracts x 5 minutes) of a Functional Program Analyst 3 beginning in FY2024. The OIC also receives approximately 70 prior authorization service contracts each year and assumes the new review standards will result in an additional 30 minutes of review per contract requiring 35 hours (70 contract filings x 30 minutes) of a Functional Program Analyst 3 beginning in FY2024.

Section 4(5)(b) authorizes the Commissioner to assess utilization of codes where a prior authorization prohibition has been adopted by rule. If the commissioner determines after 3 years that utilization of the code has changed significantly, the commissioner can initiate rulemaking to reinstate prior authorization for that code. To obtain the information necessary to determine whether utilization of one or more codes has increased over a three-year period will require OIC to contract with Onpoint, the data vendor for the Washington State All Payer Claims data base annually beginning in FY2025. Based upon previous contracts with Onpoint, OIC estimates the cost of this analysis will be $40,000 per year. Obtaining this information through Onpoint is a more efficient and accurate alternative that an annual data call to carriers requiring submission of claims data related to codes for which prior authorization has been prohibited.

Section 4(5)(b): 'Complex' rulemaking will be required on an annual basis beginning in FY2024 to implement this subsection. The rulemaking will require analysis of the previous year's report prepared under RCW 48.43.0161. Given the breadth and variability of codes reported under that statute, the variation in codes from year to year that would no longer be subject to prior authorization would be considerable. In addition, beginning in SFY 2026, OIC is authorized to engage in rulemaking to allow the reimposition of prior authorization if the agency determines that utilization of a code for which prior authorization was prohibited has changed significantly.

The provisions in Sections 1 and 4 will lead to an increase in enforcement actions. The OIC anticipates an average of two additional enforcement action per year to address allegations specific to the untimely processing of prior authorization requests. Enforcement actions require the equivalent of approximately 40 hours per case requiring 80 hours (2 cases x 40 hours) of an Insurance Enforcement Specialist beginning in FY2024.

Ongoing Costs:
Salary, benefits and associated costs for .14 FTE Functional Program Analyst 3, .05 FTE Insurance Enforcement Specialist, .66 FTE Senior Policy Analyst, and .16 Functional Program Analyst 4.

Part III: Expenditure Detail

III. A - Operating Budget Expenditures

Account	Account Title	Type	FY 2024	FY 2025	2023-25	2025-27	2027-29
138-1	Insurance Commissioners Regulatory Account	State	211,580	233,868	445,448	409,918	409,918
		Total $	211,580	233,868	445,448	409,918	409,918

III. B - Expenditures by Object Or Purpose

	FY 2024	FY 2025	2023-25	2025-27	2027-29
FTE Staff Years	1.4	1.2	1.3	1.0	1.0
A-Salaries and Wages	126,933	116,599	243,532	199,498	199,498
B-Employee Benefits	42,331	38,495	80,826	64,436	64,436
C-Professional Service Contracts		40,000	40,000	80,000	80,000
E-Goods and Other Services	42,316	38,774	81,090	65,984	65,984
G-Travel					
J-Capital Outlays					
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services					
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements					
9-					
Total $	211,580	233,868	445,448	409,918	409,918

III. C - Operating FTE Detail: *List FTEs by classification and corresponding annual compensation. Totals need to agree with total FTEs in Part I and Part IIIA*

Job Classification	Salary	FY 2024	FY 2025	2023-25	2025-27	2027-29
Functional Program Analyst 3	73,260	0.5	0.4	0.4	0.1	0.1
Functional Program Analyst 4	80,952	0.2	0.2	0.2	0.2	0.2
Insurance Enforcement Specialist	99,516	0.1	0.1	0.1	0.1	0.1
Senior Policy Analyst	108,432	0.7	0.7	0.7	0.7	0.7
Total FTEs		1.4	1.2	1.3	1.0	1.0

III. D - Expenditures By Program (optional)

NONE

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout

Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.

NONE

IV. D - Capital FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.*

NONE

Part V: New Rule Making Required

Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.

Section 4(5)(b): ‘Complex’ rulemaking will be required on an annual basis beginning in FY2024 to implement this subsection. The rulemaking will require analysis of the previous year’s report prepared under RCW 48.43.0161. Given the breadth and variability of codes reported under that statute, the variation in codes from year to year that would no longer be subject to prior authorization would be considerable. In addition, beginning in SFY 2026, OIC is authorized to engage in rulemaking to allow the reimposition of prior authorization if the agency determines that utilization of a code for which prior authorization was prohibited has changed significantly.