Multiple Agency Fiscal Note Summary

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

Estimated Cash Receipts

NONE

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	Fiscal note not available											
Office of Insurance Commissioner	.8	0	0	214,826	.6	0	0	194,708	.6	0	0	154,708
Total $	**0.8**	**0**	**0**	**214,826**	**0.6**	**0**	**0**	**194,708**	**0.6**	**0**	**0**	**154,708**

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	Fiscal note not available								
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

NONE

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FNPID 67505

FNS029 Multi Agency rollup

Individual State Agency Fiscal Note

Bill Number: 1357 S HB 1357-S	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	0.8	0.8	0.8	0.6	0.6
Account					
Insurance Commissioners Regulatory Account-State 138-1	108,560	106,266	214,826	194,708	154,708
Total $	108,560	106,266	214,826	194,708	154,708

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: 02/15/2023
Agency Preparation:	Jane Beyer	Phone: 360-725-7043	Date: 02/20/2023
Agency Approval:	Michael Wood	Phone: 360-725-7007	Date: 02/20/2023
OFM Review:	Jason Brown	Phone: (360) 742-7277	Date: 02/22/2023

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, with timeframes differing for requests submitted through an electronic standardized prior authorization process and those that are processed manually. Prior authorization criteria must be based on peer-reviewed clinical review criteria, and be evidence-based, but also accommodate new and emerging information related to the appropriateness of clinical criteria with respect to race or ethnicity, gender or underserved population status. The legislation sets out requirements for requires provider and consumer access to carriers' prior authorization requirements.

Section 4 provides that for health plans issued on or after January 1, 2024, carriers cannot require prior authorization for any code submitted under the reporting requirements of RCW 48.43.0161 that, as reported for calendar year 2021, had at least 50 prior authorization requests submitted and a prior authorization approval threshold of 98 percent or greater as aggregated across carriers and reported health service categories. The Office of Insurance Commissioner (OIC) is directed to publish on its website the list of those codes, without engaging in rulemaking.

Section 5(4) amends RCW 48.43.0160 to require OIC to include in its 2027 annual report information on trends in utilization during CY 2024 and 2025 of the codes identified in section 4 that have not been subject to prior authorization. The utilization information in the report can be based upon data submitted by carriers or obtained from an independent data source or sources, such as the Washington all payer claims database.

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, with timeframes differing for requests submitted through an electronic standardized prior authorization process and those that are processed manually. Prior authorization criteria must be based on peer-reviewed clinical review criteria, and be evidence-based, but also accommodate new and emerging information related to the appropriateness of clinical criteria with respect to race or ethnicity, gender or underserved population status. The legislation sets out requirements for requires provider and consumer access to carriers' prior authorization requirements.

Section 1(1) will generate additional consumer and provider 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 65 written inquiries, 142 calls and 97 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% and provider contacts are expected to double given the significant changes in prior authorization timelines and processes. 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 108 hours (86 info cases x 10 minutes + 29 complaint cases x 3.25 hours) of a Functional Program Analyst 3 each year beginning in FY2024.

The changes to prior authorization processes in Section 1, such as the requirement for carriers to implement a new

standardized electronic prior authorization process while maintaining a manual prior authorization process will require additional market analysis and market conduct reviews of carriers. The Office of Insurance Commissioner (OIC) assumes it will need to conduct an additional 4 market conduct continuums/examinations (MCEs) in FY2025, and one MCE 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 will require 'normal' rulemaking, in FY2024, to revise the OIC's current prior authorization rules to be consistent with the provisions of the new law.

Section 4 provides that for health plans issued on or after January 1, 2024, carriers cannot require prior authorization for any code submitted under the reporting requirements of RCW 48.43.0161 that, as reported for calendar year 2021, had at least 50 prior authorization requests submitted and a prior authorization approval threshold of 98 percent or greater as aggregated across carriers and reported health service categories. The OIC is directed to publish on its website the list of those codes, without engaging in rulemaking. 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 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 10 minutes of review per contract requiring 12 hours (70 contract filings x 10 minutes) of a Functional Program Analyst 3 beginning in FY2024.

Sections 1(1)(a) and 4 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; and that health plans are not requiring prior authorization for any codes that had at least 50 prior authorization requests submitted and a prior authorization approval threshold of at least 98%. The OIC will require one-time costs, in FY2024, of 19 hours of a Functional Program Analyst 4 to update filing review standards, update checklist documents and filing instructions, train staff, and educate carriers. 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 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 or to the imposition of prior authorization for services for which prior authorization is prohibited under Section 4. 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.

Section 5(4) amends RCW 48.43.0160 to require OIC to include in its 2027 annual report information on trends in utilization during CY 2024 and 2025 of the codes identified in section 4 that have not been subject to prior authorization. The utilization information in the report can be based upon data submitted by carriers or obtained from an independent data source or sources, such as the Washington all payer claims database. To obtain the information necessary to determine whether utilization of these 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 in FY2026. Based upon previous contracts with Onpoint, OIC estimates the cost of this analysis will be $40,000. 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.

Ongoing costs:

Salary, benefits and associated costs for .55 FTE Functional Program Analyst 3 and .05 FTE Insurance Enforcement Specialist.

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	108,560	106,266	214,826	194,708	154,708
		Total $	108,560	106,266	214,826	194,708	154,708

III. B - Expenditures by Object Or Purpose

	FY 2024	FY 2025	2023-25	2025-27	2027-29
FTE Staff Years	0.8	0.8	0.8	0.6	0.6
A-Salaries and Wages	64,271	62,119	126,390	90,538	90,538
B-Employee Benefits	22,577	22,894	45,471	33,228	33,228
C-Professional Service Contracts				40,000	
E-Goods and Other Services	21,712	21,253	42,965	30,942	30,942
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 $	108,560	106,266	214,826	194,708	154,708

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	0.8	0.7	0.6	0.6
Functional Program Analyst 4	80,952	0.1		0.0		
Insurance Enforcement Specialist	99,516	0.1	0.1	0.1	0.1	0.1
Senior Policy Analyst	108,432	0.2		0.1		
Total FTEs		0.8	0.8	0.8	0.6	0.6

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 1 will require 'normal' rulemaking, in FY2024, to revise the Office of Insurance Commissioner's current prior authorization rules to be consistent with the provisions of the new law.