

Multiple Agency Fiscal Note Summary

Bill Number: 1357 2S HB	Title: Prior authorization/health
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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	1,170,000	0	0	1,170,000	0	0	1,170,000
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	1,170,000	0	0	1,170,000	0	0	1,170,000

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	7.8	1,448,000	1,448,000	2,618,000	7.8	1,448,000	1,448,000	2,618,000	7.8	1,448,000	1,448,000	2,618,000
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	.5	0	0	132,761	.2	0	0	59,788	.2	0	0	59,788
Total \$	8.3	1,448,000	1,448,000	2,750,761	8.0	1,448,000	1,448,000	2,677,788	8.0	1,448,000	1,448,000	2,677,788

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: Preliminary 3/12/2023
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Individual State Agency Fiscal Note

Revised

Bill Number: 1357 2S HB	Title: Prior authorization/health	Agency: 107-Washington State Health Care Authority
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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	585,000	585,000	1,170,000	1,170,000	1,170,000
Total \$	585,000	585,000	1,170,000	1,170,000	1,170,000

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	7.8	7.8	7.8	7.8	7.8
Account					
General Fund-State 001-1	724,000	724,000	1,448,000	1,448,000	1,448,000
General Fund-Federal 001-2	585,000	585,000	1,170,000	1,170,000	1,170,000
Total \$	1,309,000	1,309,000	2,618,000	2,618,000	2,618,000

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: Meghan Morris	Phone: 360-786-7119	Date: 02/27/2023
Agency Preparation: Lena Johnson	Phone: 360-725-5295	Date: 03/08/2023
Agency Approval: Cliff Hicks	Phone: 360-725-0875	Date: 03/08/2023
OFM Review: Jason Brown	Phone: (360) 742-7277	Date: 03/12/2023

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	724,000	724,000	1,448,000	1,448,000	1,448,000
001-2	General Fund	Federal	585,000	585,000	1,170,000	1,170,000	1,170,000
Total \$			1,309,000	1,309,000	2,618,000	2,618,000	2,618,000

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	7.8	7.8	7.8	7.8	7.8
A-Salaries and Wages	618,000	618,000	1,236,000	1,236,000	1,236,000
B-Employee Benefits	203,000	203,000	406,000	406,000	406,000
C-Professional Service Contracts	242,000	242,000	484,000	484,000	484,000
E-Goods and Other Services	12,000	12,000	24,000	24,000	24,000
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	234,000	234,000	468,000	468,000	468,000
9-					
Total \$	1,309,000	1,309,000	2,618,000	2,618,000	2,618,000

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	1.8	1.8	1.8	1.8	1.8
Medical Assistance Program Specialist 2	76,000	2.0	2.0	2.0	2.0	2.0
Medical Assistance Program Specialist 3	83,000	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
Pharmacist 4	121,000	1.0	1.0	1.0	1.0	1.0
Total FTEs		7.8	7.8	7.8	7.8	7.8

III. D - Expenditures By Program (optional)

Program	FY 2024	FY 2025	2023-25	2025-27	2027-29
200 - HCA - OTHER (200)	1,309,000	1,309,000	2,618,000	2,618,000	2,618,000
Total \$	1,309,000	1,309,000	2,618,000	2,618,000	2,618,000

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.

HCA Fiscal Note

Bill Number: 1357 2SHB

HCA Request #: 23-182

Part II: Narrative Explanation

AN ACT Relating to modernizing the prior authorization (PA) process; amending RCW 48.43.420, 48.43.0161, and 48.43.400; adding a new section to chapter 48.43 RCW; adding a new section to chapter 41.05 RCW; adding a new section to chapter 74.09 RCW; creating a new section; repealing RCW 48.43.410; and providing an effective date.

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

2SHB 1357 requires the Washington State Health Care Authority (HCA) to require that commercial carriers, UMP carriers, and Medicaid MCOs comply with shorter prior authorization (PA) turnaround times, provide certain notifications, and perform specific prior authorization processes for both health care services and prescriptions drugs. The bill does not impact Medicaid FFS prior authorization operational processes at HCA but does impact HCA's:

- Medicaid clinical policy review processes,
- Oversight of carriers, and
- Contracts with carriers.

More specifically, the bill requires that:

- PA decisions for electronically submitted requests must be made within 3 calendar days (except holidays) for standard requests and 1 calendar day for expedited requests.
- PA decisions for non-electronically submitted requests must be made within 5 calendar days standard/2 calendar days expedited.
- The time allowed for carriers to request additional information in support of a PA request is shortened – in most cases to 1 calendar day.
- Allows carriers to establish reasonable timeframes for providing additional information requested.
- PA requirements must be written and provided electronically upon request.
- PA requirements must be peer-reviewed, evidence based, consider new information about underserved populations, and reviewed annually.
- Carriers must provide an API that facilitates electronic PA and meets certain specific requirements by:
 - 1/1/25 for health care services (delayed to 1/1/26 if certain federal rulemaking dates are not met), and
 - 1/1/27 for prescriptions drugs.
- Individual and group health plans must submit certain prescription drug information to OIC annually.

This bill is null and void if not funded in the state budget.

Employee and Retiree Benefits (ERB):

This second substitute version amends SHB 1357 to:

- Extend the prior authorization (PA) determination requirements to include prescription drugs for both commercial carriers and the Uniform Medical Plans offered under the Public Employees' Benefits Board (PEBB) and School Employees' Benefits Board (SEBB) programs.

HCA Fiscal Note

Bill Number: 1357 2SHB

HCA Request #: 23-182

- Change the functional requirements for the electronic PA system that health carriers are required to develop, extend the commencement date for operability, and offer criteria for extension.
 - Amend the response time for electronic PA submissions from business days to calendar days.
 - Remove the PA prohibition on codes with at least 50 PA requests and an approval rating of 98% or higher, as well as the related monitoring and reporting for these codes.
 - Add prescription drugs to health carriers' reporting requirements related to PA practices for commercial group and individual health plans.
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Section 1 of this bill adds a new section to RCW 48.43 (Insurance Reform) that requires carriers offering commercial health plans issued on or after January 1, 2024, to create an electronic PA application programming interface and follow new PA determination timelines for electronic and non-electronic requests for health care services and prescription drugs.

Carriers must make a PA determination and notify a provider or facility of the results:

- For electronic requests within three (3) calendar days of a complete standard request and within one (1) calendar day for an expedited request. Providers must supply any additional information requested by the health plan within one (1) calendar day.
- For non-electronic submissions within five (5) calendar days of a complete standard request and two (2) calendar days for an expedited request. Providers must supply any additional information requested by the health plan within five (5) calendar days for a standard request and two (2) calendar days for an expedited request.

If carriers determine that a provider or facility has not provided sufficient information for a determination, they may establish a specific reasonable time frame for submission of additional information.

PA determination requirements established by health carriers must be described in detail based on peer-reviewed, evidence-based clinical criteria and be easily accessible to providers and enrollees in an electronic format upon request. Criteria must also accommodate new and emerging information related to appropriateness of application for black and indigenous populations, other people of color, gender, and underserved populations.

Carriers must create an electronic PA application programming interface (API) that is able to automate the PA determination process for in-network providers and follow specific functional requirements including use of fast health care interoperability resources and capabilities for automation. The application must be available for health care determinations by January 1, 2025 and for prescription drug determinations by January 1, 2027. If the federal Centers for Medicare and Medicaid Services (CMS) rules related to PA API are not finalized by September 13, 2023, carriers will have until January 1, 2026, to implement the API for health services. Carriers may apply to the Office of the Insurance Commissioner for a one-year extension.

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 PEBB and SEBB programs.

Section 5 amends RCW 48.43.0161 (Prior authorization practices—Carrier annual reporting requirements—Commissioner's standardized report) to create new reporting requirements for commercial health plans related to prescription drug PAs.

HCA Fiscal Note

Bill Number: 1357 2SHB

HCA Request #: 23-182

Section 9 adds a new section stipulating that if the bill is not funded it is null and void.

Apple Health:

2SHB 1357 differs in impact from the last version by:

- Requires that the health carriers' electronic prior authorization process use national transaction standards for prior authorization.
- Splits the prior authorization determination timelines into two categories: (1) requests submitted through the standardized electronic prior authorization transaction process; and (2) non-electronic requests.
- Requires that requests submitted through a non-electronic prior authorization process have decision results for standard requests within five calendar days of a complete request and within two calendar days for an expedited request. Requires that any request for additional information be made within five calendar days for a standard request and within one calendar day for an expedited request.
- Allows health carriers to establish reasonable time frames for the submission of additional information.
- Requires that, in addition to being based on evidence-based criteria, clinical review criteria must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous populations, other people of color, gender, and underserved populations.

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	585,000	585,000	585,000	585,000	585,000	585,000	1,170,000	1,170,000	1,170,000
Totals	\$ 585,000	\$ 585,000	\$ 585,000	\$ 585,000	\$ 585,000	\$ 585,000	\$ 1,170,000	\$ 1,170,000	\$ 1,170,000

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 costs for some carriers to build the PA API and process PAs under a shorter time frame. This could result in higher premiums charged to HCA by the fully insured carriers and will increase expenses for UMP. These costs could be reflected in a potential increase to employee premiums and the state medical benefit contribution.

There is amended language throughout the bill that applies new PA determination requirements to prescription drugs; however, Section 1(3) retains language from the prior bill versions that exempts prior authorization determinations for prescription drugs as described in RCW 48.43.400 through 48.43.420. Furthermore, Section 2 applies requirements to health carriers, not health plans. Moda, the pharmacy benefit manager for UMP prescription drug coverage, does not meet the definition of a "health carrier" per RCW 48.43.005. Based on the apparent intent of this bill version, however, HCA

HCA Fiscal Note

Bill Number: 1357 2SHB

HCA Request #: 23-182

assumes that PA requirements apply to prescription drugs for commercial health plans and for Moda for UMP.

Section 1 of this bill adds a new section to RCW 48.43, which governs fully insured carriers, that requires health plans to create a PA API with specific capabilities available by January 1, 2025 and shortens the prior authorization timeline for electronic requests from five (5) calendar days (existing OIC regulations) to three (3) calendar days for standard requests and from forty-eight (48) hours (existing OIC regulations) to one (1) calendar day for expedited requests. Under the second substitute, this section also applies to prescription drug PAs.

Section 2 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 create the new PA API and follow the updated determination timelines.

Regence estimates this legislation will have an approximately \$8.5 million operational and administrative cost to bring UMP into compliance with the proposed requirements. This estimate includes implementation costs and one year of operational costs. The main cost driver is the significantly faster PA request turnaround times being placed on UMP, which will require additional staff to comply. As a self-funded health plan, UMP follows federally mandated turnaround times for PA (15 days for standard, 3 days for urgent), creating a much bigger change in turnaround times for UMP versus Regence's fully insured book of business that follows current state law for turnaround times. Additional cost drivers include multiple technology investments to comply with the PA API requirements for UMP.

Section 5 extends annual PA reporting requirements to the Office of the Insurance Commissioner (OIC) to include detailed data on the top ten (10) prescription drugs with the highest total number of PA requests; the highest percentage of approved PA requests; and (iii) with the highest percentage of PA requests that were initially denied and then subsequently approved on appeal.

The new PA API, condensed review period for requests, and new reporting requirements for prescription drug PAs would increase some PEBB and SEBB carriers' costs associated with administration of prior authorizations. PEBB and SEBB carriers will need additional staffing to process prior authorizations under the shorter timeframes imposed in Sections 1 and 2. The electronic interface would also take time and resources to develop.

It is unknown how this bill will impact future rates for UMP 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.

HCA Fiscal Note

Bill Number: 1357 2SHB

HCA Request #: 23-182

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 \$2,618,000 (\$1,448,000 of GF-State) and 7.8 Full Time Equivalent (FTE) staff in the 2023-25 Biennium. Of these amounts, \$1,666,000 is needed cover the cost of the 7.8 FTEs to implement the bill as written, \$484,000 is needed to complete the 11 additional Health Technology Assessment program (HTA) annual searches, and \$468,000 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, the Clinical Quality and Care Transformation (CQCT) Division 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.

CQCT Medicaid clinical 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 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.

CQCT Pharmacy Team staffing costs:

- 1.0 FTE Pharmacist 4 to develop pharmacy policies and oversee implementation with MCOs
- 2.0 FTE Medical Assistance Program Specialist 2 (MAPS 2) to help with coordination of these policies, including programming, communications, and coordination during policy development.

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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. Across the five MCOs, per-plan estimated costs ranging from \$1 million to \$6.2 million in increased expenditures annually, with up to an additional \$8 million in one-time expenditures for implementation of systems requirements. Across all plans, total ongoing expenditures per year were estimated at approximately \$13.4 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. 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 5 days non-urgent, and 2 days expedited (PA waived if emergent), so moving to shorter turnaround times for electronically submitted PA requests and shorter turnaround times to request additional information are major shifts.

- The faster turnaround times will require additional resource and staffing investments on the part of providers and payers.
- Prior to the availability of such additional resources there will likely be unnecessary denials, appeals, and increased administrative costs. This investment would be required in HCA for all HCA contracted payers (and would additionally be necessary in FFS Medicaid if it were included in the scope of the bill).
- Plans may err on the side of denying claims before the response deadlines, leading to an increase in appeals and associated costs.
- PA service would need to be available 24/7 in order to request any needed additional information within one calendar day in some cases, thereby increasing costs for evening and weekend staff.
- Current standards already waive PA for emergent care, so the faster turnaround times proposed would have no effect on the speed of emergent care services.

As MCO costs to provide these services increases, those increases will be passed along to HCA through contracts. Changes to prior authorization would increase the expenditure of the Medicaid program as cost containment is then altered because policy changes would either remove or change authorization to be expedited prior authorization.

Potential staffing costs associated with this bill may include:

- Assume RN increase due to lost automation and non-clinical staff approvals - \$175K/year minimum.
- Assume increase in UM staff for increased weekend, evening coverage, plus 1 new MD - \$620K/year minimum.

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- Assume increase in Appeals staffing due to increased appeals for denials due to lack of information - \$135K/year minimum.

Assumptions:

- HCA would implement the required PA turnaround times in contracts, not in agency rules.
- This draft bill does not currently apply to Medicaid Fee-For-Service (FFS) prior authorization processing. If this bill were to pass, we anticipate that FFS would eventually also be expected to meet the same standards and will have significant impacts as noted above.
- The shorter PA response times apply to all services, for all eligibility categories, for Managed Care Organizations (MCOs), Employee and Retiree Benefits (ERB), and Carriers governed by the Office of the Insurance Commissioner (OIC).
- Under the bill, the determination of “expedited” is at the sole discretion of the provider and we assume that requiring clinical justification for expedited processing would not be allowed. Such services would be provided immediately following the receipt of the PA. We will need to verify that this provision meets federal requirements to enable HCA to draw down Medicaid match.
- The criteria of “peer-reviewed evidence” will align to the current medical necessity rule allowing HCA to continue to draw down federal Medicaid match.
- Pricing (DME) and coverage determinations (AEM) would also need to comply with the bill’s PA turnaround times, since not excluded.
- The definition of “expedited” has the same definition as “urgent.”
- CQCT 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.
- HCA would not implement any requirement that violates federal standards for Medicaid, allowing HCA to continue to receive federal match funding for Medicaid.

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	724,000	724,000	724,000	724,000	724,000	724,000	1,448,000	1,448,000	1,448,000
001-C	General Fund	Medicaid	585,000	585,000	585,000	585,000	585,000	585,000	1,170,000	1,170,000	1,170,000
Totals			\$ 1,309,000	\$ 1,309,000	\$ 1,309,000	\$ 1,309,000	\$ 1,309,000	\$ 1,309,000	\$ 2,618,000	\$ 2,618,000	\$ 2,618,000

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	7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8	
A Salaries and Wages	618,000	618,000	618,000	618,000	618,000	618,000	1,236,000	1,236,000	1,236,000	
B Employee Benefits	203,000	203,000	203,000	203,000	203,000	203,000	406,000	406,000	406,000	
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	12,000	12,000	12,000	12,000	12,000	12,000	24,000	24,000	24,000	
T Intra-Agency Reimbursements	234,000	234,000	234,000	234,000	234,000	234,000	468,000	468,000	468,000	
Totals			\$ 1,309,000	\$ 1,309,000	\$ 1,309,000	\$ 1,309,000	\$ 1,309,000	\$ 2,618,000	\$ 2,618,000	\$ 2,618,000

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	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8
MEDICAL ASSISTANCE PROGRAM SPECIALIST 2	76,000	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
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
PHARMACIST 4	121,000	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Totals		7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8

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	1,309,000	1,309,000	1,309,000	1,309,000	1,309,000	1,309,000	2,618,000	2,618,000	2,618,000
Totals			\$ 1,309,000	\$ 1,309,000	\$ 1,309,000	\$ 1,309,000	\$ 2,618,000	\$ 2,618,000	\$ 2,618,000

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.

HCA Fiscal Note

Bill Number: 1357 2SHB

HCA Request #: 23-182

Part IV: Capital Budget Impact

None.

Part V: New Rule Making Require

None.

Individual State Agency Fiscal Note

Bill Number: 1357 2S HB	Title: Prior authorization/health	Agency: 160-Office of Insurance Commissioner
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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	0.4	0.5	0.5	0.2	0.2
Account					
Insurance Commissioners Regulatory Account-State 138-1	62,448	70,313	132,761	59,788	59,788
Total \$	62,448	70,313	132,761	59,788	59,788

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: Meghan Morris	Phone: 360-786-7119	Date: 02/27/2023
Agency Preparation: Jane Beyer	Phone: 360-725-7043	Date: 03/02/2023
Agency Approval: Michael Wood	Phone: 360-725-7007	Date: 03/02/2023
OFM Review: Jason Brown	Phone: (360) 742-7277	Date: 03/02/2023

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.

Section 1(1) adds a new section to chapter 48.43 RCW concerning prior authorization standards which is effective for health plans issued or renewed on or after January 1, 2024. The new section addresses timeframes for electronic and non-electronic prior authorization request reviews and decisions. It also requires carriers to implement a prior authorization “application programming interface” that meets standards currently included in proposed federal rules. 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(2)(d) authorizes OIC to grant a one-year delay in enforcement of the requirements if the Insurance Commissioner determines that the carrier has made a good faith effort to comply with the requirements.

Section 2(1) adds a new section to chapter 41.05 RCW concerning prior authorization standards which applies to public employee health plans issued or renewed on or after January 1, 2024. The substantive requirements of Section 2 parallel those of Section 1.

Section 4(5)(a) & (7) amend RCW 48.43.420(5)(a) to require health carriers or prescription drug utilization management entities to meet the decision and notification requirements established in Section 1 of the act for prescription drug utilization management exception requests.

Section 5 amends RCW 48.43.0161 to expand carrier data reporting to OIC for the annual prior authorization report required by current law. The new data will include prescription drug prior authorization data.

Section 7 establishes January 1, 2024, as the effective date for Sections 4, 5, & 6.

Section 8 repeals RCW 48.43.410 because its provisions are integrated into section 1 of the bill.

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(1) adds a new section to chapter 48.43 RCW concerning prior authorization standards which is effective for health plans issued or renewed on or after January 1, 2024. The new section addresses timeframes for electronic and non-electronic prior authorization request reviews and decisions. It also requires carriers to implement a prior authorization “application programming interface” that meets standards currently included in proposed federal rules. 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)(a)(i) and (ii) 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.

Section 1(2)(d) authorizes OIC to grant a one-year delay in enforcement of the requirements if the Insurance Commissioner determines that the carrier has made a good faith effort to comply with the requirements. OIC assumes for purposes of this fiscal note that the federal government will finalize the rules referenced in Section 1 by September 2023 and that some carriers will request enforcement delays. Enforcement will still occur in situations in which a carrier did not make a timely request for a delay or OIC did not grant a delay because the carrier did not demonstrate good faith efforts to comply.

The provisions in Section 1 will lead to an increase in enforcement actions. The OIC anticipates four additional enforcement actions in FY2025, reduced to an average of one additional enforcement action each year beginning in FY2026 to address the deadline for carrier implementation of the health services interface and allegations specific to the untimely processing of prior authorization requests. Enforcement actions require the equivalent of approximately 40 hours per case requiring 160 hours (4 cases x 40 hours) in FY2025 and 40 hours (1 case x 40 hours) in FY2026 and thereafter of an Insurance Enforcement Specialist.

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 four 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 MCE x 120 hours) in FY2026 and thereafter of a Functional Program Analyst 3.

Section 2(1) adds a new section to chapter 41.05 RCW concerning prior authorization standards which applies to public employee health plans issued or renewed on or after January 1, 2024. The substantive requirements of Section 2 parallel those of Section 1.

Section 4(5)(a) & (7) amend RCW 48.43.420(5)(a) to require health carriers or prescription drug utilization management entities to meet the decision and notification requirements established in Section 1 of the act for prescription drug utilization management exception requests. These sections will require additional review of health carrier and health care benefit manager contracts that include utilization management services for compliance with updated language revising timeframes for prescription drug utilization management exception determinations. The OIC will require one-time costs, in FY2024, of 4 hours of a Functional Program Analyst 4 to update checklists and train staff. The OIC 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.

Section 5 amends RCW 48.43.0161 to expand carrier data reporting to OIC for the annual prior authorization report required by current law. The new data will include prescription drug prior authorization data. The report must be completed annually by January 1. Updating the current reporting templates and analysis of the additional data reported will require 40 hours of a Policy Analyst beginning in FY2024.

Section 8 repeals RCW 48.43.410 because its provisions are integrated into Section 1 of the bill.

Sections 1, 2, 4 and 8 will require additional review of health plan form filings to ensure plans have updated the change in timeframes for determinations and notifications related to both medical and prescription drug prior authorization. The OIC

will require one-time costs, in FY2024, of 22 hours of a Functional Program Analyst 4 to update filing review standards, update checklists and speed-to-market tools, 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 30 minutes of review per form filing in FY2024 and an additional 5 minutes of review per form filing in FY2025 and thereafter requiring 156 hours (312 form filings x 30 minutes) in FY2024 and 26 hours (312 form filings x 5 minutes) in FY2025 and thereafter of a Functional Program Analyst 3. Section 8 repeals RCW 48.43.410 in its entirety. Normally this would result in a decrease of review work, but Section 4 (7) replaces the requirements of RCW 48.43.410 with the clinical review standards established in Section 1 of the act. Updates to the checklists, speed-to-market tools, training of health forms analysts and educating carriers is still required and the new clinical review standards are different from those required under RCW 48.43.410. Due to this, the removal of RCW 48.43.410 does not result in a net decrease of review hours.

Ongoing costs:

Salary, benefits and associated costs for .16 FTE Functional Program Analyst 3, .03 FTE Insurance Enforcement Specialist, and .03 FTE Policy Analyst.

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	62,448	70,313	132,761	59,788	59,788
Total \$			62,448	70,313	132,761	59,788	59,788

III. B - Expenditures by Object Or Purpose

	FY 2024	FY 2025	2023-25	2025-27	2027-29
FTE Staff Years	0.4	0.5	0.5	0.2	0.2
A-Salaries and Wages	37,314	41,451	78,765	35,270	35,270
B-Employee Benefits	12,644	14,799	27,443	12,560	12,560
C-Professional Service Contracts					
E-Goods and Other Services	12,490	14,063	26,553	11,958	11,958
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 \$	62,448	70,313	132,761	59,788	59,788

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	0.2	0.4	0.3	0.2	0.2
Functional Program Analyst 4	80,952	0.1		0.0		
Insurance Enforcement Specialist	99,516		0.1	0.1	0.0	0.0
Policy Analyst	97,584	0.0	0.0	0.0	0.0	0.0
Senior Policy Analyst	108,432	0.2		0.1		
Total FTEs		0.4	0.5	0.5	0.2	0.2

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.