Multiple Agency Fiscal Note Summary

Bill Number: 1357 E 2S 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	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	.6	0	0	172,966	.2	0	0	59,788	.2	0	0	59,788
Total $	**8.4**	**1,448,000**	**1,448,000**	**2,790,966**	**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 3/16/2023

Individual State Agency Fiscal Note

Revised

Bill Number: 1357 E 2S 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	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:	Greg Attanasio	Phone: 360-786-7410	Date: 03/10/2023
Agency Preparation:	Lena Johnson	Phone: 360-725-5295	Date: 03/16/2023
Agency Approval:	Cliff Hicks	Phone: 360-725-0875	Date: 03/16/2023
OFM Review:	Jason Brown	Phone: (360) 742-7277	Date: 03/16/2023

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.

Bill Number: 1357 E2SHB HCA Request #: 23-206

Part II: Narrative Explanation

AN ACT Relating to modernizing the prior authorization process; amending RCW 48.43.420, 48.43.0161; 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; and providing an effective date.

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

E2SHB 1357 requires the Washington State Health Care Authority (HCA) to require that commercial carriers, UMP health plans, 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 engrossed second substitute version amends 2SHB 1357 to:

- Require that an implementation plan be submitted when a health carrier requests an extension for implementing its prior authorization (PA) application programming interface (API).
- Remove the requirement that the electronic PA process be "standardized" for PA timelines to apply.

- Restore existing law related to prescription drug utilization management requirements and clarifies that the changes to prescription drug standards only apply to PA timelines, not exception requests.
- Add retirees to the PA provisions related to the Uniform Medical Plan (UMP).
- Require HCA to evaluate applications for API implementation delays for UMP.
- Change reference from "carriers" to "health plans" in the PA provisions related to UMP under Section 2. This clarifies that the required PA turnaround times apply to UMP's third-party administrator (TPA) and pharmacy benefit manager (PBM).

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 API 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.
- For non-electronic submissions within five (5) calendar days of a complete 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 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 (OIC) 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, retirees, and their covered dependents in the PEBB and SEBB programs. Requests to delay implementation of the PA API for health services must be submitted to HCA for review.

Section 4 amends RCW 48.43.0161 (Prior authorization practices—Carrier annual reporting requirements—Commissioner's standardized report) creating new annual reporting requirements to the OIC concerning prescription drug PAs.

Section 6 adds a new section stipulating that if the bill is not funded it is null and void.

Bill Number: 1357 E2SHB HCA Request #: 23-206

Apple Health:

E2SHB 1357 differs in impact from the last version by:

- Requires that an implementation plan be submitted when a health carrier, health plan, or managed care organization (MCO) requests an extension for implementing its prior authorization application programming interface.
- Removes the requirement that the electronic prior authorization process be a "standardized" process for the prior authorization timelines to apply.
- Restores existing law related to prescription drug utilization management requirements and clarifies that the changes to prescription drug standards only apply to prior authorization timelines, but not exception requests.
- Adds retirees to the prior authorization provisions related to UMP.
- Changes the state agency responsible for evaluating any delay justification for the implementation date of a UMP health plan API from OIC to HCA.
- Changes references to "carriers" to "health plans" in the prior authorization provisions related to UMP. This clarifies that the required PA turnaround times do apply to Moda.
- Changes references to "managed health care systems" to "managed care organizations" in the prior authorization provisions related to Medicaid.
- Conforms the reference to federal rules in the provisions related to MCOs (Section 3) to be like the references in the provisions related to health carriers and health plans (Sections 1 and 2).
- Adds Section 5, a new section, states Section 4 of this act takes effect January 1, 2024.
- Adds Section 6, a new section, states this act is null and void if funding for the purposes of this act are not provided by June 30, 2023.

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).

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.

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 health services and prescription drug 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.

Kaiser estimates that these changes will have approximately a 5% administrative impact and 0.5% premium impact. This translates to $4 million combined for the PEBB and SEBB programs in the KPNW and KPWA regions. This estimate does not include the yearly ongoing administrative expenses and software upgrades that would be needed.

Premera does not anticipate a cost impact because their fully-insured plans are already in accordance with the PA timelines in this bill.

Section 2 of this bill adds a new section that requires health plans, including PBMs, 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 TPA and PBM (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 PA determinations. Additional cost drivers include multiple technology investments to comply with the PA API requirements for medical pharmacy PA requests for all Regence health plans, including UMP.

HCA assumes spending authority will be increased for the UMP in the PEBB UMP benefits administration account (Fund 439) and the SEBB medical benefits administration account (Fund 494) to fund implementation of this bill.

Section 4 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.

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 ongoing policy 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.

HTA TAC costs:

HCA's HTA program is directed in RCW 70.14.100 to contract for health technology assessments that are reviewed by the HTCC. The policies of the HTCC are commonly adopted in Medicaid and the expectation is that the policies are used by the MCOs. To comply with the bill, the 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 currently on an annual review cycle and CQCT is not staffed to meet such a requirement. To meet the annual update requirement, CQCT will need additional staff identified above. 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.

- 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.

A signal search is a structured, formal literature search. It is a service typically performed by a contractor. It involves searching the scientific literature for studies that can inform a clinical policy and supports HCA decisions about whether a particular policy needs to be updated.

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.
- 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 the federal single agency standard 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**	**$ 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**	**$ 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.

Part IV: Capital Budget Impact

None.

Part V: New Rule Making Require

None.

Individual State Agency Fiscal Note

Bill Number: 1357 E 2S 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	0.4	0.8	0.6	0.2	0.2
Account					
Insurance Commissioners Regulatory Account-State 138-1	61,080	111,886	172,966	59,788	59,788
Total $	61,080	111,886	172,966	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:	Greg Attanasio	Phone: 360-786-7410	Date: 03/10/2023
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Agency Approval:	Michael Wood	Phone: 360-725-7007	Date: 03/15/2023
OFM Review:	Jason Brown	Phone: (360) 742-7277	Date: 03/16/2023

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 the Office of Insurance Commissioner (OIC) to grant a one-year delay in enforcement of the requirements if the OIC 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 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.

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" (API) that meets standards currently included in proposed federal rules. The first round of API implementation is due January 1, 2025 and the second round, which adds prescription drugs, is due January 1, 2027. 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) and (b) 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.

Under Section 1(2)(d), if a carrier is unable to meet the requirements to implement an API system by January 1, 2025, it must file a narrative justification with the Office of Insurance Commissioner (OIC) describing the reasons for not meeting the requirements and the impacts of noncompliance upon providers and enrollees. The OIC may grant a one-year delay in enforcement if the carrier has made a good faith effort to comply with the law. The OIC estimates that two thirds of the health carriers in the Washington market will be unable to meet the API requirements and will be required to file a narrative justification with the OIC. Each narrative justification will take an average of 25 hours to complete a detailed review and address multiple rounds of follow-up questions and answers requiring one-time costs of 400 hours (16 carriers x 25 hours) of a Health Forms Program Manager in FY2025.

The provisions in Section 1 will lead to an increase in enforcement actions, including the potential for enforcement in situations in which a carrier did not make a timely request for a delay under section 1(2)(d) or OIC did not grant a delay because the carrier could not demonstrate good faith efforts to comply. 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 shorter turnaround times for responding to prior authorization requests and the requirement for carriers to implement a new prior authorization API while maintaining a manual prior authorization process will require additional market analysis and market conduct reviews of carriers. The 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.

Sections 1 and 2 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 4 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.

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	61,080	111,886	172,966	59,788	59,788
		Total $	61,080	111,886	172,966	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	0.8	0.6	0.2	0.2
A-Salaries and Wages	36,505	66,645	103,150	35,270	35,270
B-Employee Benefits	12,359	22,864	35,223	12,560	12,560
C-Professional Service Contracts					
E-Goods and Other Services	12,216	22,377	34,593	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 $	61,080	111,886	172,966	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		
Health Forms Program Manager	100,776		0.3	0.1		
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	0.8	0.6	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.