Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1566

Brief Description: Making improvements to transparency and accountability in the prior authorization determination process.

Sponsors: Representatives Rule, Marshall, Shavers, Pollet and Kloba.

Brief Summary of Bill

- Modifies requirements related to determination notifications, peer review, and the use of artificial intelligence as part of the prior authorization process for private health insurance, Public Employee Benefit Board and School Employee Benefit Board health programs, and Medicaid programs,

Hearing Date: 2/5/25

Staff: Emily Poole (786-7106).

Background:

Prior authorization is the requirement that a health care provider seek approval of a drug, procedure, or test before receiving reimbursement from a health carrier, health plan, or managed care organization. Requested drugs, procedures, or tests may be evaluated based on medical necessity, clinical appropriateness, level of care, and effectiveness. Health plans offered by health carriers, health plans offered to public or school employees, retirees, and their dependents, and medical assistance coverage offered through managed care organizations are subject to certain requirements regarding the prior authorization process.

Health carriers, health plans, and managed care organizations must follow specified timing requirements when making and communicating prior authorization determinations. They must

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also describe their prior authorization requirements in detailed, easily understandable language. The prior authorization requirements must be based on peer-reviewed, evidence-based clinical review criteria which are evaluated and updated at least annually.

Health carriers, health plans, and managed care organizations must build and maintain a prior authorization application programming interface (API) that automates the process for determining the necessity for a prior authorization, identifying information and documentation requirements, and facilitating the exchange of prior authorization requests and determinations. The API must automate the prior authorization determination process, allow providers to query prior authorization documentation requirements, and support automated compiling and exchange of necessary data elements to populate the prior authorization requirements, among other requirements.

Health carriers that offer health plans may not retrospectively deny coverage for care that had prior authorization under the plan's written policies at the time the care was rendered.

Health carriers are required to report certain information relating to prior authorization to the Office of the Insurance Commissioner (Commissioner) on an annual basis. The Commissioner must aggregate and deidentify the data collected into a standard report and make the report available to interested parties.

Summary of Bill:

Prior Authorization Determinations and Policy Changes.
When issuing a notification for a prior authorization determination, a carrier, health plan, or managed care organization and any contracted health care benefit manager are required to include a unique identifier for the individual who initially reviewed and made the determination. The carrier, health plan, or managed care organization must also include the national provider identification (NPI) number of the physician who had clinical oversight for the determination, as well as the physician's credentials, board certifications, and areas of specialty expertise and training. This requirement also applies to notifications sent through a prior authorization API.

In the case of an adverse benefit determination, a health carrier, health plan, or managed care organization must make available to the requesting provider a peer-to-peer review discussion. The peer reviewer must be licensed to practice medicine in Washington and must be knowledgeable of and have experience providing the same or similar service as the health care service under review. The peer reviewer must also have authority to modify or overturn the care determination decision.

Health carriers, health plans, and managed care organizations may continue to make adjustments to policies and procedures that impact the applicability of their prior authorization requirements. However, beginning August 1, 2025, these adjustments may only be made once annually and must go into effect January 1st of any given calendar year. Notification of policy changes must be provided to all in-network providers at least four months prior to the effective date.

Use of Artificial Intelligence.
Only a licensed physician or health professional working within their scope of practice may make determinations of medical necessity. The licensed physician or health professional must evaluate the specific clinical issues involved in the health care services requested by the requesting provider. An artificial intelligence (AI), algorithm, or related software tool may not be the sole means used to deny, delay, or modify health care services.

A carrier, health plan, or managed care organization and any contracted health care benefit manager that uses, or contracts for the use of, an AI, algorithm, or other software tool for the purpose of prior authorization, based in whole or in part on medical necessity, must ensure that:

- the AI, algorithm, or other software tool bases its determination on the following information, as applicable:
    - an enrollee's medical or other clinical history;
    - individual clinical circumstances; and
    - other relevant clinical information contained in the enrollee's medical or other clinical record;
- the AI, algorithm, or other software tool does not base its determination solely on a group data set;
- the AI, algorithm, or other software tool's criteria and guidelines comply with these requirements and applicable state and federal law;
- the use of the AI, algorithm, or other software tool does not discriminate against an enrollee in violation of state or federal law;
- the AI, algorithm, or other software tool is fairly and equitably applied, including in accordance with any applicable regulations and guidance issued by the federal Department of Health and Human Services;
- the policies and procedures for using the AI, algorithm, or other software tool is open to audit by the Commissioner or the Health Care Authority (Authority), as applicable;
- the AI, algorithm, or other software tool's performance, use, and outcomes are periodically reviewed to maximize accuracy and reliability; and
- patient data is not used beyond its intended and stated purpose, consistent with state and federal privacy laws.

"Artificial intelligence" is defined as the use of machine learning and related technologies that use data to train statistical models for the purpose of enabling computer systems to perform tasks normally associated with human intelligence or perception, such as computer vision, speech or natural language processing, content generation, and forecasting future outcomes.

Carrier Retrospective Denials.
Retrospective denials may not be considered adverse benefit determinations and will not be required to follow standard appeal processes or any carrier policies related to their own grievance and appeals process. If an enrollee or the provider requesting the original authorization demonstrates the authorization was valid per the plan's written policies, then the carrier must deem the authorization approved and payable. Interest must be assessed on the associated claim

at the rate of one percent per month, retroactive to the original date of the authorization request.

Reporting.
By January 1, 2026, managed care organizations must submit the total number of prior authorization requests, approvals, and denials to the Authority on a quarterly basis. Managed care organizations must report these totals by health plan and for each health care benefit manager that is delegated to provide care determinations on behalf of the managed care organization. Managed care organizations must indicate the percentage of total denials that were aided by AI tools and algorithms and the percent of care determinations made after the required turnaround times. By July 1, 2027, the Authority must determine which treatments, prescription drugs, and services do not require prior authorization by managed care organizations for any Medicaid enrollee.

Beginning January 1, 2026, carriers that are required to report to the Commissioner annually must provide information regarding the prior quarter, including the total number of prior authorization requests, approvals, and denial. Carriers must report these totals by health plan and by each health care benefit manager that is delegated to provide care determinations on behalf of the carrier. Carriers must also indicate the percentage of total denials that were aided by AI tools and algorithms and the percent of care determinations made after the required turnaround times.

Annual reports by the Commissioner regarding carrier data must contain trend data for total authorization requests, approvals, and denials by plan and health care benefit managers.

Appropriation: None.

Fiscal Note: Requested on January 29, 2025.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.