HOUSE BILL REPORT
HB 1566

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to making improvements to transparency and accountability in the prior authorization determination process.

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

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

Brief History:
Committee Activity:
Health Care & Wellness: 2/5/25, 2/19/25 [DPS].

Brief Summary of Substitute Bill

- Modifies requirements related to determination notifications, reporting, policy changes, retrospective denials 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.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 17 members: Representatives Bronoske, Chair; Lekanoff, Vice Chair; Rule, Vice Chair; Caldier, Assistant Ranking Minority Member; Marshall, Assistant Ranking Minority Member; Davis, Engell, Low, Macri, Obras, Parshley, Shavers, Simmons, Stonier, Stuebe, Thai and Tharinger.

Minority Report: Without recommendation. Signed by 2 members: Representatives Schmick, Ranking Minority Member; Manjarrez.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

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 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 Substitute Bill:

<u>Prior Authorization Determinations and Policy Changes</u>.

When denying a prior authorization determination, a carrier, health plan, or managed care organization is required to include the credentials, board certifications, and areas of specialty expertise and training of the provider who had clinical oversight over the determination in the denial notification.

Carriers, health plans, and managed care organizations maintain the ability to make adjustments to policies and procedures that impact the applicability of their prior authorization requirements. Unless an exception applies, beginning August 1, 2025, these adjustments may only be made quarterly and must go into effect January 1, April 1, July 1, or October 1 of any given calendar year. Notification of policy changes must be provided to all in-network providers at least 45 days prior to the effective date and must be available to providers in a single website location.

Adjustments to prior authorization requirements that are made to reflect federal Food and Drug Administration approvals, National Comprehensive Cancer Network guidelines, United States Preventive Services Task Force guidelines, or public health emergencies may be made at any time.

Use of Artificial Intelligence.
Only a licensed physician or health professional working within their scope of practice may deny a prior authorization request based on 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) tool may not be the sole means used to deny, delay, or modify health care services. Algorithms may be used to process and approve prior authorization requests, but may not be used without human review to deny care based on a determination of medical necessity.

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

- the AI tool bases its determination on the following information, as applicable:
    - an enrollee's medical or other clinical history, including demographic data; and
    - individual clinical circumstances;
- the AI tool does not base its determination solely on a group data set;
- the AI tool's criteria and guidelines comply with these requirements and applicable state and federal law;
- the use of the AI tool does not discriminate against an enrollee in violation of state or federal law;
- the AI 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 tool are open to audit by the Commissioner or the Health Care Authority (Authority), as applicable;
- the AI 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, and content generation. "Artificial intelligence" includes "generative artificial intelligence."

Requirements regarding prior authorization determinations and functions apply to contracted health care benefit managers.

Carrier Retrospective Denials.
A carrier may not retrospectively deny coverage, or modify to a service less intensive than that included in the original request, for care that had prior authorization, including for medical necessity, unless the prior authorization was based on a material representation or the underlying health plan coverage is lawfully rescinded, canceled, or terminated retrospectively through the date of service.

Retrospective denials or modifications to a less intensive service due to a change in a carrier's determination of medical necessity are prohibited, may not be considered adverse benefit determinations, and are not required to follow standard appeal processes or 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 1 percent per month, retroactive to the original date of the authorization request.

Reporting.
By July 1, 2027, the Authority must publish a list of treatments, prescription drugs, equipment, and services that specifies under which circumstances prior authorization is required, prohibited, or has another uniform application across the Medicaid program. The Authority must update the list annually and provide an opportunity for public comment prior to finalizing the list.

Beginning January 1, 2026, carriers that are required to report to the Commissioner annually must provide information regarding the prior plan year, including the total number of prior authorization requests, approvals, and denials. Carriers must report these totals separately for approvals or denials made by the carrier directly and for approvals or denials made by a health care benefit manager. Carriers must also indicate the percentage of total denials that were aided by AI tools and the percent of prior authorization 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.

Substitute Bill Compared to Original Bill:

The substitute bill:

- removes the requirement that when issuing a notification for a prior authorization determination, a carrier, managed care organization, or health plan must provide a unique identifier for the individual who made the determination and the national provider identification number of the physician who had clinical oversight;
- requires carriers, managed care organizations, and health plans to include specified information regarding the provider who had clinical oversight when denying a prior authorization determination;
- removes the requirement that a carrier, managed care organization, or health plan must make a peer-to-peer review discussion available to a requesting provider in the case of an adverse benefit determination;
- requires carriers, managed care organizations, and health plans to only make changes to prior authorization requirements quarterly, instead of annually, and requires notification of such changes 45 days in advance, instead of four months in advance, unless an exception applies;
- requires changes to prior authorization requirements to be made available to providers in a single location on a carrier's, managed care organization's, or health plan's website;
- establishes an exception to the requirement regarding the frequency with which changes to prior authorization policies may be made for changes that are made to reflect federal Food and Drug Administration approvals, National Comprehensive Cancer Network guidelines, United States Preventive Services Task Force guidelines, or public health emergencies;
- changes references to an "artificial intelligence, algorithm, or related software tool" to an "artificial intelligence tool;"
- modifies the definition of "artificial intelligence" by removing a reference to the ability of the technology to forecast future outcomes and by specifying that "artificial intelligence" includes "generative artificial intelligence;"
- provides definitions of "generative artificial intelligence" and "machine learning;"
- establishes that algorithms may be used to process and approve prior authorization requests, but may not be used without human review to deny care based on a determination of medical necessity;
- specifies that requirements relating to prior authorization determinations apply to health care benefit managers under direct or indirect contract with a carrier, managed care organization, or health plan;
- specifies that the Commissioner and the Authority may adopt rules necessary to implement requirements relating to prior authorization determinations;
- removes the requirement that managed care organizations must submit data on prior authorization requests, approvals, and denials to the Authority;
- expands requirements relating to the Authority's review of treatments, prescription drugs, and services that do not require prior authorization by requiring the Authority to publish a list of treatments, prescription drugs, equipment, and services that specifies under which circumstances prior authorization is required or prohibited for Medicaid;

- requires the Authority to update its list of prior authorization determinations annually, with an opportunity for public comment, and requires the Authority to focus on treatments, drugs, equipment, and services that are treated inconsistently under existing requirements;
- specifies that a carrier may not retrospectively modify to a service less intensive than that included in the original request for care that had prior authorization under the plan's written policies at the time the care was rendered, unless an exception applies;
- permits a carrier to retrospectively deny coverage or modify the authorized service when the prior authorization was based on a material representation or the underlying health plan coverage has been lawfully rescinded, cancelled, or terminated retrospectively through the date of service;
- specifies that retrospective denials due to changes in a carrier's determination of medical necessity are prohibited; and
- restores the requirement under current law that a carrier annually report certain prior authorization information to the Commissioner for the prior plan year, instead of the prior quarter, and requires that information regarding the total number of prior authorization approvals and denials be reported separately for decisions made by carriers and decisions made by health care benefit managers.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available.

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

Staff Summary of Public Testimony:

(In support) This bill would bring clarity and transparency to the prior authorization process and ensure that prior authorization decisions are made by qualified professionals. Requirements for prior authorization have been increasing, resulting in a reduction of timely care. Insurers make and communicate policy changes at various times throughout the year, which can be difficult for hospitals and providers to track down. There is a role for AI in health care, but it should not replace clinical decision making. This bill will regulate and reduce the use of AI in prior authorization. It would be helpful to have the option of a peer review in the case of an adverse determination, and peer reviews would connect providers with people who are knowledgeable and experienced with the service that is being recommended. The professionals who conduct peer reviews should not be affiliated with the carrier or managed care organization that is making the decision. The prior authorization process leads to delays in care, an increased administrative burden, and hardship for patients that receive denials. There has been an increase in denials and retrospective denials, and these can lead to unexpected medical debt. Prior authorization presents a barrier to care for people with disabilities and low-income people.

(Opposed) Requirements regarding the technology used for prior authorization determinations and notifications are new and helping to decrease response time. This bill could move things backward. The language regarding AI in the bill is too broad. Many prior authorization requests are submitted via fax, and until that is addressed, there will be problems with delays. When there is a denial, it is done by a human. The practice of medicine changes rapidly, and carriers update policies to match new guidelines, approvals, and best practices. Only allowing annual updates could result in prior authorization practices no longer reflecting best practices.

Persons Testifying: (In support) Representative Alicia Rule, prime sponsor; Troy Simonson, CEO, Proliance Surgeons; Chelene Whiteaker, Washington State Hospital Association; Adam Dittemore, EvergreenHealth; Vanessa Saavedra, Northwest Health Law Advocates; Malorie Toman, WA State Medical Association; Stephanie Hansen, DO; Garrett Jeffery, DO; and Matthew Lang, National Organization of Women-WA.

(Opposed) Dr. Romilla Batra, Premera Blue Cross; and Jennifer Ziegler, Association of Washington Health Care Plans.

Persons Signed In To Testify But Not Testifying: None.