HOUSE BILL REPORT
E2SSB 5395

As Reported by House Committee On:
Health Care & Wellness
Appropriations

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: Senate Committee on Ways & Means (originally sponsored by Senators Orwall, Muzzall, Hasegawa, Lovelett, Nobles and Slatter).

Brief History:
Committee Activity:
Health Care & Wellness: 2/18/26, 2/25/26 [DPA];
Appropriations: 2/27/26, 3/2/26 [DPA(APP w/o HCW)].

Brief Summary of Engrossed Second Substitute Bill
(As Amended by Committee)

- Modifies requirements related to determination notifications and the use of artificial intelligence as part of the prior authorization process for private health insurance and health plans offered to public or school employees.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 16 members: Representatives Bronoske, Chair; Lekanoff, Vice Chair; Rule, Vice Chair; Valdez, Assistant Ranking Minority Member; Davis, Engell, Low, Macri, Manjarrez, Obras, Parshley, Shavers, Simmons, Stonier, Stuebe and Thai.

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.

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

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 and health plans offered to public or school employees, retirees, and their dependents are subject to certain requirements regarding the prior authorization process.

Health carriers and health plans 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 and health plans 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 Amended Bill:

Prior Authorization Determinations and Policy Changes.
When denying a prior authorization determination, a carrier or health plan is required to include the credentials, board certifications, and areas of specialty of the provider who had

clinical oversight over the determination in the denial notification.

Carriers and health plans must post any adjustments to policies and procedures that impact the applicability of their prior authorization requirements in a single location on the carrier's or health plan's website.

After December 30, 2030, a new application of prior authorization for health care services must be available to providers on the electronic prior authorization system or prior authorization API.

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. Artificial intelligence (AI) 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 or health plan that uses, or contracts for the use of, AI for the purpose of prior authorization, based in whole or in part on medical necessity, must ensure that:

- the AI bases its determination, as applicable, on an enrollee's medical or other clinical history, including demographic data, and individual clinical circumstances;
- the AI does not base its determination solely on a group data set;
- the AI's criteria and guidelines comply with these requirements and applicable state and federal law;
- the use of AI does not discriminate against an enrollee in violation of state or federal law;
- the AI 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 AI are open to audit by the Commissioner;
- the AI'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.

Requirements regarding prior authorization APIs are modified to require that such APIs are consistent with final rules issued by the federal Centers for Medicare and Medicaid Services.

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 date of service.

Reporting.
Beginning October 1, 2026, carriers that are required to report to the Commissioner annually must also provide information regarding 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, the percent of prior authorization determinations made after the required turnaround times, and the total number of nonelectronic standard and nonelectronic expedited prior authorization requests.

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

Amended Bill Compared to Engrossed Second Substitute Bill:

The amended bill requires carriers to report certain information regarding prior authorization to the Commissioner by October 1, 2026, instead of January 1, 2027.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill contains multiple effective dates. Please see the bill.

Staff Summary of Public Testimony:

As part of a pilot project, testimony in this section of the bill report was summarized by generative artificial intelligence and reviewed for accuracy by non-partisan legislative staff. Generative artificial intelligence was used only in this section of the bill report; all other sections were prepared by non-partisan legislative staff without the use of any generative artificial intelligence.

(In support) The testimony in support of Senate Bill 5395 describes the legislation as the product of extensive stakeholder collaboration over multiple years and characterizes it as a carefully negotiated compromise focused on improving the prior authorization process in private insurance. Proponents emphasize the need to modernize utilization management practices by establishing guardrails around the use of artificial intelligence, particularly in connection with denials of care. While acknowledging that AI may help expedite authorizations, the testimony stresses that decisions to deny, delay, or modify care should involve review by a qualified clinician to ensure appropriate medical judgment and patient safety. Supporters also underscore concerns about retrospective denials or modifications of services that were previously authorized, asserting that once prior authorization has been granted, coverage should not later be revoked or altered.

Testimony from providers and patient advocates highlights the increasing volume of prior authorization denials, the administrative burden and costs associated with appeals, and delays in patient access to medically necessary treatment. Examples are offered of retrospective denials following approved authorizations and of inaction or lack of timely response during critical transitions of care, particularly in mental health treatment for minors. The bill is described as strengthening accountability, transparency, and predictability by setting clearer expectations for timely decision-making and reinforcing protections against inappropriate denials. While some express interest in narrowly tailored amendments to address specific continuity-of-care concerns, the overall testimony urges advancement of the bill as an important step toward reducing unnecessary delays and denials, protecting patients, and restoring confidence in the prior authorization process.

(Opposed) None.

(Other) The testimony expresses general support for efforts to streamline prior authorization processes and protect patients from unnecessary delays in care. However, concerns are raised regarding Section 5 of Senate Bill 5395, and a narrow amendment is requested to address those concerns. While acknowledging prior stakeholder discussions and noting that the bill has been scaled back from earlier versions, the testimony explains that two developments have prompted reconsideration of the current language: the interaction with forthcoming clean claims legislation and a reported 15 percent increase in service-level intensity coding in 2025, which is believed to be influenced in part by artificial intelligence. The testimony emphasizes that current law does not permit denial of coverage for services that were previously authorized and notes the significant scale of claims processing, including millions of claims annually across a broad network of providers and hospital systems. It further states that prior authorization is used in a small percentage of claims to

ensure clinical necessity reviews are consistent, equitable, and fair. The primary concern is that Section 5 may restrict the ability to review whether the services ultimately rendered align with those originally authorized, prompting the request for a targeted amendment.

Persons Testifying: (In support) Senator Tina Orwall, prime sponsor; Adam Dittemore, EvergreenHealth; Lisa Thatcher, Washington State Hospital Association; Sean Graham, Washington State Medical Association; Brian Fordham; and Vanessa Saavedra, Northwest Health Law Advocates.

(Other) David Foster, Assoc of WA Healthcare Plans; and Christine Brewer, Premera Blue Cross.

Persons Signed In To Testify But Not Testifying: None.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended by Committee on Appropriations and without amendment by Committee on Health Care & Wellness. Signed by 29 members: Representatives Ormsby, Chair; Gregerson, Vice Chair; Macri, Vice Chair; Couture, Ranking Minority Member; Connors, Assistant Ranking Minority Member; Penner, Assistant Ranking Minority Member; Berg, Bergquist, Burnett, Callan, Corry, Cortes, Doglio, Dye, Fitzgibbon, Keaton, Leavitt, Lekanoff, Manjarrez, Marshall, Peterson, Pollet, Rude, Ryu, Springer, Stonier, Street, Thai and Valdez.

Staff: Meghan Morris (786-7119).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Health Care & Wellness:

The Appropriations Committee recommended the following changes:

- The requirement for health plans offered to public employees to include information about the expertise and training of the provider with clinical oversight over the determination when denying a prior authorization request is removed.
- The requirements for carriers relating to retrospective denials or modifications of services that apply to denials or modifications of approved prior authorizations are specified.
- Interest on approved and payable claims will be assessed from the date of claim submission instead of the date of service when an enrollee or provider is able to demonstrate that a prior authorization was valid on retrospective denials or modifications of claims by carriers.
- An enrollee, or provider on behalf of an enrollee, may seek review by an independent review organization of a carrier decision relating to a retrospective denial or modification without the need to engage in, exhaust, or wait for any timelines related to the carrier's grievance process.

- The requirements relating to retrospective denials and modifications do not prevent carriers from reimbursing only for services billed and rendered.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on February 23, 2026.

Effective Date of Amended Bill: The bill contains multiple effective dates. Please see the bill.

Staff Summary of Public Testimony:

(In support) A version of this bill was introduced last year, and the fiscal impacts are from the Office of the Insurance Commissioner's regulatory account. This bill continues the work of modernizing prior authorization policies. There is work occurring with stakeholders on an amendment to the bill regarding retroactive denials. The amendment would clarify that insurers would not be required to pay for services not provided.

(Opposed) None.

Persons Testifying: Lisa Thatcher, Washington State Hospital Association; and Sean Graham, Washington State Medical Association.

Persons Signed In To Testify But Not Testifying: None.