SENATE BILL REPORT
SB 5395

As of February 5, 2025

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: Senators Orwall, Muzzall, Hasegawa, Lovelett, Nobles and Slatter.

Brief History:
Committee Activity: Health & Long-Term Care: 2/07/25.

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.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Greg Attanasio (786-7410)

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 carriers may impose different prior authorization standards and criteria for a covered service among tiers of contracting providers. In 2023, the Legislature passed HB 1357, establishing timeframes for standard and expedited prior authorization requests for health plans offered by health carriers, health plans offered to public or school employees, retirees, and their dependents, and Medicaid coverage offered through managed care organizations.

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.

Health carriers, health plans, and managed care organizations must describe their prior authorization requirements in detailed, easily understandable language. Health carriers, health plans, and managed care organizations must make the most current prior authorization requirements and restrictions available upon request in an electronic format. The prior authorization requirements must be based on peer-reviewed, evidence-based clinical review criteria which is evaluated and updated at least annually. The clinical review criteria must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to Black and indigenous people, other people of color, gender, and underserved populations.

Health carriers, health plans, and managed care organizations must build and maintain a prior authorization application programming interface 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 application programming interface must use Health Level 7 Fast Healthcare Interoperability Resources, automate the prior authorization determination process, allow providers to query prior authorization documentation requirements, support automated compiling and exchange of necessary data elements to populate the prior authorization requirements, and indicate that prior authorization denials or authorizations of less intensive services are adverse benefit determinations subject to grievance and appeal processes. As an alternative to using an application programming interface, health carriers, health plans, and managed care organizations may establish an interoperable electronic process for prior authorizations related to prescription drugs.

The application programming interface must support prior authorization requests and determinations for health care services beginning January 1, 2025, and for prescription drugs beginning January 1, 2027. If federal regulations on the application programming interface standards are not finalized by September 13, 2023, the commencement date for standards related to health care services will be delayed until January 1, 2026.

By October 1, 2020, and annually thereafter, for individual and group health plans issued by a carrier that has written at least 1 percent of the total accident and health insurance premiums written by all companies authorized to offer accident and health insurance in Washington in the most recently available year, the carrier must report to the Office of the Insurance Commissioner certain prior authorization data for the prior plan year related to procedures and services with the highest number of requests, approvals, and denials.

Summary of Bill: Prior Authorization Requirements. When issuing a notification for a prior authorization determination, the carrier, health plan, or managed care organization and any contracted health care benefit manager must 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 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 in any

notification sent to the enrollee and provider requesting or referring the service.

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

Carriers, health plans, and managed care organizations may make adjustments to policies and procedures that impact the applicability of their prior authorization requirements. Beginning August 1, 2025, these adjustments can only be made once annually and 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 January 1st effective date. The notification must be provided independent to other policy changes or provider notification publications and be easily accessible in electronic provider and enrollee portals.

Artificial Intelligence. A determination of medical necessity shall be made only by a licensed physician or a licensed health professional working within their scope of practice. The licensed physician or licensed health professional shall evaluate the specific clinical issues involved in the health care services requested by the requesting provider by reviewing and considering the requesting provider's recommendation, the enrollee's medical or other clinical history, as applicable, and individual clinical circumstances. An artificial intelligence, algorithm, or related software tool shall 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 an artificial intelligence, algorithm, or other software tool for the purpose of prior authorization or prior authorization functions, based in whole or in part on medical necessity, or that contracts with or otherwise works through a third party for these purposes, shall ensure all of the following:

- the artificial intelligence, algorithm, or other software tool bases its determination on the following information, as applicable:
    1. an enrollee's medical or other clinical history;
    2. individual clinical circumstances as presented by the requesting provider; and
    3. other relevant clinical information contained in the enrollee's medical or other clinical record;
- the artificial intelligence, algorithm, or other software tool does not base its determination solely on a group data set;
- the artificial intelligence, algorithm, or other software tool's criteria and guidelines complies with this act and applicable state and federal law;
- the use of the artificial intelligence, algorithm, or other software tool does not discriminate, directly or indirectly, against an enrollee in violation of state or federal

law;

- the artificial intelligence, 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 artificial intelligence, algorithm, or other software tool is open to audit by the Office of the Insurance Commissioner;
- the artificial intelligence, 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 law.

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 1 percent per month, retroactive to the original date of the authorization request

Reporting Requirements. By January 1, 2026, managed care organizations must submit the total number of prior authorization requests, approvals, and denials to the Health Care Authority (HCA) on a quarterly basis. Managed care organizations shall 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 shall indicate the percentage of total denials that were aided by artificial intelligence tools and algorithms and the percent of care determinations that do not meet the emergent and nonemergent authorization request turnaround times. HCA shall provide a reporting template to managed care organizations 90 days prior to the first report submission and shall review the template annually for updates. HCA shall publish on its website the results of each managed care organization's report 45 days after submission, along with their own prior authorization statistics for fee-for-service Medicaid enrollees.

By July 1, 2027, HCA shall determine which treatments, prescription drugs, and services, along with their applicable billing codes, do not require prior authorization by managed care organizations. HCA must consider applicable state and federal program integrity regulations when deciding which services they will waive prior authorization requirements.

Beginning January 1, 2026, existing reporting related to procedures and services with the highest number of prior authorization requests, approvals, and denials from the previous year is changed to the previous quarter. Carriers must also report the total number of prior authorization requests, approvals, and denials made in that time. The carrier must report these totals by both health plan and each health care benefit manager that is delegated to provide care determinations on behalf of the carrier. In the report, carriers must also indicate the percentage of total denials that were aided by artificial intelligence tools and algorithms

and the percent of care determinations made after the required emergent and nonemergent authorization request turnaround times.

Appropriation: None.

Fiscal Note: Requested on January 24, 2025.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.