SENATE BILL REPORT
SB 5395

As Reported by Senate Committee On:
Ways & Means, January 27, 2026

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: Ways & Means: 2/26/25; 1/27/26 [DP2S, w/oRec].

Brief Summary of Second Substitute Bill

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

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5395 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Cleveland, Chair; Orwall, Vice Chair; Bateman, Chapman, Holy, Riccelli, Robinson and Slatter.

Minority Report: That it be referred without recommendation.

Signed by Senators Muzzall, Ranking Member; Christian and Harris.

Staff: Greg Attanasio (786-7410)

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.

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 5395 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Robinson, Chair; Stanford, Vice Chair, Operating; Trudeau, Vice Chair, Capital; Frame, Vice Chair, Finance; Gildon, Ranking Member, Operating; Torres, Assistant Ranking Member, Operating; Dozier, Assistant Ranking Member, Capital; Boehnke, Cleveland, Conway, Dhingra, Hansen, Hasegawa, Kauffman, Muzzall, Pedersen, Riccelli, Saldaña, Warnick, Wellman and Wilson, C..

Minority Report: That it be referred without recommendation.

Signed by Senators Schoesler, Ranking Member, Capital; Wagoner.

Staff: Sandy Stith (786-7710)

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.

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 (Second Substitute): Prior Authorization Requirements. When issuing a notification for a prior authorization determination, the carrier or health plan, and contracted health care benefit managers must provide the credentials, board certifications, and areas of specialty expertise and training of the provider who had clinical oversight over the determination in any notification sent to the health plan enrollee and provider requesting or referring the service.

Carriers and health plans must post any adjustments to policies and procedures that impact the applicability of their prior authorization requirements for health care services or prescription drugs, including new applications of prior authorization, in a single location on their website. After December 30, 2030, any new application of prior authorization for health care services must be available to providers on the electronic prior authorization system or application programming interface system.

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. Artificial intelligence shall 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 and any contracted health care benefit manager that uses artificial intelligence 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 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 does not base its determination solely on a group data set;
- the artificial intelligence criteria and guidelines complies with this act and applicable state and federal law;
- the use of artificial intelligence does not discriminate, directly or indirectly, against an enrollee in violation of state or federal law;
- the artificial intelligence 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 artificial intelligence is open to audit by the Office of the Insurance Commissioner;
- the artificial intelligence 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. Carriers shall not retrospectively deny coverage or retrospectively modify to a service less intensive than that included in the original request for emergency and nonemergency care that had prior authorization, including for medical necessity, under the plan's written policies at the time the care was rendered, unless the prior authorization was based upon a material misrepresentation by the provider, facility, or covered person or the underlying health plan coverage is lawfully rescinded, canceled, or terminated retrospectively through the date of service.

Retrospective denials of services with prior authorization or retrospective modification to less intensive services due to a change in the carrier's determination of medical necessity are prohibited, shall not be considered adverse benefit determinations, and will not be required to follow the standard appeals processes.

Beginning January 1, 2027, carriers 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 and the percent of care determinations made after the required emergent and nonemergent authorization request turnaround times.

EFFECT OF CHANGES MADE BY WAYS & MEANS COMMITTEE (Second Substitute):

- Removes modifications to the prior authorization process and associated reporting requirements for Medicaid.
- Requires carriers and health plans offered to public employees and school employees to post any adjustments to prior authorization policies in a single location on their carrier's or plan's website.

Appropriation: None.

Fiscal Note: Available.

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

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

Staff Summary of Public Testimony on Original Bill (Health & Long-Term Care) (Regular Session 2025): *The committee recommended a different version of the bill than what was heard.* PRO: Prior authorization decisions should be made by health professionals and based on the specific circumstances of the patient. Prior authorization affects many services and products, and this bill would increase transparency. A peer to peer process will expedite the prior authorization process. Prior authorization denials increasing due to AI. Retroactive denials undermine the trust in the process.

CON: Data does not suggest use of AI for prior authorization denials. Unique identifiers in prior authorization decisions compromises safety of those making the decisions. Limiting prior authorization criteria updates prevents updating evolving research, delays care and limits access.

Persons Testifying (Health & Long-Term Care): PRO: Senator Tina Orwall, Prime Sponsor; Dr. Addison Stone, Proliance Surgeons; Vanessa Saavedra, Northwest Health Law Advocates; Dr. Douglas Backous; Lisa Thatcher, Washington State Hospital Association; Adam Dittemore, EvergreenHealth; Rena Cardenas, MultiCare Health System; Katina Rue, DO, WA State Medical Assn; Malorie Toman, WA State Medical Assn.

CON: Dr. Romilla Batra, Premera Blue Cross; Jennifer Ziegler, Association of Washington Health Care Plans; Peggi Lewis Fu, Association of Washington Health Care Plans; Marissa Ingalls, Coordinated Caare; Dr. Chris Berlin, Kaiser Permanente.

Persons Signed In To Testify But Not Testifying (Health & Long-Term Care): No one.

Staff Summary of Public Testimony on First Substitute (Ways & Means) (Regular Session 2025): PRO: We support the new parameters on the use of AI for prior authorization and the prohibition on retroactive denials. This bill was well stakeholdered, especially with OIC and HCA. The portions of the bill with substantive costs were removed. The remaining costs are related to licensed people doing reviews. This will help remove

delays and barriers and provide more transparency and prevent AI from being the sole arbiter of service denial. This will allow physicians more time to focus on their patients.

CON: Prior authorization already carries a heavy burden, especially for behavioral health providers. This will further destabilize vulnerable patients.

Persons Testifying (Ways & Means): PRO: Lisa Thatcher, Washington State Hospital Association; Sean Graham, Washington State Medical Association; Vanessa Saavedra, Northwest Health Law Advocates; Rick Marhula, Proliance Surgeons.

CON: Nancy L. Belcher, King County Medical Society - Seattle, WA; Natalie Fuller, King County Medical Society.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.