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**SUBSTITUTE SENATE BILL 5395**

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**State of Washington**

**69th Legislature**

**2025 Regular Session**

**By** Senate Health & Long-Term Care (originally sponsored by Senators Orwall, Muzzall, Hasegawa, Lovelett, Nobles, and Slatter)

READ FIRST TIME 02/21/25.

1 AN ACT Relating to making improvements to transparency and  
2 accountability in the prior authorization determination process;  
3 amending RCW 48.43.830, 74.09.840, 41.05.845, 48.43.525, and  
4 48.43.0161; and creating a new section.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6 NEW SECTION. **Sec. 1.** (1) The legislature finds that health  
7 insurance carriers, health plans, and managed care organizations are  
8 the decision makers for the type and level of care covered for an  
9 enrollee's health care benefits and are not responsible for  
10 determining or altering an enrollee's diagnosis or treatment plan. It  
11 is not always transparent who the decision maker is or how decisions  
12 are made in determining enrollee coverage for treatment, prescription  
13 drugs, or services. Artificial intelligence is being increasingly  
14 utilized by carriers, health plans, and managed care organizations to  
15 make or aid in decisions about medical necessity and coverage of  
16 provider-recommended treatment.

17 (2) It is the intent of the legislature to increase transparency  
18 in the prior authorization process for health care coverage decisions  
19 and to ensure licensed physicians and licensed health professionals  
20 remain responsible for making determinations about coverage for  
21 treatment, prescription drugs, and services that are medically

1 necessary. If artificial intelligence is used to aid in the decision-  
2 making process, standards must be put in place to ensure artificial  
3 intelligence is not used to make inappropriate determinations that  
4 could impact the health of an enrollee.

5 **Sec. 2.** RCW 48.43.830 and 2023 c 382 s 1 are each amended to  
6 read as follows:

7 (1) Each carrier offering a health plan issued or renewed on or  
8 after January 1, 2024, shall comply with the following standards  
9 related to prior authorization for health care services and  
10 prescription drugs:

11 (a) The carrier shall meet the following time frames for prior  
12 authorization determinations and notifications to a participating  
13 provider or facility that submits the prior authorization request  
14 through an electronic prior authorization process, as designated by  
15 each carrier:

16 (i) For electronic standard prior authorization requests, the  
17 carrier shall make a decision and notify the provider or facility of  
18 the results of the decision within three calendar days, excluding  
19 holidays, of submission of an electronic prior authorization request  
20 by the provider or facility that contains the necessary information  
21 to make a determination. If insufficient information has been  
22 provided to the carrier to make a decision, the carrier shall request  
23 any additional information from the provider or facility within one  
24 calendar day of submission of the electronic prior authorization  
25 request.

26 (ii) For electronic expedited prior authorization requests, the  
27 carrier shall make a decision and notify the provider or facility of  
28 the results of the decision within one calendar day of submission of  
29 an electronic prior authorization request by the provider or facility  
30 that contains the necessary information to make a determination. If  
31 insufficient information has been provided to the carrier to make a  
32 decision, the carrier shall request any additional information from  
33 the provider or facility within one calendar day of submission of the  
34 electronic prior authorization request.

35 (b) The carrier shall meet the following time frames for prior  
36 authorization determinations and notifications to a participating  
37 provider or facility that submits the prior authorization request  
38 through a process other than an electronic prior authorization  
39 process:

1 (i) For nonelectronic standard prior authorization requests, the  
2 carrier shall make a decision and notify the provider or facility of  
3 the results of the decision within five calendar days of submission  
4 of a nonelectronic prior authorization request by the provider or  
5 facility that contains the necessary information to make a  
6 determination. If insufficient information has been provided to the  
7 carrier to make a decision, the carrier shall request any additional  
8 information from the provider or facility within five calendar days  
9 of submission of the nonelectronic prior authorization request.

10 (ii) For nonelectronic expedited prior authorization requests,  
11 the carrier shall make a decision and notify the provider or facility  
12 of the results of the decision within two calendar days of submission  
13 of a nonelectronic prior authorization request by the provider or  
14 facility that contains the necessary information to make a  
15 determination. If insufficient information has been provided to the  
16 carrier to make a decision, the carrier shall request any additional  
17 information from the provider or facility within one calendar day of  
18 submission of the nonelectronic prior authorization request.

19 (c) In any instance in which a carrier has determined that a  
20 provider or facility has not provided sufficient information for  
21 making a determination under (a) and (b) of this subsection, a  
22 carrier may establish a specific reasonable time frame for submission  
23 of the additional information. This time frame must be communicated  
24 to the provider and enrollee with a carrier's request for additional  
25 information.

26 (d) The carrier's prior authorization requirements must be  
27 described in detail and written in easily understandable language.  
28 The carrier shall make its most current prior authorization  
29 requirements and restrictions, including the written clinical review  
30 criteria, available to providers and facilities in an electronic  
31 format upon request. The prior authorization requirements must be  
32 based on peer-reviewed clinical review criteria. The clinical review  
33 criteria must be evidence-based criteria and must accommodate new and  
34 emerging information related to the appropriateness of clinical  
35 criteria with respect to black and indigenous people, other people of  
36 color, gender, and underserved populations. The clinical review  
37 criteria must be evaluated and updated, if necessary, at least  
38 annually.

39 ~~((2))~~ (e) When denying a prior authorization determination, the  
40 carrier shall include the credentials, board certifications, and

1 areas of specialty expertise and training of the provider who had  
2 clinical oversight over the determination in any notification sent to  
3 the health plan enrollee and provider requesting or referring the  
4 service.

5 (2)(a) Carriers maintain the ability to make adjustments to  
6 policies and procedures that impact the applicability of their prior  
7 authorization requirements. Except as provided in (b) of this  
8 subsection, beginning August 1, 2025, new application of prior  
9 authorization for health care services or prescription drugs can only  
10 be made quarterly and go into effect either January 1st, April 1st,  
11 July 1st, or October 1st of any given calendar year. Notification of  
12 policy changes must be provided to all in-network providers at least  
13 45 days prior to the quarterly update and must be available to  
14 providers on the electronic prior authorization system or application  
15 programming interface system. Until January 1, 2028, this information  
16 must also be provided in a single location on the carrier's website.  
17 The notification must be provided independent of other policy changes  
18 or provider notification publications and be easily accessible in  
19 electronic provider and enrollee portals.

20 (b) Adjustments to policies and procedures that impact the  
21 applicability of prior authorization requirements to reflect new  
22 evidence for health care services or prescription drugs including  
23 nationally recognized standards of care that are publicly available,  
24 consensus guidelines of nonprofit health care provider professional  
25 associations, nationally recognized clinical practice guidelines that  
26 are publicly available, guidelines or recommendations of federal  
27 government agencies including federal food and drug administration  
28 approvals, or state or national public health emergencies may be made  
29 at any time. Notification of adjustments made under this subsection  
30 must be provided to all in-network providers as soon as possible and  
31 must be available to providers on the electronic prior authorization  
32 system or application programming interface system. Until January 1,  
33 2028, this information must also be provided in a single location on  
34 the carrier's website referenced in (a) of this subsection. Carriers  
35 may remove prior authorization requirements at any time.

36 (3)(a) Only a licensed physician or a licensed health  
37 professional working within their scope of practice may deny a prior  
38 authorization request based on medical necessity. The licensed  
39 physician or licensed health professional shall evaluate the specific  
40 clinical issues involved in the health care services requested by the

1 requesting provider by reviewing and considering the requesting  
2 provider's recommendation, the enrollee's medical or other clinical  
3 history, as applicable, and individual clinical circumstances.  
4 Artificial intelligence shall not be the sole means used to deny,  
5 delay, or modify health care services. Algorithms may be used to  
6 process and approve prior authorization requests, but may not be used  
7 without human review to deny care based on a determination of medical  
8 necessity.

9 (b) A carrier that uses artificial intelligence for the purpose  
10 of prior authorization or prior authorization functions, based in  
11 whole or in part on medical necessity, or that contracts with or  
12 otherwise works through an entity that uses artificial intelligence  
13 for the purpose of prior authorization or prior authorization  
14 functions, based in whole or in part on medical necessity, shall  
15 ensure all of the following:

16 (i) The artificial intelligence bases its determination on the  
17 following information, as applicable:

18 (A) An enrollee's medical or other clinical history, including  
19 demographic data; and

20 (B) Individual clinical circumstances as presented by the  
21 requesting provider;

22 (ii) The artificial intelligence does not base its determination  
23 solely on a group data set;

24 (iii) The artificial intelligence's criteria and guidelines  
25 comply with this chapter and applicable state and federal law;

26 (iv) The use of the artificial intelligence does not  
27 discriminate, directly or indirectly, against an enrollee in  
28 violation of state or federal law;

29 (v) The artificial intelligence is fairly and equitably applied,  
30 including in accordance with any applicable regulations and guidance  
31 issued by the federal department of health and human services;

32 (vi) The policies and procedures for using artificial  
33 intelligence are open to audit by the office of the insurance  
34 commissioner under chapter 48.37 RCW;

35 (vii) The artificial intelligence's performance, use, and  
36 outcomes are periodically reviewed by the carrier to maximize  
37 accuracy and reliability; and

38 (viii) Patient data is not used beyond its intended and stated  
39 purpose, consistent with chapter 70.02 RCW and the federal health

1 insurance portability and accountability act of 1996, 42 U.S.C. Sec.  
2 1320d et al., as applicable.

3 (4)(a) Each carrier shall build and maintain a prior  
4 authorization application programming interface that automates the  
5 process for in-network providers to determine whether a prior  
6 authorization is required for health care services, identify prior  
7 authorization information and documentation requirements, and  
8 facilitate the exchange of prior authorization requests and  
9 determinations from its electronic health records or practice  
10 management system. The application programming interface must support  
11 the exchange of prior authorization requests and determinations for  
12 health care services beginning January 1, 2025, and must:

13 (i) Use health level 7 fast health care interoperability  
14 resources in accordance with standards and provisions defined in 45  
15 C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);

16 (ii) Automate the process to determine whether a prior  
17 authorization is required for durable medical equipment or a health  
18 care service;

19 (iii) Allow providers to query the carrier's prior authorization  
20 documentation requirements;

21 (iv) Support an automated approach using nonproprietary open  
22 workflows to compile and exchange the necessary data elements to  
23 populate the prior authorization requirements that are compliant with  
24 the federal health insurance portability and accountability act of  
25 1996 or have an exception from the federal centers for medicare and  
26 medicaid services; and

27 (v) Indicate that a prior authorization denial or authorization  
28 of a service less intensive than that included in the original  
29 request is an adverse benefit determination and is subject to the  
30 carrier's grievance and appeal process under RCW 48.43.535.

31 (b) Each carrier shall establish and maintain an interoperable  
32 electronic process or application programming interface that  
33 automates the process for in-network providers to determine whether a  
34 prior authorization is required for a covered prescription drug. The  
35 application programming interface must support the exchange of prior  
36 authorization requests and determinations for prescription drugs,  
37 including information on covered alternative prescription drugs,  
38 beginning January 1, 2027, and must:

39 (i) Allow providers to identify prior authorization information  
40 and documentation requirements;

1 (ii) Facilitate the exchange of prior authorization requests and  
2 determinations from its electronic health records or practice  
3 management system, and may include the necessary data elements to  
4 populate the prior authorization requirements that are compliant with  
5 the federal health insurance portability and accountability act of  
6 1996 or have an exception from the federal centers for medicare and  
7 medicaid services; and

8 (iii) Indicate that a prior authorization denial or authorization  
9 of a drug other than the one included in the original prior  
10 authorization request is an adverse benefit determination and is  
11 subject to the carrier's grievance and appeal process under RCW  
12 48.43.535.

13 (c) If federal rules related to standards for using an  
14 application programming interface to communicate prior authorization  
15 status to providers are not finalized by the federal centers for  
16 medicare and medicaid services by September 13, 2023, the  
17 requirements of (a) of this subsection may not be enforced until  
18 January 1, 2026.

19 (d)(i) If a carrier determines that it will not be able to  
20 satisfy the requirements of (a) of this subsection by January 1,  
21 2025, the carrier shall submit a narrative justification to the  
22 commissioner on or before September 1, 2024, describing:

23 (A) The reasons that the carrier cannot reasonably satisfy the  
24 requirements;

25 (B) The impact of noncompliance upon providers and enrollees;

26 (C) The current or proposed means of providing health information  
27 to the providers; and

28 (D) A timeline and implementation plan to achieve compliance with  
29 the requirements.

30 (ii) The commissioner may grant a one-year delay in enforcement  
31 of the requirements of (a) of this subsection (~~((+2+))~~) (4) if the  
32 commissioner determines that the carrier has made a good faith effort  
33 to comply with the requirements.

34 (iii) This subsection (~~((+2+))~~) (4)(d) shall not apply if the delay  
35 in enforcement in (c) of this subsection takes effect because the  
36 federal centers for medicare and medicaid services did not finalize  
37 the applicable regulations by September 13, 2023.

38 (e) By September 13, 2023, and at least every six months  
39 thereafter until September 13, 2026, the commissioner shall provide  
40 an update to the health care policy committees of the legislature on

1 the development of rules and implementation guidance from the federal  
2 centers for medicare and medicaid services regarding the standards  
3 for development of application programming interfaces and  
4 interoperable electronic processes related to prior authorization  
5 functions. The updates should include recommendations, as  
6 appropriate, on whether the status of the federal rule development  
7 aligns with the provisions of chapter 382, Laws of 2023. The  
8 commissioner also shall report on any actions by the federal centers  
9 for medicare and medicaid services to exercise enforcement discretion  
10 related to the implementation and maintenance of an application  
11 programming interface for prior authorization functions. The  
12 commissioner shall consult with the health care authority, carriers,  
13 providers, and consumers on the development of these updates and any  
14 recommendations.

15 ~~((3))~~ (5) Nothing in this section applies to prior  
16 authorization determinations made pursuant to RCW 48.43.761.

17 ~~((4))~~ (6) This section applies to prior authorization functions  
18 carried out by health care benefit managers, as defined in RCW  
19 48.200.020, under direct or indirect contract with a carrier.

20 (7) The commissioner may adopt any rules necessary to implement  
21 this section.

22 (8) For the purposes of this section:

23 (a) "Artificial intelligence" means the use of machine learning  
24 and related technologies that use data to train statistical models  
25 for the purpose of enabling computer systems to perform tasks  
26 normally associated with human intelligence or perception, such as  
27 computer vision, speech or natural language processing, and content  
28 generation. "Artificial intelligence" includes generative artificial  
29 intelligence.

30 (b) "Expedited prior authorization request" means a request by a  
31 provider or facility for approval of a health care service or  
32 prescription drug where:

33 (i) The passage of time:

34 (A) Could seriously jeopardize the life or health of the  
35 enrollee;

36 (B) Could seriously jeopardize the enrollee's ability to regain  
37 maximum function; or

38 (C) In the opinion of a provider or facility with knowledge of  
39 the enrollee's medical condition, would subject the enrollee to



1 severe pain that cannot be adequately managed without the health care  
2 service or prescription drug that is the subject of the request; or

3 (ii) The enrollee is undergoing a current course of treatment  
4 using a nonformulary drug.

5 ~~((b))~~ (c) "Generative artificial intelligence" means an  
6 artificial intelligence system that generates novel data or content  
7 based on a foundation model.

8 (d) "Machine learning" means the process by which artificial  
9 intelligence is developed using data and algorithms to draw  
10 inferences therefrom to automatically adapt or improve its accuracy  
11 without explicit programming.

12 (e) "Standard prior authorization request" means a request by a  
13 provider or facility for approval of a health care service or  
14 prescription drug where the request is made in advance of the  
15 enrollee obtaining a health care service or prescription drug that is  
16 not required to be expedited.

17 **Sec. 3.** RCW 74.09.840 and 2023 c 382 s 3 are each amended to  
18 read as follows:

19 (1) Beginning January 1, 2024, the authority shall require each  
20 managed care organization to comply with the following standards  
21 related to prior authorization for health care services and  
22 prescription drugs:

23 (a) The managed care organization shall meet the following time  
24 frames for prior authorization determinations and notifications to a  
25 participating provider or facility that submits the prior  
26 authorization request through an electronic prior authorization  
27 process, as designated by each managed care organization:

28 (i) For electronic standard prior authorization requests, the  
29 managed care organization shall make a decision and notify the  
30 provider or facility of the results of the decision within three  
31 calendar days, excluding holidays, of submission of an electronic  
32 prior authorization request by the provider or facility that contains  
33 the necessary information to make a determination. If insufficient  
34 information has been provided to the managed care organization to  
35 make a decision, the managed care organization shall request any  
36 additional information from the provider or facility within one  
37 calendar day of submission of the electronic prior authorization  
38 request.

1 (ii) For electronic expedited prior authorization requests, the  
2 managed care organization shall make a decision and notify the  
3 provider or facility of the results of the decision within one  
4 calendar day of submission of an electronic prior authorization  
5 request by the provider or facility that contains the necessary  
6 information to make a determination. If insufficient information has  
7 been provided to the managed care organization to make a decision,  
8 the managed care organization shall request any additional  
9 information from the provider or facility within one calendar day of  
10 submission of the electronic prior authorization request.

11 (b) The managed care organization shall meet the following time  
12 frames for prior authorization determinations and notifications to a  
13 participating provider or facility that submits the prior  
14 authorization request through a process other than an electronic  
15 prior authorization process described in subsection (~~((2))~~) (6) of  
16 this section:

17 (i) For nonelectronic standard prior authorization requests, the  
18 managed care organization shall make a decision and notify the  
19 provider or facility of the results of the decision within five  
20 calendar days of submission of a nonelectronic prior authorization  
21 request by the provider or facility that contains the necessary  
22 information to make a determination. If insufficient information has  
23 been provided to the managed care organization to make a decision,  
24 the managed care organization shall request any additional  
25 information from the provider or facility within five calendar days  
26 of submission of the nonelectronic prior authorization request.

27 (ii) For nonelectronic expedited prior authorization requests,  
28 the managed care organization shall make a decision and notify the  
29 provider or facility of the results of the decision within two  
30 calendar days of submission of a nonelectronic prior authorization  
31 request by the provider or facility that contains the necessary  
32 information to make a determination. If insufficient information has  
33 been provided to the managed care organization to make a decision,  
34 the managed care organization shall request any additional  
35 information from the provider or facility within one calendar day of  
36 submission of the nonelectronic prior authorization request.

37 (c) In any instance in which a managed care organization has  
38 determined that a provider or facility has not provided sufficient  
39 information for making a determination under (a) and (b) of this  
40 subsection, a managed care organization may establish a specific

1 reasonable time frame for submission of the additional information.  
2 This time frame must be communicated to the provider and enrollee  
3 with a managed care organization's request for additional  
4 information.

5 (d) The prior authorization requirements of the managed care  
6 organization must be described in detail and written in easily  
7 understandable language. The managed care organization shall make its  
8 most current prior authorization requirements and restrictions,  
9 including the written clinical review criteria, available to  
10 providers and facilities in an electronic format upon request. The  
11 prior authorization requirements must be based on peer-reviewed  
12 clinical review criteria. The clinical review criteria must be  
13 evidence-based criteria and must accommodate new and emerging  
14 information related to the appropriateness of clinical criteria with  
15 respect to black and indigenous people, other people of color,  
16 gender, and underserved populations. The clinical review criteria  
17 must be evaluated and updated, if necessary, at least annually.

18 ~~((2))~~ (e) When denying a prior authorization determination, the  
19 managed care organization shall include the credentials, board  
20 certifications, and areas of specialty expertise and training of the  
21 provider who had clinical oversight over the determination in any  
22 notification sent to the managed care enrollee and provider  
23 requesting or referring the service.

24 (2)(a) Managed care organizations maintain the ability to make  
25 adjustments to policies and procedures that impact the applicability  
26 of their prior authorization requirements. Except as provided in (b)  
27 of this subsection, beginning August 1, 2025, new application of  
28 prior authorization for health care services or prescription drugs  
29 can only be made quarterly and go into effect either January 1st,  
30 April 1st, July 1st, or October 1st of any given calendar year.  
31 Notification of policy changes must be provided to all in-network  
32 providers on the electronic prior authorization system or application  
33 programming interface system. Until January 1, 2028, this information  
34 must also be provided at least 45 days prior to the quarterly update  
35 and must be available to providers in a single location on the  
36 managed care organization's website. The notification must be  
37 provided independent of other policy changes or provider notification  
38 publications and be easily accessible in electronic provider and  
39 enrollee portals.

1       (b) Adjustments to policies and procedures that impact the  
2 applicability of prior authorization requirements to reflect new  
3 evidence for health care services or prescription drugs including  
4 nationally recognized standards of care that are publicly available,  
5 consensus guidelines of nonprofit health care provider professional  
6 associations, nationally recognized clinical practice guidelines that  
7 are publicly available, guidelines or recommendations of federal  
8 government agencies including federal food and drug administration  
9 approvals, or state or national public health emergencies may be made  
10 at any time. Notification of adjustments made under this subsection  
11 must be provided to all in-network providers as soon as possible and  
12 must be available to providers on the electronic prior authorization  
13 system or application programming interface system. Until January 1,  
14 2028, this information must also be provided in a single location on  
15 the managed care organization's website referenced in (a) of this  
16 subsection. Managed care organizations may remove prior authorization  
17 requirements at any time.

18       (3) (a) Only a licensed physician or a licensed health  
19 professional working within their scope of practice may deny a prior  
20 authorization request based on medical necessity. The licensed  
21 physician or licensed health professional shall evaluate the specific  
22 clinical issues involved in the health care services requested by the  
23 requesting provider by reviewing and considering the requesting  
24 provider's recommendation, the enrollee's medical or other clinical  
25 history, as applicable, and individual clinical circumstances.  
26 Artificial intelligence shall not be the sole means used to deny,  
27 delay, or modify health care services. Algorithms may be used to  
28 process and approve prior authorization requests, but may not be used  
29 without human review to deny care based on a determination of medical  
30 necessity.

31       (b) A managed care organization that uses artificial intelligence  
32 for the purpose of prior authorization or prior authorization  
33 functions, based in whole or in part on medical necessity, or that  
34 contracts with or otherwise works through an entity that uses  
35 artificial intelligence for the purpose of prior authorization or  
36 prior authorization functions, based in whole or in part on medical  
37 necessity, shall ensure all of the following:

38       (i) The artificial intelligence bases its determination on the  
39 following information, as applicable:

1 (A) An enrollee's medical or other clinical history, including  
2 demographic data; and

3 (B) Individual clinical circumstances as presented by the  
4 requesting provider;

5 (ii) The artificial intelligence does not base its determination  
6 solely on a group data set;

7 (iii) The artificial intelligence's criteria and guidelines  
8 comply with this chapter and applicable state and federal law;

9 (iv) The use of the artificial intelligence does not  
10 discriminate, directly or indirectly, against an enrollee in  
11 violation of state or federal law;

12 (v) The artificial intelligence is fairly and equitably applied,  
13 including in accordance with any applicable regulations and guidance  
14 issued by the federal department of health and human services;

15 (vi) The policies and procedures for using artificial  
16 intelligence are open to audit by the authority consistent with RCW  
17 74.09.200;

18 (vii) The artificial intelligence's performance, use, and  
19 outcomes are periodically reviewed by the managed care organization  
20 to maximize accuracy and reliability; and

21 (viii) Patient data is not used beyond its intended and stated  
22 purpose, consistent with chapter 70.02 RCW and the federal health  
23 insurance portability and accountability act of 1996, 42 U.S.C. Sec.  
24 1320d et al., as applicable.

25 (4) (a) By January 1, 2026, managed care organizations shall  
26 submit the total number of prior authorization requests, approvals,  
27 and denials to the authority on a quarterly basis. Managed care  
28 organizations shall report these totals by health plan and for each  
29 health care benefit manager that is delegated to provide care  
30 determinations on behalf of the managed care organization. Managed  
31 care organizations shall indicate the percentage of total denials  
32 that were aided by artificial intelligence and the percent of care  
33 determinations made after the emergent and nonemergent authorization  
34 request turnaround times listed in subsection (1) of this section.

35 (b) The authority shall provide a reporting template to managed  
36 care organizations 90 days prior to the first report submission and  
37 shall review the template annually for updates.

38 (c) The authority shall publish on its website the results of  
39 each managed care organization's report 45 days after submission,

1 along with their own prior authorization statistics for fee-for-  
2 service medicaid enrollees.

3 (5) By July 1, 2027, the authority shall publish a list of  
4 treatments, prescription drugs, equipment, and services, along with  
5 their applicable billing codes, that specifies under which  
6 circumstances prior authorization is required, prohibited, or has  
7 other uniform application across the medical assistance program under  
8 this chapter. The authority must consider applicable state and  
9 federal laws when deciding which services are not subject to prior  
10 authorization. The authority shall focus on existing prior  
11 authorization requirements and treatments, prescription drugs,  
12 equipment, and services that are treated inconsistently in the  
13 medical assistance program. The authority shall update the list at  
14 least annually and provide notice and an opportunity for public  
15 comment prior to finalizing the list. Nothing in this subsection  
16 alters existing obligations of the authority and managed care  
17 organizations to ensure enrollee access to treatments, prescription  
18 drugs, equipment, and services that are not included in the list.  
19 Nothing in this section prohibits the authority and managed care  
20 organizations from applying other utilization management strategies,  
21 consistent with state and federal law, for services for which prior  
22 authorization is not required.

23 (6)(a) Each managed care organization shall build and maintain a  
24 prior authorization application programming interface that automates  
25 the process for in-network providers to determine whether a prior  
26 authorization is required for health care services, identify prior  
27 authorization information and documentation requirements, and  
28 facilitate the exchange of prior authorization requests and  
29 determinations from its electronic health records or practice  
30 management system. The application programming interface must support  
31 the exchange of prior authorization requests and determinations for  
32 health care services beginning January 1, 2025, and must:

33 (i) Use health level 7 fast health care interoperability  
34 resources in accordance with standards and provisions defined in 45  
35 C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);

36 (ii) Automate the process to determine whether a prior  
37 authorization is required for durable medical equipment or a health  
38 care service;

39 (iii) Allow providers to query the managed care organization's  
40 prior authorization documentation requirements;

1 (iv) Support an automated approach using nonproprietary open  
2 workflows to compile and exchange the necessary data elements to  
3 populate the prior authorization requirements that are compliant with  
4 the federal health insurance portability and accountability act of  
5 1996 or have an exception from the federal centers for medicare and  
6 medicaid services; and

7 (v) Indicate that a prior authorization denial or authorization  
8 of a service less intensive than that included in the original  
9 request is an adverse benefit determination and is subject to the  
10 managed care organization's grievance and appeal process under RCW  
11 48.43.535.

12 (b) Each managed care organization shall establish and maintain  
13 an interoperable electronic process or application programming  
14 interface that automates the process for in-network providers to  
15 determine whether a prior authorization is required for a covered  
16 prescription drug. The application programming interface must support  
17 the exchange of prior authorization requests and determinations for  
18 prescription drugs, including information on covered alternative  
19 prescription drugs, beginning January 1, 2027, and must:

20 (i) Allow providers to identify prior authorization information  
21 and documentation requirements;

22 (ii) Facilitate the exchange of prior authorization requests and  
23 determinations from its electronic health records or practice  
24 management system, and may include the necessary data elements to  
25 populate the prior authorization requirements that are compliant with  
26 the federal health insurance portability and accountability act of  
27 1996 or have an exception from the federal centers for medicare and  
28 medicaid services; and

29 (iii) Indicate that a prior authorization denial or authorization  
30 of a drug other than the one included in the original prior  
31 authorization request is an adverse benefit determination and is  
32 subject to the managed care organization's grievance and appeal  
33 process under RCW 48.43.535.

34 (c) If federal rules related to standards for using an  
35 application programming interface to communicate prior authorization  
36 status to providers are not finalized by September 13, 2023, the  
37 requirements of (a) of this subsection may not be enforced until  
38 January 1, 2026.

39 (d) (i) If a managed care organization determines that it will not  
40 be able to satisfy the requirements of (a) of this subsection by

1 January 1, 2025, the managed care organization shall submit a  
2 narrative justification to the authority on or before September 1,  
3 2024, describing:

4 (A) The reasons that the managed care organization cannot  
5 reasonably satisfy the requirements;

6 (B) The impact of noncompliance upon providers and enrollees;

7 (C) The current or proposed means of providing health information  
8 to the providers; and

9 (D) A timeline and implementation plan to achieve compliance with  
10 the requirements.

11 (ii) The authority may grant a one-year delay in enforcement of  
12 the requirements of (a) of this subsection (~~((2))~~) (6) if the  
13 authority determines that the managed care organization has made a  
14 good faith effort to comply with the requirements.

15 (iii) This subsection (~~((2))~~) (6)(d) shall not apply if the delay  
16 in enforcement in (c) of this subsection takes effect because the  
17 federal centers for medicare and medicaid services did not finalize  
18 the applicable regulations by September 13, 2023.

19 (~~((3))~~) (7) This section applies to prior authorization functions  
20 carried out by health care benefit managers, as defined in RCW  
21 48.200.020, under direct or indirect contract with a carrier.

22 (8) The authority may adopt any rules necessary to implement this  
23 section.

24 (9) Nothing in this section applies to prior authorization  
25 determinations made pursuant to RCW 71.24.618 or 74.09.490.

26 (~~((4))~~) (10) For the purposes of this section:

27 (a) "Artificial intelligence" means the use of machine learning  
28 and related technologies that use data to train statistical models  
29 for the purpose of enabling computer systems to perform tasks  
30 normally associated with human intelligence or perception, such as  
31 computer vision, speech or natural language processing, and content  
32 generation. "Artificial intelligence" includes generative artificial  
33 intelligence.

34 (b) "Expedited prior authorization request" means a request by a  
35 provider or facility for approval of a health care service or  
36 prescription drug where:

37 (i) The passage of time:

38 (A) Could seriously jeopardize the life or health of the  
39 enrollee;



1 (B) Could seriously jeopardize the enrollee's ability to regain  
2 maximum function; or

3 (C) In the opinion of a provider or facility with knowledge of  
4 the enrollee's medical condition, would subject the enrollee to  
5 severe pain that cannot be adequately managed without the health care  
6 service or prescription drug that is the subject of the request; or

7 (ii) The enrollee is undergoing a current course of treatment  
8 using a nonformulary drug.

9 (~~(b)~~) (c) "Generative artificial intelligence" means an  
10 artificial intelligence system that generates novel data or content  
11 based on a foundation model.

12 (d) "Machine learning" means the process by which artificial  
13 intelligence is developed using data and algorithms to draw  
14 inferences therefrom to automatically adapt or improve its accuracy  
15 without explicit programming.

16 (e) "Standard prior authorization request" means a request by a  
17 provider or facility for approval of a health care service or  
18 prescription drug where the request is made in advance of the  
19 enrollee obtaining a health care service or prescription drug that is  
20 not required to be expedited.

21 **Sec. 4.** RCW 41.05.845 and 2023 c 382 s 2 are each amended to  
22 read as follows:

23 (1) A health plan offered to public employees, retirees, and  
24 their covered dependents under this chapter issued or renewed on or  
25 after January 1, 2024, shall comply with the following standards  
26 related to prior authorization for health care services and  
27 prescription drugs:

28 (a) The health plan shall meet the following time frames for  
29 prior authorization determinations and notifications to a  
30 participating provider or facility that submits the prior  
31 authorization request through an electronic prior authorization  
32 process:

33 (i) For electronic standard prior authorization requests, the  
34 health plan shall make a decision and notify the provider or facility  
35 of the results of the decision within three calendar days, excluding  
36 holidays, of submission of an electronic prior authorization request  
37 by the provider or facility that contains the necessary information  
38 to make a determination. If insufficient information has been  
39 provided to the health plan to make a decision, the health plan shall

1 request any additional information from the provider or facility  
2 within one calendar day of submission of the electronic prior  
3 authorization request.

4 (ii) For electronic expedited prior authorization requests, the  
5 health plan shall make a decision and notify the provider or facility  
6 of the results of the decision within one calendar day of submission  
7 of an electronic prior authorization request by the provider or  
8 facility that contains the necessary information to make a  
9 determination. If insufficient information has been provided to the  
10 health plan to make a decision, the health plan shall request any  
11 additional information from the provider or facility within one  
12 calendar day of submission of the electronic prior authorization  
13 request.

14 (b) The health plan shall meet the following time frames for  
15 prior authorization determinations and notifications to a  
16 participating provider or facility that submits the prior  
17 authorization request through a process other than an electronic  
18 prior authorization process described in subsection (~~((2))~~) (4) of  
19 this section:

20 (i) For nonelectronic standard prior authorization requests, the  
21 health plan shall make a decision and notify the provider or facility  
22 of the results of the decision within five calendar days of  
23 submission of a nonelectronic prior authorization request by the  
24 provider or facility that contains the necessary information to make  
25 a determination. If insufficient information has been provided to the  
26 health plan to make a decision, the health plan shall request any  
27 additional information from the provider or facility within five  
28 calendar days of submission of the nonelectronic prior authorization  
29 request.

30 (ii) For nonelectronic expedited prior authorization requests,  
31 the health plan shall make a decision and notify the provider or  
32 facility of the results of the decision within two calendar days of  
33 submission of a nonelectronic prior authorization request by the  
34 provider or facility that contains the necessary information to make  
35 a determination. If insufficient information has been provided to the  
36 health plan to make a decision, the health plan shall request any  
37 additional information from the provider or facility within one  
38 calendar day of submission of the nonelectronic prior authorization  
39 request.

1 (c) In any instance in which the health plan has determined that  
2 a provider or facility has not provided sufficient information for  
3 making a determination under (a) and (b) of this subsection, the  
4 health plan may establish a specific reasonable time frame for  
5 submission of the additional information. This time frame must be  
6 communicated to the provider and enrollee with the health plan's  
7 request for additional information.

8 (d) The prior authorization requirements of the health plan must  
9 be described in detail and written in easily understandable language.  
10 The health plan shall make its most current prior authorization  
11 requirements and restrictions, including the written clinical review  
12 criteria, available to providers and facilities in an electronic  
13 format upon request. The prior authorization requirements must be  
14 based on peer-reviewed clinical review criteria. The clinical review  
15 criteria must be evidence-based criteria and must accommodate new and  
16 emerging information related to the appropriateness of clinical  
17 criteria with respect to black and indigenous people, other people of  
18 color, gender, and underserved populations. The clinical review  
19 criteria must be evaluated and updated, if necessary, at least  
20 annually.

21 ~~((2))~~ (e) When denying a prior authorization determination, the  
22 health plan shall include the credentials, board certifications, and  
23 areas of specialty expertise and training of the provider who had  
24 clinical oversight over the determination in any notification sent to  
25 the health plan enrollee and provider requesting or referring the  
26 service.

27 (2)(a) Health plans maintain the ability to make adjustments to  
28 policies and procedures that impact the applicability of their prior  
29 authorization requirements. Except as provided in (b) of this  
30 subsection, beginning August 1, 2025, new application of prior  
31 authorization for health care services or prescription drugs can only  
32 be made quarterly and go into effect either January 1st, April 1st,  
33 July 1st, or October 1st of any given calendar year. Notification of  
34 policy changes must be provided to all in-network providers at least  
35 45 days prior to the quarterly update and must be available to  
36 providers on the electronic prior authorization system or application  
37 programming interface system. Until January 1, 2028, this information  
38 must also be provided in a single location on the health plan's  
39 website. The notification must be provided independent of other

1 policy changes or provider notification publications and be easily  
2 accessible in electronic provider and enrollee portals.

3 (b) Adjustments to policies and procedures that impact the  
4 applicability of prior authorization requirements to reflect new  
5 evidence for health care services or prescription drugs including  
6 nationally recognized standards of care that are publicly available,  
7 consensus guidelines of nonprofit health care provider professional  
8 associations, nationally recognized clinical practice guidelines that  
9 are publicly available, guidelines or recommendations of federal  
10 government agencies including federal food and drug administration  
11 approvals, or state or national public health emergencies may be made  
12 at any time. Notification of adjustments made under this subsection  
13 must be provided to all in-network providers as soon as possible and  
14 must be available to providers on the electronic prior authorization  
15 system or application programming interface system. Until January 1,  
16 2028, this information must also be provided in a single location on  
17 the health plan's website referenced in (a) of this subsection.  
18 Health plans may remove prior authorization requirements at any time.

19 (3) (a) Only a licensed physician or a licensed health  
20 professional working within their scope of practice may deny a prior  
21 authorization request based on medical necessity. The licensed  
22 physician or licensed health professional shall evaluate the specific  
23 clinical issues involved in the health care services requested by the  
24 requesting provider by reviewing and considering the requesting  
25 provider's recommendation, the enrollee's medical or other clinical  
26 history, as applicable, and individual clinical circumstances.  
27 Artificial intelligence shall not be the sole means used to deny,  
28 delay, or modify health care services. Algorithms may be used to  
29 process and approve prior authorization requests, but may not be used  
30 without human review to deny care based on a determination of medical  
31 necessity.

32 (b) A health plan that uses artificial intelligence for the  
33 purpose of prior authorization or prior authorization functions,  
34 based in whole or in part on medical necessity, or that contracts  
35 with or otherwise works through an entity that uses artificial  
36 intelligence for the purpose of prior authorization or prior  
37 authorization functions, based in whole or in part on medical  
38 necessity, shall ensure all of the following:

39 (i) The artificial intelligence bases its determination on the  
40 following information, as applicable:

1 (A) An enrollee's medical or other clinical history, including  
2 demographic data; and

3 (B) Individual clinical circumstances as presented by the  
4 requesting provider;

5 (ii) The artificial intelligence does not base its determination  
6 solely on a group data set;

7 (iii) The artificial intelligence's criteria and guidelines  
8 comply with this chapter and applicable state and federal law;

9 (iv) The use of the artificial intelligence does not  
10 discriminate, directly or indirectly, against an enrollee in  
11 violation of state or federal law;

12 (v) The artificial intelligence is fairly and equitably applied,  
13 including in accordance with any applicable regulations and guidance  
14 issued by the federal department of health and human services;

15 (vi) The policies and procedures for using the artificial  
16 intelligence is open to audit by the office of the insurance  
17 commissioner;

18 (vii) The artificial intelligence's performance, use, and  
19 outcomes are periodically reviewed by the health plan to maximize  
20 accuracy and reliability; and

21 (viii) Patient data is not used beyond its intended and stated  
22 purpose, consistent with chapter 70.02 RCW and the federal health  
23 insurance portability and accountability act of 1996, U.S.C. Sec.  
24 1320d et al., as applicable.

25 (4)(a) Each health plan offered to public employees, retirees,  
26 and their covered dependents under this chapter shall build and  
27 maintain a prior authorization application programming interface that  
28 automates the process for in-network providers to determine whether a  
29 prior authorization is required for health care services, identify  
30 prior authorization information and documentation requirements, and  
31 facilitate the exchange of prior authorization requests and  
32 determinations from its electronic health records or practice  
33 management system. The application programming interface must support  
34 the exchange of prior authorization requests and determinations for  
35 health care services beginning January 1, 2025, and must:

36 (i) Use health level 7 fast health care interoperability  
37 resources in accordance with standards and provisions defined in 45  
38 C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);

1 (ii) Automate the process to determine whether a prior  
2 authorization is required for durable medical equipment or a health  
3 care service;

4 (iii) Allow providers to query the health plan's prior  
5 authorization documentation requirements;

6 (iv) Support an automated approach using nonproprietary open  
7 workflows to compile and exchange the necessary data elements to  
8 populate the prior authorization requirements that are compliant with  
9 the federal health insurance portability and accountability act of  
10 1996 or have an exception from the federal centers for medicare and  
11 medicaid services; and

12 (v) Indicate that a prior authorization denial or authorization  
13 of a service less intensive than that included in the original  
14 request is an adverse benefit determination and is subject to the  
15 health plan's grievance and appeal process under RCW 48.43.535.

16 (b) Each health plan offered to public employees, retirees, and  
17 their covered dependents under this chapter shall establish and  
18 maintain an interoperable electronic process or application  
19 programming interface that automates the process for in-network  
20 providers to determine whether a prior authorization is required for  
21 a covered prescription drug. The application programming interface  
22 must support the exchange of prior authorization requests and  
23 determinations for prescription drugs, including information on  
24 covered alternative prescription drugs, beginning January 1, 2027,  
25 and must:

26 (i) Allow providers to identify prior authorization information  
27 and documentation requirements;

28 (ii) Facilitate the exchange of prior authorization requests and  
29 determinations from its electronic health records or practice  
30 management system, and may include the necessary data elements to  
31 populate the prior authorization requirements that are compliant with  
32 the federal health insurance portability and accountability act of  
33 1996 or have an exception from the federal centers for medicare and  
34 medicaid services; and

35 (iii) Indicate that a prior authorization denial or authorization  
36 of a drug other than the one included in the original prior  
37 authorization request is an adverse benefit determination and is  
38 subject to the health plan's grievance and appeal process under RCW  
39 48.43.535.

1 (c) If federal rules related to standards for using an  
2 application programming interface to communicate prior authorization  
3 status to providers are not finalized by the federal centers for  
4 medicare and medicaid services by September 13, 2023, the  
5 requirements of (a) of this subsection may not be enforced until  
6 January 1, 2026.

7 (d)(i) If the health plan determines that it will not be able to  
8 satisfy the requirements of (a) of this subsection by January 1,  
9 2025, the health plan shall submit a narrative justification to the  
10 authority on or before September 1, 2024, describing:

11 (A) The reasons that the health plan cannot reasonably satisfy  
12 the requirements;

13 (B) The impact of noncompliance upon providers and enrollees;

14 (C) The current or proposed means of providing health information  
15 to the providers; and

16 (D) A timeline and implementation plan to achieve compliance with  
17 the requirements.

18 (ii) The authority may grant a one-year delay in enforcement of  
19 the requirements of (a) of this subsection (~~((2))~~) (4) if the  
20 authority determines that the health plan has made a good faith  
21 effort to comply with the requirements.

22 (iii) This subsection (~~((2))~~) (4)(d) shall not apply if the delay  
23 in enforcement in (c) of this subsection takes effect because the  
24 federal centers for medicare and medicaid services did not finalize  
25 the applicable regulations by September 13, 2023.

26 (~~((3))~~) (5) Nothing in this section applies to prior  
27 authorization determinations made pursuant to RCW 41.05.526.

28 (~~((4))~~) (6) This section applies to prior authorization functions  
29 carried out by health care benefit managers, as defined in RCW  
30 48.200.020, under direct or indirect contract with a carrier.

31 (7) The authority may adopt any rules necessary to implement this  
32 section.

33 (8) For the purposes of this section:

34 (a) "Artificial intelligence" means the use of machine learning  
35 and related technologies that use data to train statistical models  
36 for the purpose of enabling computer systems to perform tasks  
37 normally associated with human intelligence or perception, such as  
38 computer vision, speech or natural language processing, and content  
39 generation. "Artificial intelligence" includes generative artificial  
40 intelligence.

1       **(b)** "Expedited prior authorization request" means a request by a  
2 provider or facility for approval of a health care service or  
3 prescription drug where:

4       (i) The passage of time:

5       (A) Could seriously jeopardize the life or health of the  
6 enrollee;

7       (B) Could seriously jeopardize the enrollee's ability to regain  
8 maximum function; or

9       (C) In the opinion of a provider or facility with knowledge of  
10 the enrollee's medical condition, would subject the enrollee to  
11 severe pain that cannot be adequately managed without the health care  
12 service or prescription drug that is the subject of the request; or

13       (ii) The enrollee is undergoing a current course of treatment  
14 using a nonformulary drug.

15       ~~((b))~~ (c) "Generative artificial intelligence" means an  
16 artificial intelligence system that generates novel data or content  
17 based on a foundation model.

18       (d) "Machine learning" means the process by which artificial  
19 intelligence is developed using data and algorithms to draw  
20 inferences therefrom to automatically adapt or improve its accuracy  
21 without explicit programming.

22       **(e)** "Standard prior authorization request" means a request by a  
23 provider or facility for approval of a health care service or  
24 prescription drug where the request is made in advance of the  
25 enrollee obtaining a health care service that is not required to be  
26 expedited.

27       ~~((5))~~ (9) This section shall not apply to coverage provided  
28 under the medicare part C or part D programs set forth in Title XVIII  
29 of the social security act of 1965, as amended.

30       **Sec. 5.** RCW 48.43.525 and 2000 c 5 s 9 are each amended to read  
31 as follows:

32       (1) A health carrier that offers a health plan shall not  
33 retrospectively deny coverage or retrospectively modify to a service  
34 less intensive than that included in the original request for  
35 emergency and nonemergency care that had prior authorization,  
36 including for medical necessity, under the plan's written policies at  
37 the time the care was rendered, unless:

38       (a) The prior authorization was based upon a material  
39 misrepresentation by the provider, facility, or covered person; or



1 (b) The underlying health plan coverage is lawfully rescinded,  
2  canceled, or terminated retrospectively through the date of service.

3 (2) Retrospective denials of services with prior authorization or  
4  retrospective modification to less intensive services due to a change  
5  in the carrier's determination of medical necessity are prohibited,  
6  shall not be considered adverse benefit determinations, and will not  
7  be required to follow the standard appeals processes in RCW 48.43.530  
8  or any carrier policies related to their own grievance and appeals  
9  process. If an enrollee or the provider requesting the original  
10  authorization demonstrates the authorization was valid per the plan's  
11  written policies, then the carrier will deem the authorization  
12  approved and payable. Interest will be assessed on the associated  
13  claim submitted by the provider at the rate of one percent per month,  
14  retroactive to the date of service.

15 (3) The commissioner shall adopt, in rule, standards for this  
16  section after considering relevant standards adopted by national  
17  managed care accreditation organizations and state agencies that  
18  purchase managed health care services.

19 **Sec. 6.** RCW 48.43.0161 and 2023 c 382 s 4 are each amended to  
20 read as follows:

21 (1) By (~~October 1, 2020,~~) January 1, 2026, and annually  
22  thereafter, for individual and group health plans issued by a carrier  
23  that has written at least one percent of the total accident and  
24  health insurance premiums written by all companies authorized to  
25  offer accident and health insurance in Washington in the most  
26  recently available year, the carrier shall report to the commissioner  
27  the following aggregated and deidentified data related to the  
28  carrier's prior authorization practices and experience for the prior  
29  plan year:

30 (a) The total number of prior authorization requests, approvals,  
31  and denials. The carrier must report these totals separately for  
32  approvals or denials made by the carrier directly and for approvals  
33  or denials made by a health care benefit manager as defined in RCW  
34  48.200.020 that is delegated to make prior authorization  
35  determinations either directly or indirectly on behalf of the  
36  carrier. In the report, carriers must also indicate:

37 (i) The percentage of total denials that were aided by artificial  
38  intelligence;

1        (ii) The percent of prior authorization determinations made after  
2 the standard and expedited authorization request turnaround times  
3 stated in RCW 48.43.830; and

4        (iii) The total number of nonelectronic standard and  
5 nonelectronic expedited prior authorization requests;

6        (b) Lists of the 10 inpatient medical or surgical codes:

7            (i) With the highest total number of prior authorization requests  
8 during the previous plan year, including the total number of prior  
9 authorization requests for each code and the percent of approved  
10 requests for each code;

11            (ii) With the highest percentage of approved prior authorization  
12 requests during the previous plan year, including the total number of  
13 prior authorization requests for each code and the percent of  
14 approved requests for each code; and

15            (iii) With the highest percentage of prior authorization requests  
16 that were initially denied and then subsequently approved on appeal,  
17 including the total number of prior authorization requests for each  
18 code and the percent of requests that were initially denied and then  
19 subsequently approved for each code;

20        ~~((b))~~ (c) Lists of the 10 outpatient medical or surgical codes:

21            (i) With the highest total number of prior authorization requests  
22 during the previous plan year, including the total number of prior  
23 authorization requests for each code and the percent of approved  
24 requests for each code;

25            (ii) With the highest percentage of approved prior authorization  
26 requests during the previous plan year, including the total number of  
27 prior authorization requests for each code and the percent of  
28 approved requests for each code; and

29            (iii) With the highest percentage of prior authorization requests  
30 that were initially denied and then subsequently approved on appeal,  
31 including the total number of prior authorization requests for each  
32 code and the percent of requests that were initially denied and then  
33 subsequently approved for each code;

34        ~~((e))~~ (d) Lists of the 10 inpatient mental health and substance  
35 use disorder service codes:

36            (i) With the highest total number of prior authorization requests  
37 during the previous plan year, including the total number of prior  
38 authorization requests for each code and the percent of approved  
39 requests for each code;

1 (ii) With the highest percentage of approved prior authorization  
2 requests during the previous plan year, including the total number of  
3 prior authorization requests for each code and the percent of  
4 approved requests for each code; and

5 (iii) With the highest percentage of prior authorization requests  
6 that were initially denied and then subsequently approved on appeal,  
7 including the total number of prior authorization requests for each  
8 code and the percent of requests that were initially denied and then  
9 subsequently approved for each code;

10 ~~((d))~~ (e) Lists of the 10 outpatient mental health and  
11 substance use disorder service codes:

12 (i) With the highest total number of prior authorization requests  
13 during the previous plan year, including the total number of prior  
14 authorization requests for each code and the percent of approved  
15 requests for each code;

16 (ii) With the highest percentage of approved prior authorization  
17 requests during the previous plan year, including the total number of  
18 prior authorization requests for each code and the percent of  
19 approved requests for each code; and

20 (iii) With the highest percentage of prior authorization requests  
21 that were initially denied and then subsequently approved on appeal,  
22 including the total number of prior authorization requests for each  
23 code and the percent of requests that were initially denied and then  
24 subsequently approved;

25 ~~((e))~~ (f) Lists of the 10 durable medical equipment codes:

26 (i) With the highest total number of prior authorization requests  
27 during the previous plan year, including the total number of prior  
28 authorization requests for each code and the percent of approved  
29 requests for each code;

30 (ii) With the highest percentage of approved prior authorization  
31 requests during the previous plan year, including the total number of  
32 prior authorization requests for each code and the percent of  
33 approved requests for each code; and

34 (iii) With the highest percentage of prior authorization requests  
35 that were initially denied and then subsequently approved on appeal,  
36 including the total number of prior authorization requests for each  
37 code and the percent of requests that were initially denied and then  
38 subsequently approved for each code;

39 ~~((f))~~ (g) Lists of the 10 diabetes supplies and equipment  
40 codes:

1 (i) With the highest total number of prior authorization requests  
2 during the previous plan year, including the total number of prior  
3 authorization requests for each code and the percent of approved  
4 requests for each code;

5 (ii) With the highest percentage of approved prior authorization  
6 requests during the previous plan year, including the total number of  
7 prior authorization requests for each code and the percent of  
8 approved requests for each code; and

9 (iii) With the highest percentage of prior authorization requests  
10 that were initially denied and then subsequently approved on appeal,  
11 including the total number of prior authorization requests for each  
12 code and the percent of requests that were initially denied and then  
13 subsequently approved for each code;

14 ~~((g))~~ (h) Lists of the 10 prescription drugs:

15 (i) With the highest total number of prior authorization requests  
16 during the previous plan year, including the total number of prior  
17 authorization requests for each prescription drug and the percent of  
18 approved requests for each prescription drug;

19 (ii) With the highest percentage of approved prior authorization  
20 requests during the previous plan year, including the total number of  
21 prior authorization requests for each prescription drug and the  
22 percent of approved requests for each prescription drug; and

23 (iii) With the highest percentage of prior authorization requests  
24 that were initially denied and then subsequently approved on appeal,  
25 including the total number of prior authorization requests for each  
26 prescription drug and the percent of requests that were initially  
27 denied and then subsequently approved for each prescription drug; and

28 ~~((h))~~ (i) The average determination response time in hours for  
29 prior authorization requests to the carrier in total reported under  
30 (a) of this subsection and with respect to each code reported under  
31 ~~((a))~~ (b) through ~~((f))~~ (h) of this subsection for each of the  
32 following categories of prior authorization:

33 (i) Expedited decisions;

34 (ii) Standard decisions; and

35 (iii) Extenuating circumstances decisions.

36 (2) (a) By January 1, 2021, and annually thereafter, the  
37 commissioner shall aggregate and deidentify the data collected under  
38 subsection (1) of this section into a standard report and may not  
39 identify the name of the carrier that submitted the data. The  
40 commissioner must make the report available to interested parties.

1       (b) The report must contain trend data for total authorization  
2 requests, approvals, and denials by plan and health care benefit  
3 managers.

4       (3) The commissioner may request additional information from  
5 carriers reporting data under this section.

6       (4) The commissioner may adopt rules to implement this section.  
7 In adopting rules, the commissioner must consult stakeholders  
8 including carriers, health care practitioners, health care  
9 facilities, and patients.

10       (5) For the purpose of this section, "prior authorization" means  
11 a mandatory process that a carrier or its designated or contracted  
12 representative requires a provider or facility to follow before a  
13 service is delivered, to determine if a service is a benefit and  
14 meets the requirements for medical necessity, clinical  
15 appropriateness, level of care, or effectiveness in relation to the  
16 applicable plan, including any term used by a carrier or its  
17 designated or contracted representative to describe this process.

--- END ---