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ENGROSSED SECOND SUBSTITUTE SENATE BILL 5395

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State of Washington

69th Legislature

2026 Regular Session

By Senate Ways & Means (originally sponsored by Senators Orwall, Muzzall, Hasegawa, Lovelett, Nobles, and Slatter)

READ FIRST TIME 01/29/26.

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

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

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

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

5 (3) It is the intent of the legislature to update the protections  
6 of this act for enrollees to include managed care organizations as  
7 soon as feasible, recognizing that low-income, publicly insured  
8 Washingtonians deserve the same patient protections as higher-income,  
9 commercially insured Washingtonians.

10 **Sec. 2.** RCW 48.43.830 and 2025 c 25 s 1 are each amended to read  
11 as follows:

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

16 (a) The carrier shall meet the following time frames for prior  
17 authorization determinations and notifications to a participating  
18 provider or facility that submits the prior authorization request  
19 through an electronic prior authorization process, as designated by  
20 each carrier:

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

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

1 (b) The carrier shall meet the following time frames for prior  
2 authorization determinations and notifications to a participating  
3 provider or facility that submits the prior authorization request  
4 through a process other than an electronic prior authorization  
5 process:

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

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

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

31 (d) The carrier's prior authorization requirements must be  
32 described in detail and written in easily understandable language.  
33 The carrier shall make its most current prior authorization  
34 requirements and restrictions, including the written clinical review  
35 criteria, available to providers and facilities in an electronic  
36 format upon request. The prior authorization requirements must be  
37 based on peer-reviewed clinical review criteria. The clinical review  
38 criteria must be evidence-based criteria and must accommodate new and  
39 emerging information related to the appropriateness of clinical  
40 criteria with respect to black and indigenous people, other people of

1 color, gender, and underserved populations. The clinical review  
2 criteria must be evaluated and updated, if necessary, at least  
3 annually.

4 ~~((2))~~ (e) When denying a prior authorization determination, the  
5 carrier shall include the credentials, board certifications, and  
6 areas of specialty of the provider who had clinical oversight over  
7 the determination in any notification sent to the health plan  
8 enrollee and provider requesting or referring the service.

9 (2) Carriers must post any adjustments to policies and procedures  
10 that impact the applicability of their prior authorization  
11 requirements for health care services or prescription drugs,  
12 including new applications of prior authorization, in a single  
13 location on the carrier's website. After December 30, 2030, any new  
14 application of prior authorization for health care services must be  
15 available to providers on the electronic prior authorization system  
16 or application programming interface system referenced in subsection  
17 (4) of this section.

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 carrier that uses artificial intelligence for the purpose  
32 of prior authorization or prior authorization functions, based in  
33 whole or in part on medical necessity, or that contracts with or  
34 otherwise works through an entity that uses artificial intelligence  
35 for the purpose of prior authorization or prior authorization  
36 functions, based in whole or in part on medical necessity, shall  
37 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 office of the insurance  
17 commissioner under chapter 48.37 RCW;

18 (vii) The artificial intelligence's performance, use, and  
19 outcomes are periodically reviewed by the carrier 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, 42 U.S.C. Sec.  
24 1320d et al., as applicable.

25 (4)(a) Each carrier shall establish and maintain a prior  
26 authorization application programming interface that is consistent  
27 with final rules issued by the federal centers for medicare and  
28 medicaid services and published in the federal register, and that  
29 indicates that a prior authorization denial or authorization of a  
30 service less intensive than that included in the original request is  
31 an adverse benefit determination and is subject to the carrier's  
32 grievance and appeal process under RCW 48.43.535.

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

1 covered alternative prescription drugs, beginning January 1, 2027,  
2 and must:

3 (i) Allow providers to identify prior authorization information  
4 and documentation requirements;

5 (ii) Facilitate the exchange of prior authorization requests and  
6 determinations from its electronic health records or practice  
7 management system; 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) Regardless of whether federal rules related to standards for  
14 using an application programming interface to communicate prior  
15 authorization status to providers are revoked, delayed, suspended, or  
16 not finalized by the federal centers for medicare and medicaid  
17 services after February 8, 2024, the requirements of (a) of this  
18 subsection shall be enforced beginning January 1, 2027.

19 (d) By September 13, 2023, and at least every six months  
20 thereafter until September 13, 2026, the commissioner shall provide  
21 an update to the health care policy committees of the legislature on  
22 the development of rules and implementation guidance from the federal  
23 centers for medicare and medicaid services regarding the standards  
24 for development of application programming interfaces and  
25 interoperable electronic processes related to prior authorization  
26 functions. The updates should include recommendations, as  
27 appropriate, on whether the status of the federal rule development  
28 aligns with the provisions of chapter 382, Laws of 2023. The  
29 commissioner also shall report on any actions by the federal centers  
30 for medicare and medicaid services to exercise enforcement discretion  
31 related to the implementation and maintenance of an application  
32 programming interface for prior authorization functions. The  
33 commissioner shall consult with the health care authority, carriers,  
34 providers, and consumers on the development of these updates and any  
35 recommendations.

36 ~~((3))~~ (5) Nothing in this section applies to prior  
37 authorization determinations made pursuant to RCW 48.43.761.

38 ~~((4))~~ (6) This section applies to prior authorization functions  
39 carried out by health care benefit managers, as defined in RCW  
40 48.200.020, under direct or indirect contract with a carrier.

1 (7) The commissioner may adopt any rules necessary to implement  
2 this section.

3 (8) For the purposes of this section:

4 (a) "Artificial intelligence" means the use of machine learning  
5 and related technologies that use data to train statistical models  
6 for the purpose of enabling computer systems to perform tasks  
7 normally associated with human intelligence or perception, such as  
8 computer vision, speech or natural language processing, and content  
9 generation. "Artificial intelligence" includes generative artificial  
10 intelligence.

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

14 (i) The passage of time:

15 (A) Could seriously jeopardize the life or health of the  
16 enrollee;

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

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

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

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

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

32 (e) "Standard prior authorization request" means a request by a  
33 provider or facility for approval of a health care service or  
34 prescription drug where the request is made in advance of the  
35 enrollee obtaining a health care service or prescription drug that is  
36 not required to be expedited.

37 **Sec. 3.** RCW 48.43.830 and 2025 c 227 s 8 and 2025 c 25 s 1 are  
38 each reenacted and amended to read as follows:

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

5 (a) The carrier shall meet the following time frames for prior  
6 authorization determinations and notifications to a participating  
7 provider or facility that submits the prior authorization request  
8 through an electronic prior authorization process, as designated by  
9 each carrier:

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

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

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

34 (i) For nonelectronic standard prior authorization requests, the  
35 carrier shall make a decision and notify the provider or facility of  
36 the results of the decision within five calendar days of submission  
37 of a nonelectronic prior authorization request by the provider or  
38 facility that contains the necessary information to make a  
39 determination. If insufficient information has been provided to the  
40 carrier to make a decision, the carrier shall request any additional

1 information from the provider or facility within five calendar days  
2 of submission of the nonelectronic prior authorization request.

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

12 (c) In any instance in which a carrier has determined that a  
13 provider or facility has not provided sufficient information for  
14 making a determination under (a) and (b) of this subsection, a  
15 carrier may establish a specific reasonable time frame for submission  
16 of the additional information. This time frame must be communicated  
17 to the provider and enrollee with a carrier's request for additional  
18 information.

19 (d) The carrier's prior authorization requirements must be  
20 described in detail and written in easily understandable language.  
21 The carrier shall make its most current prior authorization  
22 requirements and restrictions, including the written clinical review  
23 criteria, available to providers and facilities in an electronic  
24 format upon request. The prior authorization requirements must be  
25 based on peer-reviewed clinical review criteria. The clinical review  
26 criteria must be evidence-based criteria and must accommodate new and  
27 emerging information related to the appropriateness of clinical  
28 criteria with respect to black and indigenous people, other people of  
29 color, gender, and underserved populations. The clinical review  
30 criteria must be evaluated and updated, if necessary, at least  
31 annually. Clinical review criteria used for purposes of reviewing and  
32 decided upon prior authorization requests related to mental health  
33 and substance use disorder services, as defined in RCW 48.43.766,  
34 must meet the requirements of RCW 48.43.766.

35 ~~((2))~~ (e) When denying a prior authorization determination, the  
36 carrier shall include the credentials, board certifications, and  
37 areas of specialty of the provider who had clinical oversight over  
38 the determination in any notification sent to the health plan  
39 enrollee and provider requesting or referring the service.

1 (2) Carriers must post any adjustments to policies and procedures  
2 that impact the applicability of their prior authorization  
3 requirements for health care services or prescription drugs,  
4 including new applications of prior authorization, in a single  
5 location on the carrier's website. After December 30, 2030, any new  
6 application of prior authorization for health care services must be  
7 available to providers on the electronic prior authorization system  
8 or application programming interface system.

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

22 (b) A carrier that uses artificial intelligence for the purpose  
23 of prior authorization or prior authorization functions, based in  
24 whole or in part on medical necessity, or that contracts with or  
25 otherwise works through an entity that uses artificial intelligence  
26 for the purpose of prior authorization or prior authorization  
27 functions, based in whole or in part on medical necessity, shall  
28 ensure all of the following:

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

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

33 (B) Individual clinical circumstances as presented by the  
34 requesting provider;

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

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

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

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

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

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

13 (viii) Patient data is not used beyond its intended and stated  
14 purpose, consistent with chapter 70.02 RCW and the federal health  
15 insurance portability and accountability act of 1996, 42 U.S.C. Sec.  
16 1320d et al., as applicable.

17 (4)(a) Each carrier shall establish and maintain a prior  
18 authorization application programming interface that is consistent  
19 with final rules issued by the federal centers for medicare and  
20 medicaid services and published in the federal register, and that  
21 indicates that a prior authorization denial or authorization of a  
22 service less intensive than that included in the original request is  
23 an adverse benefit determination and is subject to the carrier's  
24 grievance and appeal process under RCW 48.43.535.

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

34 (i) Allow providers to identify prior authorization information  
35 and documentation requirements;

36 (ii) Facilitate the exchange of prior authorization requests and  
37 determinations from its electronic health records or practice  
38 management system; and

39 (iii) Indicate that a prior authorization denial or authorization  
40 of a drug other than the one included in the original prior

1 authorization request is an adverse benefit determination and is  
2 subject to the carrier's grievance and appeal process under RCW  
3 48.43.535.

4 (c) Regardless of whether federal rules related to standards for  
5 using an application programming interface to communicate prior  
6 authorization status to providers are revoked, delayed, suspended, or  
7 not finalized by the federal centers for medicare and medicaid  
8 services after February 8, 2024, the requirements of (a) of this  
9 subsection shall be enforced beginning January 1, 2027.

10 (d) By September 13, 2023, and at least every six months  
11 thereafter until September 13, 2026, the commissioner shall provide  
12 an update to the health care policy committees of the legislature on  
13 the development of rules and implementation guidance from the federal  
14 centers for medicare and medicaid services regarding the standards  
15 for development of application programming interfaces and  
16 interoperable electronic processes related to prior authorization  
17 functions. The updates should include recommendations, as  
18 appropriate, on whether the status of the federal rule development  
19 aligns with the provisions of chapter 382, Laws of 2023. The  
20 commissioner also shall report on any actions by the federal centers  
21 for medicare and medicaid services to exercise enforcement discretion  
22 related to the implementation and maintenance of an application  
23 programming interface for prior authorization functions. The  
24 commissioner shall consult with the health care authority, carriers,  
25 providers, and consumers on the development of these updates and any  
26 recommendations.

27 ~~((3))~~ (5) Nothing in this section applies to prior  
28 authorization determinations made pursuant to RCW 48.43.761.

29 ~~((4))~~ (6) This section applies to prior authorization functions  
30 carried out by health care benefit managers, as defined in RCW  
31 48.200.020, under direct or indirect contract with a carrier.

32 (7) The commissioner may adopt any rules necessary to implement  
33 this section.

34 (8) For the purposes of this section:

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

1 generation. "Artificial intelligence" includes generative artificial  
2 intelligence.

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

6 (i) The passage of time:

7 (A) Could seriously jeopardize the life or health of the  
8 enrollee;

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

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

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

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

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

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

29 **Sec. 4.** RCW 41.05.845 and 2025 c 25 s 2 are each amended to read  
30 as follows:

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

36 (a) The health plan shall meet the following time frames for  
37 prior authorization determinations and notifications to a  
38 participating provider or facility that submits the prior

1 authorization request through an electronic prior authorization  
2 process:

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

13 (ii) For electronic expedited prior authorization requests, the  
14 health plan shall make a decision and notify the provider or facility  
15 of the results of the decision within one calendar day of submission  
16 of an electronic prior authorization request by the provider or  
17 facility that contains the necessary information to make a  
18 determination. If insufficient information has been provided to the  
19 health plan to make a decision, the health plan shall request any  
20 additional information from the provider or facility within one  
21 calendar day of submission of the electronic prior authorization  
22 request.

23 (b) The health plan shall meet the following time frames for  
24 prior authorization determinations and notifications to a  
25 participating provider or facility that submits the prior  
26 authorization request through a process other than an electronic  
27 prior authorization process described in subsection (2) of this  
28 section:

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

39 (ii) For nonelectronic expedited prior authorization requests,  
40 the health plan shall make a decision and notify the provider or

1 facility of the results of the decision within two calendar days of  
2 submission of a nonelectronic prior authorization request by the  
3 provider or facility that contains the necessary information to make  
4 a determination. If insufficient information has been provided to the  
5 health plan to make a decision, the health plan shall request any  
6 additional information from the provider or facility within one  
7 calendar day of submission of the nonelectronic prior authorization  
8 request.

9 (c) In any instance in which the health plan has determined that  
10 a provider or facility has not provided sufficient information for  
11 making a determination under (a) and (b) of this subsection, the  
12 health plan may establish a specific reasonable time frame for  
13 submission of the additional information. This time frame must be  
14 communicated to the provider and enrollee with the health plan's  
15 request for additional information.

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

29 ~~((2))~~ (e) When denying a prior authorization determination, the  
30 health plan shall include the credentials, board certifications, and  
31 areas of specialty, expertise, and training of the provider who had  
32 clinical oversight over the determination in any notification sent to  
33 the health plan enrollee and provider requesting or referring the  
34 service.

35 (2) Health plans must post, and maintain the ability to make  
36 adjustments to policies and procedures that impact the applicability  
37 of their prior authorization requirements for health care services or  
38 prescription drugs, including new applications of prior  
39 authorization, in a single location on the health plan's website.  
40 After December 30, 2030, any new application of prior authorization

1 for health care services must be available to providers on the  
2 electronic prior authorization system or application programming  
3 interface system.

4 (3) (a) Only a licensed physician or a licensed health  
5 professional working within their scope of practice may deny a prior  
6 authorization request based on medical necessity. The licensed  
7 physician or licensed health professional shall evaluate the specific  
8 clinical issues involved in the health care services requested by the  
9 requesting provider by reviewing and considering the requesting  
10 provider's recommendation, the enrollee's medical or other clinical  
11 history, as applicable, and individual clinical circumstances.  
12 Artificial intelligence shall not be the sole means used to deny,  
13 delay, or modify health care services. Algorithms may be used to  
14 process and approve prior authorization requests, but may not be used  
15 without human review to deny care based on a determination of medical  
16 necessity.

17 (b) A health plan that uses artificial intelligence for the  
18 purpose of prior authorization or prior authorization functions,  
19 based in whole or in part on medical necessity, or that contracts  
20 with or otherwise works through an entity that uses artificial  
21 intelligence for the purpose of prior authorization or prior  
22 authorization functions, based in whole or in part on medical  
23 necessity, shall ensure all of the following:

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

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

28 (B) Individual clinical circumstances as presented by the  
29 requesting provider;

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

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

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

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

1 (vi) The policies and procedures for using the artificial  
2 intelligence is open to audit by the office of the insurance  
3 commissioner;

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

7 (viii) Patient data is not used beyond its intended and stated  
8 purpose, consistent with chapter 70.02 RCW and the federal health  
9 insurance portability and accountability act of 1996, U.S.C. Sec.  
10 1320d et al., as applicable.

11 (4)(a) Each health plan offered to public employees, retirees,  
12 and their covered dependents under this chapter shall establish and  
13 maintain a prior authorization application programming interface that  
14 is consistent with final rules issued by the federal centers for  
15 medicare and medicaid services and published in the federal register,  
16 and that indicates that a prior authorization denial or authorization  
17 of a service less intensive than that included in the original  
18 request is an adverse benefit determination and is subject to the  
19 health plan's grievance and appeal process under RCW 48.43.535.

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

30 (i) Allow providers to identify prior authorization information  
31 and documentation requirements;

32 (ii) Facilitate the exchange of prior authorization requests and  
33 determinations from its electronic health records or practice  
34 management system; 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) Regardless of whether federal rules related to standards for  
2 using an application programming interface to communicate prior  
3 authorization status to providers are revoked, delayed, suspended, or  
4 not finalized by the federal centers for medicare and medicaid  
5 services after February 8, 2024, the requirements of (a) of this  
6 subsection shall be enforced beginning January 1, 2027.

7 ~~((3))~~ (5) Nothing in this section applies to prior  
8 authorization determinations made pursuant to RCW 41.05.526.

9 ~~((4))~~ (6) This section applies to prior authorization functions  
10 carried out by health care benefit managers, as defined in RCW  
11 48.200.020, under direct or indirect contract with a carrier.

12 (7) The authority may adopt any rules necessary to implement this  
13 section.

14 (8) For the purposes of this section:

15 (a) "Artificial intelligence" means the use of machine learning  
16 and related technologies that use data to train statistical models  
17 for the purpose of enabling computer systems to perform tasks  
18 normally associated with human intelligence or perception, such as  
19 computer vision, speech or natural language processing, and content  
20 generation. "Artificial intelligence" includes generative artificial  
21 intelligence.

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

25 (i) The passage of time:

26 (A) Could seriously jeopardize the life or health of the  
27 enrollee;

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

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

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

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

39 (d) "Machine learning" means the process by which artificial  
40 intelligence is developed using data and algorithms to draw

1 inferences therefrom to automatically adapt or improve its accuracy  
2 without explicit programming.

3 (e) "Standard prior authorization request" means a request by a  
4 provider or facility for approval of a health care service or  
5 prescription drug where the request is made in advance of the  
6 enrollee obtaining a health care service that is not required to be  
7 expedited.

8 ~~((+5))~~ (9) This section shall not apply to coverage provided  
9 under the medicare part C or part D programs set forth in Title XVIII  
10 of the social security act of 1965, as amended.

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

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

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

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

23 (2) Retrospective denials of services with prior authorization or  
24 retrospective modification to less intensive services due to a change  
25 in the carrier's determination of medical necessity are prohibited,  
26 shall not be considered adverse benefit determinations, and will not  
27 be required to follow the standard appeals processes in RCW 48.43.530  
28 or any carrier policies related to their own grievance and appeals  
29 process. If an enrollee or the provider requesting the original  
30 authorization demonstrates the authorization was valid per the plan's  
31 written policies, then the carrier will deem the authorization  
32 approved and payable. Interest will be assessed on the associated  
33 claim submitted by the provider at the rate of one percent per month,  
34 retroactive to the date of service.

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

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

3       (1) By (~~October 1, 2020,~~) January 1, 2027, and annually  
4 thereafter, for individual and group health plans issued by a carrier  
5 that has written at least one percent of the total accident and  
6 health insurance premiums written by all companies authorized to  
7 offer accident and health insurance in Washington in the most  
8 recently available year, the carrier shall report to the commissioner  
9 the following aggregated and deidentified data related to the  
10 carrier's prior authorization practices and experience for the prior  
11 plan year:

12       (a) The total number of prior authorization requests, approvals,  
13 and denials. The carrier must report these totals separately for  
14 approvals or denials made by the carrier directly and for approvals  
15 or denials made by a health care benefit manager as defined in RCW  
16 48.200.020 that is delegated to make prior authorization  
17 determinations either directly or indirectly on behalf of the  
18 carrier. In the report, carriers must also indicate:

19       (i) The percentage of total denials that were aided by artificial  
20 intelligence;

21       (ii) The percent of prior authorization determinations made after  
22 the standard and expedited authorization request turnaround times  
23 stated in RCW 48.43.830; and

24       (iii) The total number of nonelectronic standard and  
25 nonelectronic expedited prior authorization requests;

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

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

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

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

40       (~~(b)~~) (c) Lists of the 10 outpatient medical or surgical 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 ~~((e))~~ (d) Lists of the 10 inpatient mental health and substance  
15 use disorder service codes:

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

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

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

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

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

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

39 (iii) With the highest percentage of prior authorization requests  
40 that were initially denied and then subsequently approved on appeal,

1 including the total number of prior authorization requests for each  
2 code and the percent of requests that were initially denied and then  
3 subsequently approved;

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

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

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

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

18 ~~((f))~~ (g) Lists of the 10 diabetes supplies and equipment  
19 codes:

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

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

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

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

34 (i) With the highest total number of prior authorization requests  
35 during the previous plan year, including the total number of prior  
36 authorization requests for each prescription drug and the percent of  
37 approved requests for each prescription drug;

38 (ii) With the highest percentage of approved prior authorization  
39 requests during the previous plan year, including the total number of

1 prior authorization requests for each prescription drug and the  
2 percent of approved requests for each prescription drug; and

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

8 ~~((h))~~ (i) The average determination response time in hours for  
9 prior authorization requests to the carrier in total reported under  
10 (a) of this subsection and with respect to each code reported under  
11 ~~((a))~~ (b) through ~~((f))~~ (h) of this subsection for each of the  
12 following categories of prior authorization:

13 (i) Expedited decisions;

14 (ii) Standard decisions; and

15 (iii) Extenuating circumstances decisions.

16 (2) (a) By January 1, 2021, and annually thereafter, the  
17 commissioner shall aggregate and deidentify the data collected under  
18 subsection (1) (b) through (h) of this section into a standard report  
19 and may not identify the name of the carrier that submitted the data.  
20 The commissioner must make the report available to interested  
21 parties.

22 (b) The report must contain trend data for total authorization  
23 requests, approvals, and denials submitted under subsection (1)(a) of  
24 this section separately for each carrier directly and for each health  
25 care benefit manager, as defined in RCW 48.200.020, that is delegated  
26 to make prior authorization determinations either directly or  
27 indirectly on behalf of the carrier.

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

30 (4) The commissioner may adopt rules to implement this section.  
31 In adopting rules, the commissioner must consult stakeholders  
32 including carriers, health care practitioners, health care  
33 facilities, and patients.

34 (5) For the purpose of this section, "prior authorization" means  
35 a mandatory process that a carrier or its designated or contracted  
36 representative requires a provider or facility to follow before a  
37 service is delivered, to determine if a service is a benefit and  
38 meets the requirements for medical necessity, clinical  
39 appropriateness, level of care, or effectiveness in relation to the

1 applicable plan, including any term used by a carrier or its  
2 designated or contracted representative to describe this process.

3 NEW SECTION. **Sec. 7.** Section 2 of this act expires January 1,  
4 2027.

5 NEW SECTION. **Sec. 8.** Section 3 of this act takes effect January  
6 1, 2027.

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