
SECOND SUBSTITUTE SENATE BILL 5395

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

18 (2) It is the intent of the legislature to increase transparency
19 in the prior authorization process for health care coverage decisions
20 and to ensure licensed physicians and licensed health professionals
21 remain responsible for making determinations about coverage for

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

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

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

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

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

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

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

1 the provider or facility within one calendar day of submission of the
2 electronic prior authorization request.

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

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

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

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

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

1 emerging information related to the appropriateness of clinical
2 criteria with respect to black and indigenous people, other people of
3 color, gender, and underserved populations. The clinical review
4 criteria must be evaluated and updated, if necessary, at least
5 annually.

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

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

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

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

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

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

5 (B) Individual clinical circumstances as presented by the
6 requesting provider;

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

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

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

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

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

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

23 (viii) Patient data is not used beyond its intended and stated
24 purpose, consistent with chapter 70.02 RCW and the federal health
25 insurance portability and accountability act of 1996, 42 U.S.C. Sec.
26 1320d et al., as applicable.

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

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

1 determinations for prescription drugs, including information on
2 covered alternative prescription drugs, beginning January 1, 2027,
3 and must:

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

6 (ii) Facilitate the exchange of prior authorization requests and
7 determinations from its electronic health records or practice
8 management system; and

9 (iii) Indicate that a prior authorization denial or authorization
10 of a drug other than the one included in the original prior
11 authorization request is an adverse benefit determination and is
12 subject to the carrier's grievance and appeal process under RCW
13 48.43.535.

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

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

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

1 ~~((4))~~ (6) This section applies to prior authorization functions
2 carried out by health care benefit managers, as defined in RCW
3 48.200.020, under direct or indirect contract with a carrier.

4 (7) The commissioner may adopt any rules necessary to implement
5 this section.

6 (8) For the purposes of this section:

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

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

17 (i) The passage of time:

18 (A) Could seriously jeopardize the life or health of the
19 enrollee;

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

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

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

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

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

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

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

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

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

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

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

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

36 (i) For nonelectronic standard prior authorization requests, the
37 carrier shall make a decision and notify the provider or facility of
38 the results of the decision within five calendar days of submission
39 of a nonelectronic prior authorization request by the provider or
40 facility that contains the necessary information to make a

1 determination. If insufficient information has been provided to the
2 carrier to make a decision, the carrier shall request any additional
3 information from the provider or facility within five calendar days
4 of submission of the nonelectronic prior authorization request.

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

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

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

37 ~~((2))~~ (e) When denying a prior authorization determination, the
38 carrier shall include the credentials, board certifications, and
39 areas of specialty, expertise, and training of the provider who had
40 clinical oversight over the determination in any notification sent to

1 the health plan enrollee and provider requesting or referring the
2 service.

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

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

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

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

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

35 (B) Individual clinical circumstances as presented by the
36 requesting provider;

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

39 (iii) The artificial intelligence's criteria and guidelines
40 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) of this section into a standard report and may not
19 identify the name of the carrier that submitted the data. The
20 commissioner must make the report available to interested parties.

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

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

26 (4) The commissioner may adopt rules to implement this section.
27 In adopting rules, the commissioner must consult stakeholders
28 including carriers, health care practitioners, health care
29 facilities, and patients.

30 (5) For the purpose of this section, "prior authorization" means
31 a mandatory process that a carrier or its designated or contracted
32 representative requires a provider or facility to follow before a
33 service is delivered, to determine if a service is a benefit and
34 meets the requirements for medical necessity, clinical
35 appropriateness, level of care, or effectiveness in relation to the
36 applicable plan, including any term used by a carrier or its
37 designated or contracted representative to describe this process.

38 NEW SECTION. **Sec. 7.** Section 2 of this act expires January 1,
39 2027.

1 NEW SECTION. **Sec. 8.** Section 3 of this act takes effect January
2 1, 2027.

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