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**SENATE BILL 5395**

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**State of Washington**

**69th Legislature**

**2025 Regular Session**

**By** Senators Orwall, Muzzall, Hasegawa, Lovelett, Nobles, and Slatter

Read first time 01/21/25. Referred to Committee on Health & Long-Term Care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39 ~~((2))~~ (e) When issuing a notification for a prior authorization  
40 determination, the carrier and any contracted health care benefit

1 manager shall include a unique identifier for the individual who  
2 initially reviewed and made the determination. The carrier must also  
3 include the national provider identification number of the physician  
4 who had clinical oversight for the determination as well as the  
5 physician's credentials, board certifications, and areas of specialty  
6 expertise and training in any notification sent to the health plan  
7 enrollee and provider requesting or referring the service.

8 (f) In the case of an adverse benefit determination, a carrier  
9 shall make available to the requesting provider a peer-to-peer review  
10 discussion. The peer reviewer provided by the carrier must possess a  
11 current and valid nonrestricted license to practice medicine in  
12 Washington state and must be knowledgeable of and have experience  
13 providing the same or similar service as the health care service  
14 under review, and must have authority to modify or overturn the care  
15 determination decision.

16 (2) Carriers maintain the ability to make adjustments to policies  
17 and procedures that impact the applicability of their prior  
18 authorization requirements. Beginning August 1, 2025, these  
19 adjustments can only be made once annually and go into effect January  
20 1st of any given calendar year. Notification of policy changes must  
21 be provided to all in-network providers at least four months prior to  
22 the January 1st effective date. The notification must be provided  
23 independent to other policy changes or provider notification  
24 publications and be easily accessible in electronic provider and  
25 enrollee portals.

26 (3) (a) A determination of medical necessity shall be made only by  
27 a licensed physician or a licensed health professional working within  
28 their scope of practice. The licensed physician or licensed health  
29 professional shall evaluate the specific clinical issues involved in  
30 the health care services requested by the requesting provider by  
31 reviewing and considering the requesting provider's recommendation,  
32 the enrollee's medical or other clinical history, as applicable, and  
33 individual clinical circumstances. An artificial intelligence,  
34 algorithm, or related software tool shall not be the sole means used  
35 to deny, delay, or modify health care services.

36 (b) A carrier and any contracted health care benefit manager that  
37 uses an artificial intelligence, algorithm, or other software tool  
38 for the purpose of prior authorization or prior authorization  
39 functions, based in whole or in part on medical necessity, or that  
40 contracts with or otherwise works through an entity that uses an

1 artificial intelligence, algorithm, or related software tool for the  
2 purpose of prior authorization or prior authorization functions,  
3 based in whole or in part on medical necessity, shall ensure all of  
4 the following:

5 (i) The artificial intelligence, algorithm, or other software  
6 tool bases its determination on the following information, as  
7 applicable:

8 (A) An enrollee's medical or other clinical history;

9 (B) Individual clinical circumstances as presented by the  
10 requesting provider; and

11 (C) Other relevant clinical information contained in the  
12 enrollee's medical or other clinical record;

13 (ii) The artificial intelligence, algorithm, or other software  
14 tool does not base its determination solely on a group data set;

15 (iii) The artificial intelligence, algorithm, or other software  
16 tool's criteria and guidelines complies with this chapter and  
17 applicable state and federal law;

18 (iv) The use of the artificial intelligence, algorithm, or other  
19 software tool does not discriminate, directly or indirectly, against  
20 an enrollee in violation of state or federal law;

21 (v) The artificial intelligence, algorithm, or other software  
22 tool is fairly and equitably applied, including in accordance with  
23 any applicable regulations and guidance issued by the federal  
24 department of health and human services;

25 (vi) The policies and procedures for using the artificial  
26 intelligence, algorithm, or other software tool is open to audit by  
27 the office of the insurance commissioner;

28 (vii) The artificial intelligence, algorithm, or other software  
29 tool's performance, use, and outcomes are periodically reviewed to  
30 maximize accuracy and reliability; and

31 (viii) Patient data is not used beyond its intended and stated  
32 purpose, consistent with chapter 70.02 RCW and the federal health  
33 insurance portability and accountability act of 1996, 42 U.S.C. Sec.  
34 1320d et al., as applicable.

35 (4)(a) Each carrier shall build and maintain a prior  
36 authorization application programming interface that automates the  
37 process for in-network providers to determine whether a prior  
38 authorization is required for health care services, identify prior  
39 authorization information and documentation requirements, and  
40 facilitate the exchange of prior authorization requests and

1 determinations from its electronic health records or practice  
2 management system. The application programming interface must support  
3 the exchange of prior authorization requests and determinations for  
4 health care services beginning January 1, 2025, and must:

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

8 (ii) Automate the process to determine whether a prior  
9 authorization is required for durable medical equipment or a health  
10 care service;

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

13 (iv) Support an automated approach using nonproprietary open  
14 workflows to compile and exchange the necessary data elements to  
15 populate the prior authorization requirements that are compliant with  
16 the federal health insurance portability and accountability act of  
17 1996 or have an exception from the federal centers for medicare and  
18 medicaid services; ~~((and))~~

19 (v) Indicate that a prior authorization denial or authorization  
20 of a service less intensive than that included in the original  
21 request is an adverse benefit determination and is subject to the  
22 carrier's grievance and appeal process under RCW 48.43.535; and

23 (vi) Include a unique identifier for the individual who initially  
24 reviewed and made the determination. The carrier and any contracted  
25 health care benefit manager must also include the national provider  
26 identification number of the physician who had clinical oversight for  
27 the determination as well as the physician's credentials, board  
28 certifications, and areas of specialty expertise and training in any  
29 notification sent to the health plan enrollee and provider requesting  
30 or referring the service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 ~~((4))~~ (6) For the purposes of this section:

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

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

27 (i) The passage of time:

28 (A) Could seriously jeopardize the life or health of the  
29 enrollee;

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

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

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

38 ~~((b))~~ (c) "Standard prior authorization request" means a  
39 request by a provider or facility for approval of a health care  
40 service or prescription drug where the request is made in advance of

1 the enrollee obtaining a health care service or prescription drug  
2 that is not required to be expedited.

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

5 (1) Beginning January 1, 2024, the authority shall require each  
6 managed care organization to comply with the following standards  
7 related to prior authorization for health care services and  
8 prescription drugs:

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

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

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

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

1 prior authorization process described in subsection (~~(+2)~~) (6) of  
2 this section:

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

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

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

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

1 respect to black and indigenous people, other people of color,  
2 gender, and underserved populations. The clinical review criteria  
3 must be evaluated and updated, if necessary, at least annually.

4 ~~((2))~~ (e) When issuing a notification for a prior authorization  
5 determination, the managed care organization and any contracted  
6 health care benefit manager shall include a unique identifier for the  
7 individual who initially reviewed and made the determination. The  
8 managed care organization shall also include the national provider  
9 identification number of the physician who had clinical oversight for  
10 the determination as well as the physician's credentials, board  
11 certifications, and areas of specialty expertise and training in any  
12 notification sent to the managed care enrollee and provider  
13 requesting or referring the service.

14 (f) In the case of an adverse benefit determination, a managed  
15 care organization shall make available to the requesting provider a  
16 peer-to-peer review discussion. The peer reviewer provided by the  
17 managed care organization must possess a current and valid  
18 nonrestricted license to practice medicine in Washington state and  
19 must be knowledgeable of and have experience providing the same or  
20 similar service as the health care service under review, and must  
21 have authority to modify or overturn the care determination decision.

22 (2) Managed care organizations maintain the ability to make  
23 adjustments to policies and procedures that impact the applicability  
24 of their prior authorization requirements. Beginning August 1, 2025,  
25 these adjustments can only be made once annually and go into effect  
26 January 1st of any given calendar year. Notification of policy  
27 changes must be provided to all in-network providers at least four  
28 months prior to the January 1st effective date. The notification must  
29 be provided independent to other policy changes or provider  
30 notification publications and be easily accessible in electronic  
31 provider and enrollee portals.

32 (3) (a) A determination of medical necessity shall be made only by  
33 a licensed physician or a licensed health professional working within  
34 their scope of practice. The licensed physician or licensed health  
35 professional shall evaluate the specific clinical issues involved in  
36 the health care services requested by the requesting provider by  
37 reviewing and considering the requesting provider's recommendation,  
38 the enrollee's medical or other clinical history, as applicable, and  
39 individual clinical circumstances. An artificial intelligence,

1 algorithm, or related software tool shall not be the sole means used  
2 to deny, delay, or modify health care services.

3 (b) A managed care organization and any contracted health care  
4 benefit manager that uses an artificial intelligence, algorithm, or  
5 other software tool for the purpose of prior authorization or prior  
6 authorization functions, based in whole or in part on medical  
7 necessity, or that contracts with or otherwise works through an  
8 entity that uses an artificial intelligence, algorithm, or related  
9 software tool for the purpose of prior authorization or prior  
10 authorization functions, based in whole or in part on medical  
11 necessity, shall ensure all of the following:

12 (i) The artificial intelligence, algorithm, or other software  
13 tool bases its determination on the following information, as  
14 applicable:

15 (A) An enrollee's medical or other clinical history;

16 (B) Individual clinical circumstances as presented by the  
17 requesting provider; and

18 (C) Other relevant clinical information contained in the  
19 enrollee's medical or other clinical record;

20 (ii) The artificial intelligence, algorithm, or other software  
21 tool does not base its determination solely on a group data set;

22 (iii) The artificial intelligence, algorithm, or other software  
23 tool's criteria and guidelines complies with this chapter and  
24 applicable state and federal law;

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

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

32 (vi) The policies and procedures for using the artificial  
33 intelligence, algorithm, or other software tool is open to audit by  
34 the authority consistent with RCW 74.09.200;

35 (vii) The artificial intelligence, algorithm, or other software  
36 tool's performance, use, and outcomes are periodically reviewed to  
37 maximize accuracy and reliability; and

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

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

3 (4) (a) By January 1, 2026, managed care organizations shall  
4 submit the total number of prior authorization requests, approvals,  
5 and denials to the authority on a quarterly basis. Managed care  
6 organizations shall report these totals by health plan and for each  
7 health care benefit manager that is delegated to provide care  
8 determinations on behalf of the managed care organization. Managed  
9 care organizations shall indicate the percentage of total denials  
10 that were aided by artificial intelligence tools and algorithms and  
11 the percent of care determinations made after the emergent and  
12 nonemergent authorization request turnaround times stated above.

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

16 (c) The authority shall publish on its website the results of  
17 each managed care organization's report 45 days after submission,  
18 along with their own prior authorization statistics for fee-for-  
19 service medicaid enrollees.

20 (5) By July 1, 2027, the authority shall determine which  
21 treatments, prescription drugs, and services, along with their  
22 applicable billing codes, do not require prior authorization by  
23 managed care organizations for any medicaid enrollee. The authority  
24 must consider applicable state and federal program integrity  
25 regulations when deciding which services they will waive prior  
26 authorization requirements.

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

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

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

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

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

12 (v) Indicate that a prior authorization denial or authorization  
13 of a service less intensive than that included in the original  
14 request is an adverse benefit determination and is subject to the  
15 managed care organization's grievance and appeal process under RCW  
16 48.43.535.

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

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

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

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

39 (iv) Include a unique identifier for the individual who initially  
40 reviewed and made the determination. The managed care organization

1 and any contracted health care benefit manager must also include the  
2 national provider identification number of the physician who had  
3 clinical oversight for the determination as well as the physician's  
4 credentials, board certifications, and areas of specialty expertise  
5 and training in any notification sent to the managed care enrollee  
6 and provider requesting or referring the service.

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

12 (d)(i) If a managed care organization determines that it will not  
13 be able to satisfy the requirements of (a) of this subsection by  
14 January 1, 2025, the managed care organization shall submit a  
15 narrative justification to the authority on or before September 1,  
16 2024, describing:

17 (A) The reasons that the managed care organization cannot  
18 reasonably satisfy the requirements;

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

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

22 (D) A timeline and implementation plan to achieve compliance with  
23 the requirements.

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

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

32 (~~((3))~~) (7) Nothing in this section applies to prior  
33 authorization determinations made pursuant to RCW 71.24.618 or  
34 74.09.490.

35 (~~((4))~~) (8) For the purposes of this section:

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

1 computer vision, speech or natural language processing, content  
2 generation, and forecasting future outcomes.

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

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

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

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

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

1 provided to the health plan to make a decision, the health plan shall  
2 request any additional information from the provider or facility  
3 within one calendar day of submission of the electronic prior  
4 authorization request.

5 (ii) For electronic expedited prior authorization requests, the  
6 health plan shall make a decision and notify the provider or facility  
7 of the results of the decision within one calendar day of submission  
8 of an electronic 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 health plan to make a decision, the health plan shall request any  
12 additional information from the provider or facility within one  
13 calendar day of submission of the electronic prior authorization  
14 request.

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

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

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

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

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

21 ~~((2))~~ (e) When issuing a notification for a prior authorization  
22 determination, the health plan and any contracted health care benefit  
23 manager shall include a unique identifier for the individual who  
24 initially reviewed and made the determination. The health plan shall  
25 also include the national provider identification number of the  
26 physician who had clinical oversight for the determination as well as  
27 the physician's credentials, board certifications, and areas of  
28 specialty expertise and training in any notification sent to the  
29 health plan enrollee and provider requesting or referring the  
30 service.

31 (f) In the case of an adverse benefit determination, a health  
32 plan shall make available to the requesting provider a peer-to-peer  
33 review discussion. The peer reviewer provided by the health plan must  
34 possess a current and valid nonrestricted license to practice  
35 medicine in Washington state and must be knowledgeable of and have  
36 experience providing the same or similar service as the health care  
37 service under review, and must have authority to modify or overturn  
38 the care determination decision.

39 (2) Health plans maintain the ability to make adjustments to  
40 policies and procedures that impact the applicability of their prior

1 authorization requirements. Beginning August 1, 2025, these  
2 adjustments can only be made once annually and go into effect January  
3 1st of any given calendar year. Notification of policy changes must  
4 be provided to all in-network providers at least four months prior to  
5 the January 1st effective date. The notification must be provided  
6 independent to other policy changes or provider notification  
7 publications and be easily accessible in electronic provider and  
8 enrollee portals.

9 (3) (a) A determination of medical necessity shall be made only by  
10 a licensed physician or a licensed health professional working within  
11 their scope of practice. The licensed physician or licensed health  
12 professional shall evaluate the specific clinical issues involved in  
13 the health care services requested by the requesting provider by  
14 reviewing and considering the requesting provider's recommendation,  
15 the enrollee's medical or other clinical history, as applicable, and  
16 individual clinical circumstances. An artificial intelligence,  
17 algorithm, or related software tool shall not be the sole means used  
18 to deny, delay, or modify health care services.

19 (b) A health plan and any contracted health care benefit manager  
20 that uses an artificial intelligence, algorithm, or other software  
21 tool for the purpose of prior authorization or prior authorization  
22 functions, based in whole or in part on medical necessity, or that  
23 contracts with or otherwise works through an entity that uses an  
24 artificial intelligence, algorithm, or related software tool for the  
25 purpose of prior authorization or prior authorization functions,  
26 based in whole or in part on medical necessity, shall ensure all of  
27 the following:

28 (i) The artificial intelligence, algorithm, or other software  
29 tool bases its determination on the following information, as  
30 applicable:

31 (A) An enrollee's medical or other clinical history;

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

34 (C) Other relevant clinical information contained in the  
35 enrollee's medical or other clinical record;

36 (ii) The artificial intelligence, algorithm, or other software  
37 tool does not base its determination solely on a group data set;

38 (iii) The artificial intelligence, algorithm, or other software  
39 tool's criteria and guidelines complies with this chapter and  
40 applicable state and federal law;

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

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

8 (vi) The policies and procedures for using the artificial  
9 intelligence, algorithm, or other software tool is open to audit by  
10 the office of the insurance commissioner;

11 (vii) The artificial intelligence, algorithm, or other software  
12 tool's performance, use, and outcomes are periodically reviewed to  
13 maximize accuracy and reliability; and

14 (viii) Patient data is not used beyond its intended and stated  
15 purpose, consistent with chapter 70.02 RCW and the federal health  
16 insurance portability and accountability act of 1996, U.S.C. Sec.  
17 1320d et al., as applicable.

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

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

32 (ii) Automate the process to determine whether a prior  
33 authorization is required for durable medical equipment or a health  
34 care service;

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

37 (iv) Support an automated approach using nonproprietary open  
38 workflows to compile and exchange the necessary data elements to  
39 populate the prior authorization requirements that are compliant with  
40 the federal health insurance portability and accountability act of

1 1996 or have an exception from the federal centers for medicare and  
2 medicaid services; ((and))

3 (v) Indicate that a prior authorization denial or authorization  
4 of a service less intensive than that included in the original  
5 request is an adverse benefit determination and is subject to the  
6 health plan's grievance and appeal process under RCW 48.43.535; and

7 (vi) Include a unique identifier for the individual who initially  
8 reviewed and made the determination. The health plan and any  
9 contracted health care benefit manager must also include the national  
10 provider identification number of the physician who had clinical  
11 oversight for the determination as well as the physician's  
12 credentials, board certifications, and areas of specialty expertise  
13 and training in any notification sent to the health plan enrollee and  
14 provider requesting or referring the service.

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

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

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

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

39 (c) If federal rules related to standards for using an  
40 application programming interface to communicate prior authorization

1 status to providers are not finalized by the federal centers for  
2 medicare and medicaid services by September 13, 2023, the  
3 requirements of (a) of this subsection may not be enforced until  
4 January 1, 2026.

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

9 (A) The reasons that the health plan cannot reasonably satisfy  
10 the requirements;

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

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

14 (D) A timeline and implementation plan to achieve compliance with  
15 the requirements.

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

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

24 (~~((3))~~) (5) Nothing in this section applies to prior  
25 authorization determinations made pursuant to RCW 41.05.526.

26 (~~((4))~~) (6) For the purposes of this section:

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

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

36 (i) The passage of time:

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

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

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

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

7 (~~(b)~~) (c) "Standard prior authorization request" means a  
8 request by a provider or facility for approval of a health care  
9 service or prescription drug where the request is made in advance of  
10 the enrollee obtaining a health care service that is not required to  
11 be expedited.

12 (~~(5)~~) (7) This section shall not apply to coverage provided  
13 under the medicare part C or part D programs set forth in Title XVIII  
14 of the social security act of 1965, as amended.

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

17 (1) A health carrier that offers a health plan shall not  
18 retrospectively deny coverage for emergency and nonemergency care  
19 that had prior authorization under the plan's written policies at the  
20 time the care was rendered.

21 (2) Retrospective denials shall not be considered adverse benefit  
22 determinations and will not be required to follow the standard  
23 appeals processes in RCW 48.43.525 or any carrier policies related to  
24 their own grievance and appeals process. If an enrollee or the  
25 provider requesting the original authorization demonstrates the  
26 authorization was valid per the plan's written policies, then the  
27 carrier will deem the authorization approved and payable. Interest  
28 will be assessed on the associated claim at the rate of one percent  
29 per month, retroactive to the original date of the authorization  
30 request.

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

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

37 (1) By (~~October 1, 2020,~~) January 1, 2026, and annually  
38 thereafter, for individual and group health plans issued by a carrier

1 that has written at least one percent of the total accident and  
2 health insurance premiums written by all companies authorized to  
3 offer accident and health insurance in Washington in the most  
4 recently available year, the carrier shall report to the commissioner  
5 the following aggregated and deidentified data related to the  
6 carrier's prior authorization practices and experience for the prior  
7 plan ((year)) quarter:

8 (a) The total number of prior authorization requests, approvals,  
9 and denials. The carrier must report these totals by both health plan  
10 and each health care benefit manager as defined in RCW 48.200.020  
11 that is delegated to provide care determinations on behalf of the  
12 carrier. In the report, carriers must also indicate:

13 (i) The percentage of total denials that were aided by artificial  
14 intelligence tools and algorithms; and

15 (ii) The percent of care determinations made after the emergent  
16 and nonemergent authorization request turnaround times stated in RCW  
17 48.43.830;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39 ~~((h))~~ (i) The average determination response time in hours for  
40 prior authorization requests to the carrier in total reported under

1 (a) of this subsection and with respect to each code reported under  
2 ~~((a))~~ (b) through ~~((f))~~ (h) of this subsection for each of the  
3 following categories of prior authorization:

- 4 (i) Expedited decisions;
- 5 (ii) Standard decisions; and
- 6 (iii) Extenuating circumstances decisions.

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

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

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

17 (4) The commissioner may adopt rules to implement this section.  
18 In adopting rules, the commissioner must consult stakeholders  
19 including carriers, health care practitioners, health care  
20 facilities, and patients.

21 (5) For the purpose of this section, "prior authorization" means  
22 a mandatory process that a carrier or its designated or contracted  
23 representative requires a provider or facility to follow before a  
24 service is delivered, to determine if a service is a benefit and  
25 meets the requirements for medical necessity, clinical  
26 appropriateness, level of care, or effectiveness in relation to the  
27 applicable plan, including any term used by a carrier or its  
28 designated or contracted representative to describe this process.

--- END ---