

CERTIFICATION OF ENROLLMENT
ENGROSSED SECOND SUBSTITUTE SENATE BILL 5395

69th Legislature
2026 Regular Session

Passed by the Senate March 9, 2026
Yeas 49 Nays 0

President of the Senate

Passed by the House March 4, 2026
Yeas 94 Nays 0

**Speaker of the House of
Representatives**

Approved

Governor of the State of Washington

CERTIFICATE

I, Sarah Bannister, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE SENATE BILL 5395** as passed by the Senate and the House of Representatives on the dates hereon set forth.

Secretary

FILED

**Secretary of State
State of Washington**

ENGROSSED SECOND SUBSTITUTE SENATE BILL 5395

AS AMENDED BY THE HOUSE

Passed Legislature - 2026 Regular Session

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, 48.43.535, 48.43.535,
4 and 48.43.0161; reenacting and amending RCW 48.43.830; creating a new
5 section; providing an effective date; and providing an expiration
6 date.

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

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

1 prescription drugs, and other health care services. If artificial
2 intelligence is used to aid in the decision-making process, standards
3 must be put in place to ensure artificial intelligence is not used to
4 make inappropriate determinations that could impact the health of an
5 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 of the provider who had clinical oversight over
9 the determination in any notification sent to the health plan
10 enrollee and provider requesting or referring the service.

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

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 of the provider who had clinical oversight over

1 the determination in any notification sent to the health plan
2 enrollee and provider requesting or referring the 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 of the provider who had clinical oversight over
32 the determination in any notification sent to the health plan
33 enrollee and provider requesting or referring the service.

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

1 electronic prior authorization system or application programming
2 interface system.

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

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

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

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

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

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

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

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

36 (v) The artificial intelligence is fairly and equitably applied,
37 including in accordance with any applicable regulations and guidance
38 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 an approved 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 approved 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 an approved prior
24 authorization or retrospective modification of an approved prior
25 authorization to less intensive services due to a change in the
26 carrier's determination of medical necessity are prohibited, shall
27 not be considered adverse benefit determinations, and will not be
28 required to follow the standard appeals processes in RCW 48.43.530 or
29 any carrier policies related to their own grievance and appeals
30 process. If an enrollee, or the provider requesting the authorization
31 demonstrates the authorization was valid per the plan's written
32 policies, then the carrier will deem the authorization approved and
33 payable. Interest will be assessed on the associated claim submitted
34 by the provider at the rate of one percent per month, retroactive to
35 the date of submission. An enrollee, or provider on behalf of the
36 enrollee, may seek review by an independent review organization under
37 RCW 48.43.535 without the need to engage in, exhaust, or wait for any
38 timelines related to the carrier's grievance process.

1 (3) This section does not prevent carriers from reimbursing only
2 for services billed and rendered.

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

7 **Sec. 6.** RCW 48.43.535 and 2022 c 263 s 4 are each amended to
8 read as follows:

9 (1) There is a need for a process for the fair consideration of
10 disputes relating to decisions by carriers that offer a health plan
11 to deny, modify, reduce, or terminate coverage of or payment for
12 health care services for an enrollee. For purposes of this section,
13 "carrier" also applies to a health plan if the health plan
14 administers the appeal process directly or through a third party.

15 (2) An enrollee may seek review by a certified independent review
16 organization of a carrier's decision to deny, modify, reduce, or
17 terminate coverage of or payment for a health care service or of any
18 adverse determination made by a carrier under RCW 48.49.020,
19 48.49.030, or sections 2799A-1 or 2799A-2 of the public health
20 service act (42 U.S.C. Secs. 300gg-111 or 300gg-112) and implementing
21 federal regulations in effect as of March 31, 2022, after exhausting
22 the carrier's grievance process and receiving a decision that is
23 unfavorable to the enrollee, or after the carrier has exceeded the
24 timelines for grievances provided in RCW 48.43.530, without good
25 cause and without reaching a decision. Any requirements that the
26 enrollee must first engage in, exhaust, or wait for any timelines
27 related to the carrier's grievance process do not apply to review
28 sought pursuant to RCW 48.43.525.

29 (3) The commissioner must establish and use a rotational registry
30 system for the assignment of a certified independent review
31 organization to each dispute. The system should be flexible enough to
32 ensure that an independent review organization has the expertise
33 necessary to review the particular medical condition or service at
34 issue in the dispute, and that any approved independent review
35 organization does not have a conflict of interest that will influence
36 its independence.

37 (4) Carriers must provide to the appropriate certified
38 independent review organization, not later than the third business

1 day after the date the carrier receives a request for review, a copy
2 of:

3 (a) Any medical records of the enrollee that are relevant to the
4 review;

5 (b) Any documents used by the carrier in making the determination
6 to be reviewed by the certified independent review organization;

7 (c) Any documentation and written information submitted to the
8 carrier in support of the appeal; and

9 (d) A list of each physician or health care provider who has
10 provided care to the enrollee and who may have medical records
11 relevant to the appeal. Health information or other confidential or
12 proprietary information in the custody of a carrier may be provided
13 to an independent review organization, subject to rules adopted by
14 the commissioner.

15 (5) Enrollees must be provided with at least five business days
16 to submit to the independent review organization in writing
17 additional information that the independent review organization must
18 consider when conducting the external review. The independent review
19 organization must forward any additional information submitted by an
20 enrollee to the plan or carrier within one business day of receipt by
21 the independent review organization.

22 (6) The medical reviewers from a certified independent review
23 organization will make determinations regarding the medical necessity
24 or appropriateness of, and the application of health plan coverage
25 provisions to, health care services for an enrollee. The medical
26 reviewers' determinations must be based upon their expert medical
27 judgment, after consideration of relevant medical, scientific, and
28 cost-effectiveness evidence, and medical standards of practice in the
29 state of Washington. Except as provided in this subsection, the
30 certified independent review organization must ensure that
31 determinations are consistent with the scope of covered benefits as
32 outlined in the medical coverage agreement. Medical reviewers may
33 override the health plan's medical necessity or appropriateness
34 standards if the standards are determined upon review to be
35 unreasonable or inconsistent with sound, evidence-based medical
36 practice.

37 (7) Once a request for an independent review determination has
38 been made, the independent review organization must proceed to a
39 final determination, unless requested otherwise by both the carrier
40 and the enrollee or the enrollee's representative.

1 (a) An enrollee or carrier may request an expedited external
2 review if the adverse benefit determination or internal adverse
3 benefit determination concerns an admission, availability of care,
4 continued stay, or health care service for which the claimant
5 received emergency services but has not been discharged from a
6 facility; or involves a medical condition for which the standard
7 external review time frame would seriously jeopardize the life or
8 health of the enrollee or jeopardize the enrollee's ability to regain
9 maximum function. The independent review organization must make its
10 decision to uphold or reverse the adverse benefit determination or
11 final internal adverse benefit determination and notify the enrollee
12 and the carrier or health plan of the determination as expeditiously
13 as possible but within not more than seventy-two hours after the
14 receipt of the request for expedited external review. If the notice
15 is not in writing, the independent review organization must provide
16 written confirmation of the decision within forty-eight hours after
17 the date of the notice of the decision.

18 (b) For claims involving experimental or investigational
19 treatments, the independent review organization must ensure that
20 adequate clinical and scientific experience and protocols are taken
21 into account as part of the external review process.

22 (8) Carriers must timely implement the certified independent
23 review organization's determination, and must pay the certified
24 independent review organization's charges.

25 (9) When an enrollee requests independent review of a dispute
26 under this section, and the dispute involves a carrier's decision to
27 modify, reduce, or terminate an otherwise covered health service that
28 an enrollee is receiving at the time the request for review is
29 submitted and the carrier's decision is based upon a finding that the
30 health service, or level of health service, is no longer medically
31 necessary or appropriate, the carrier must continue to provide the
32 health service if requested by the enrollee until a determination is
33 made under this section. If the determination affirms the carrier's
34 decision, the enrollee may be responsible for the cost of the
35 continued health service.

36 (10) Each certified independent review organization must maintain
37 written records and make them available upon request to the
38 commissioner.

39 (11) A certified independent review organization may notify the
40 office of the insurance commissioner if, based upon its review of

1 disputes under this section, it finds a pattern of substandard or
2 egregious conduct by a carrier.

3 (12)(a) The commissioner shall adopt rules to implement this
4 section after considering relevant standards adopted by national
5 managed care accreditation organizations and the national association
6 of insurance commissioners.

7 (b) This section is not intended to supplant any existing
8 authority of the office of the insurance commissioner under this
9 title to oversee and enforce carrier compliance with applicable
10 statutes and rules.

11 **Sec. 7.** RCW 48.43.535 and 2025 c 227 s 6 are each amended to
12 read as follows:

13 (1) There is a need for a process for the fair consideration of
14 disputes relating to decisions by carriers that offer a health plan
15 to deny, modify, reduce, or terminate coverage of or payment for
16 health care services for an enrollee. For purposes of this section,
17 "carrier" also applies to a health plan if the health plan
18 administers the appeal process directly or through a third party.

19 (2) An enrollee may seek review by a certified independent review
20 organization of a carrier's decision to deny, modify, reduce, or
21 terminate coverage of or payment for a health care service or of any
22 adverse determination made by a carrier under RCW 48.49.020,
23 48.49.030, or sections 2799A-1 or 2799A-2 of the public health
24 service act (42 U.S.C. Secs. 300gg-111 or 300gg-112) and implementing
25 federal regulations in effect as of March 31, 2022, after exhausting
26 the carrier's grievance process and receiving a decision that is
27 unfavorable to the enrollee, or after the carrier has exceeded the
28 timelines for grievances provided in RCW 48.43.530, without good
29 cause and without reaching a decision. Any requirements that the
30 enrollee must first engage in, exhaust, or wait for any timelines
31 related to the carrier's grievance process do not apply to review
32 sought pursuant to RCW 48.43.525.

33 (3) The commissioner must establish and use a rotational registry
34 system for the assignment of a certified independent review
35 organization to each dispute. The system should be flexible enough to
36 ensure that an independent review organization has the expertise
37 necessary to review the particular medical condition or service at
38 issue in the dispute, and that any approved independent review

1 organization does not have a conflict of interest that will influence
2 its independence.

3 (4) Carriers must provide to the appropriate certified
4 independent review organization, not later than the third business
5 day after the date the carrier receives a request for review, a copy
6 of:

7 (a) Any medical records of the enrollee that are relevant to the
8 review;

9 (b) Any documents used by the carrier in making the determination
10 to be reviewed by the certified independent review organization;

11 (c) Any documentation and written information submitted to the
12 carrier in support of the appeal; and

13 (d) A list of each physician or health care provider who has
14 provided care to the enrollee and who may have medical records
15 relevant to the appeal. Health information or other confidential or
16 proprietary information in the custody of a carrier may be provided
17 to an independent review organization, subject to rules adopted by
18 the commissioner.

19 (5) Enrollees must be provided with at least five business days
20 to submit to the independent review organization in writing
21 additional information that the independent review organization must
22 consider when conducting the external review. The independent review
23 organization must forward any additional information submitted by an
24 enrollee to the plan or carrier within one business day of receipt by
25 the independent review organization.

26 (6) The medical reviewers from a certified independent review
27 organization will make determinations regarding the medical necessity
28 or appropriateness of, and the application of health plan coverage
29 provisions to, health care services for an enrollee. The medical
30 reviewers' determinations must be based upon their expert medical
31 judgment, after consideration of relevant medical, scientific, and
32 cost-effectiveness evidence, and medical standards of practice in the
33 state of Washington. Except as provided in this subsection, the
34 certified independent review organization must ensure that
35 determinations are consistent with the scope of covered benefits as
36 outlined in the medical coverage agreement. Medical reviewers may
37 override the health plan's medical necessity or appropriateness
38 standards if the standards are determined upon review to be
39 unreasonable or inconsistent with sound, evidence-based medical
40 practice. For reviews of mental health and substance use disorder

1 services, as defined in RCW 48.43.766, the medical reviewers must
2 conduct reviews and make determinations in a manner consistent with
3 the requirements of RCW 48.43.766.

4 (7) Once a request for an independent review determination has
5 been made, the independent review organization must proceed to a
6 final determination, unless requested otherwise by both the carrier
7 and the enrollee or the enrollee's representative.

8 (a) An enrollee or carrier may request an expedited external
9 review if the adverse benefit determination or internal adverse
10 benefit determination concerns an admission, availability of care,
11 continued stay, or health care service for which the claimant
12 received emergency services but has not been discharged from a
13 facility; or involves a medical condition for which the standard
14 external review time frame would seriously jeopardize the life or
15 health of the enrollee or jeopardize the enrollee's ability to regain
16 maximum function. The independent review organization must make its
17 decision to uphold or reverse the adverse benefit determination or
18 final internal adverse benefit determination and notify the enrollee
19 and the carrier or health plan of the determination as expeditiously
20 as possible but within not more than seventy-two hours after the
21 receipt of the request for expedited external review. If the notice
22 is not in writing, the independent review organization must provide
23 written confirmation of the decision within forty-eight hours after
24 the date of the notice of the decision.

25 (b) For claims involving experimental or investigational
26 treatments, the independent review organization must ensure that
27 adequate clinical and scientific experience and protocols are taken
28 into account as part of the external review process.

29 (8) Carriers must timely implement the certified independent
30 review organization's determination, and must pay the certified
31 independent review organization's charges.

32 (9) When an enrollee requests independent review of a dispute
33 under this section, and the dispute involves a carrier's decision to
34 modify, reduce, or terminate an otherwise covered health service that
35 an enrollee is receiving at the time the request for review is
36 submitted and the carrier's decision is based upon a finding that the
37 health service, or level of health service, is no longer medically
38 necessary or appropriate, the carrier must continue to provide the
39 health service if requested by the enrollee until a determination is
40 made under this section. If the determination affirms the carrier's

1 decision, the enrollee may be responsible for the cost of the
2 continued health service.

3 (10) Each certified independent review organization must maintain
4 written records and make them available upon request to the
5 commissioner.

6 (11) A certified independent review organization may notify the
7 office of the insurance commissioner if, based upon its review of
8 disputes under this section, it finds a pattern of substandard or
9 egregious conduct by a carrier.

10 (12)(a) The commissioner shall adopt rules to implement this
11 section after considering relevant standards adopted by national
12 managed care accreditation organizations and the national association
13 of insurance commissioners.

14 (b) This section is not intended to supplant any existing
15 authority of the office of the insurance commissioner under this
16 title to oversee and enforce carrier compliance with applicable
17 statutes and rules.

18 **Sec. 8.** RCW 48.43.0161 and 2023 c 382 s 4 are each amended to
19 read as follows:

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

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

35 (i) The percentage of total denials that were aided by artificial
36 intelligence;

37 (ii) The percent of prior authorization determinations made after
38 the standard and expedited authorization request turnaround times
39 stated in RCW 48.43.830; and

1 (iii) The total number of nonelectronic standard and
2 nonelectronic expedited prior authorization requests;

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

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

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

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

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

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

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

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

31 ~~((e))~~ (d) Lists of the 10 inpatient mental health and substance
32 use disorder service 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 ~~((d))~~ (e) Lists of the 10 outpatient mental health and
7 substance 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;

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

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

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

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

35 ~~((f))~~ (g) Lists of the 10 diabetes supplies and equipment
36 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 ~~((g))~~ (h) Lists of the 10 prescription drugs:

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

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

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

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

29 (i) Expedited decisions;

30 (ii) Standard decisions; and

31 (iii) Extenuating circumstances decisions.

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

38 (b) The report must contain trend data for total authorization
39 requests, approvals, and denials submitted under subsection (1)(a) of
40 this section separately for each carrier directly and for each health

1 care benefit manager, as defined in RCW 48.200.020, that is delegated
2 to make prior authorization determinations either directly or
3 indirectly on behalf of the carrier.

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

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

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

18 NEW SECTION. Sec. 9. Sections 2 and 6 of this act expire
19 January 1, 2027.

20 NEW SECTION. Sec. 10. Sections 3 and 7 of this act take effect
21 January 1, 2027.

--- END ---