
HOUSE BILL 1566

State of Washington

69th Legislature

2025 Regular Session

By Representatives Rule, Marshall, Shavers, Pollet, and Kloba

Read first time 01/24/25. Referred to Committee on Health Care & Wellness.

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 ---