Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 2145

Brief Description: Concerning medically necessary treatment of a mental health or substance use disorder.

Sponsors: Representatives Simmons, Senn, Callan, Reeves and Kloba.

Brief Summary of Bill

- Requires health plans, including health plans offered to public and school employees, to cover medically necessary treatment of a mental health or substance use disorder and defines "medically necessary" for these purposes.
- Requires health carriers to base medical necessity determinations and utilization review criteria on current generally accepted standards of mental health and substance use disorder care and defines generally accepted standards for this purpose.
- Prohibits a health carrier that authorizes a specific type of treatment from rescinding or modifying the authorization after the provider rendered the health care service in good faith.

Hearing Date: 1/19/24

Staff: Kim Weidenaar (786-7120).

Background:

Medically Necessary.
Health plans generally only cover services that are medically necessary. How medically necessary is defined generally depends on the circumstance and the health plan. For purposes of Medicaid, Health Care Authority regulations define "medically necessary" as a term for

---

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

Mental Health Parity.
State and federal law require health insurers to provide coverage for mental health services on the same terms that medical and surgical benefits are covered. Health plans that provide coverage for medical and surgical services must provide coverage for mental health services and must apply the same deductible, copayment, coinsurance, out-of-pocket maximum, preventive services coverage, and treatment limitations or other financial requirements to mental health services, including prescription drugs, as are provided for medical and surgical services. "Mental health services" is defined as medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, on June 11, 2020, or such subsequent date as may be provided by the Insurance Commissioner by rule, with the exception of the following categories, codes, and services: substance-related disorders; life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association; skilled nursing facility services, home health care, residential treatment, and custodial care; and court-ordered treatment unless the insurer's medical director or designee determines the treatment to be medically necessary.

Summary of Bill:

Every health plan, including health plans offered to public and school employees, issued or renewed on or after January 1, 2025, that provides hospital, medical, or surgical coverage must provide coverage for the medically necessary treatment of mental health and substance use disorders, which is a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is: in accordance with the generally accepted standards of mental health and substance use disorder care; clinically appropriate in terms of type, frequency, extent, site, and duration; and not primarily for the economic benefit of the health carrier or purchaser, or for the convenience of the patient, treating physician, or other health care provider.

A health carrier that authorizes a specific type of treatment for mental health or substance use disorder by a provider may not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason including, the health carrier's subsequent rescission, cancellation, or modification of the enrollee's contract, or

the health carrier's subsequent determination that it did not make an accurate determination of the enrollee's eligibility.

A health carrier may not:

- limit benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment at any level of care placement;
- limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program;
- include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program; and
- adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this Act.

A health carrier that provides hospital, medical, or surgical coverage must base any medical necessity determination or the utilization review criteria that the health carrier, and any entity acting on the carrier's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care. In conducting utilization reviews for these services, including level of care placement and prescription drugs, a health carrier must apply the criteria and practice guidelines set forth in the most recent versions of such criteria and practice guidelines developed by the nonprofit professional association for the relevant clinical specialty. A health carrier may not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria described above.

To ensure the proper use of the criteria, health carriers must:

- sponsor a formal education program by nonprofit clinical specialty associations to educate the health carrier's staff, including any third parties contracted with the health carrier to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria;
- make the education program available to other stakeholders;
- provide, at no cost, the clinical review criteria and any training material or resources to providers and enrollees;
- track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process;
- conduct interrater reliability testing to ensure consistency in utilization review decision making covering how medical necessity decisions are made;
- run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities; and
- achieve interrater reliability pass rates of at least 90% and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

All medical necessity determinations made by the health carrier concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with mental health and substance use disorders must be conducted in accordance with these requirements.

If the Commissioner determines that a health carrier has violated these requirements or prohibitions, the Commissioner may, after appropriate notice and opportunity for hearing as required by state law, by order, assess a civil monetary penalty not to exceed $5,000 for each violation, or, if a violation was willful, a civil monetary penalty not to exceed $10,000 for each violation.

Discretionary Authority.
If a health carrier contract issued or renewed on or after January 1, 2025, contains a provision that reserves discretionary authority to the carrier, or an agent of the carrier, to determine eligibility for benefits or coverage, interpret terms of the contract, or provide standards of interpretation or review that are inconsistent with the laws of Washington, those provisions are void and unenforceable. Discretionary authority is a contract provision that has the effect of conferring discretion on a health carrier or other claims administrator to determine entitlement to benefits or interpret contract language related to mental health and substance use disorders that, in turn, could lead to a deferential standard of review by a reviewing court. This provision does not prohibit a health carrier from including a provision in a contract that informs an enrollee that, as part of its routine operations, the plan applies the terms of its contracts for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes, so long as the provision could not give rise to a deferential standard of review by a reviewing court.

Other definitions.
"Generally accepted standards of mental health and substance use disorder care" is defined as the standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature; recommendations of nonprofit health care provider professional associations and specialty societies, including but not limited to patient placement criteria and clinical practice guidelines; recommendations of federal government agencies; and drug labeling approved by the United States Food and Drug Administration.

"Mental health and substance use disorders" means mental health conditions or substance use disorders that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and

substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems may not affect the conditions covered by this section, as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

"Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a health carrier to conduct utilization review.

Severability.
If any provision of the act or its application is held invalid, the remainder of the act or other applications of it is not affected.

Appropriation: None.

Fiscal Note: Requested on January 10, 2024.

Effective Date: The bill takes effect on January 1, 2025.