Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1432

Brief Description: Improving access to appropriate mental health and substance use disorder services.

Sponsors: Representatives Simmons, Eslick, Rule, Davis, Macri, Stearns, Reed, Goodman, Salahuddin, Pollet, Timmons and Santos.

Brief Summary of Bill

- Defines medically necessary for purposes of requirements for health plans to provide coverage of mental health services.
- Modifies the definition of mental health services and repeals and recodifies the Mental Health Parity Act.
- Requires utilization review and clinical review criteria to be consistent with generally accepted standards of mental health and substance use disorder care and establishes other requirements for utilization review including prior authorization.
- Requires health carriers to approve coverage of mental health services that are the subject of a prescription drug exception request, an enrollee grievance, or appeal, or a prior authorization request if the health carrier does not respond to the request, grievance, or appeal within the applicable statutorily allowed time frame.
- Incorporates the requirements of the final rules issued September 23, 2024, related to the Mental Health Parity and Addiction Equity Act into the act.
- Requires health carriers to provide meaningful benefits for mental health conditions and substance use disorder conditions it covers in every classification in which medical or surgical benefits are covered.

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.

- Authorizes the Insurance Commissioner to assess civil penalties for certain violations and to adopt rules regarding specifying data requirements to determine plan design and in-operation parity compliance, specifying requirements relating to increasing in-network reimbursement rates for mental health services to address network inadequacies; and to ensure consistent utilization review and application of clinical review criteria.

Hearing Date: 1/29/25

Staff: Kim Weidenaar (786-7120).

Background:

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.

Mental Health Parity and Addiction Equity Act.
The Mental Health Parity and Addiction Equity Act (MHPAEA), and its implementing regulations and guidance, prohibits health plans that cover mental health and substance use disorder (SUD) benefits from imposing limitations on these benefits that are less favorable than the limitations imposed on medical and surgical benefits. On September 23, 2024, the Department of Labor, the Department of Health and Human Services (HHS), and the Department of the Treasury issued final rules that went into effect November 22, 2024, though most requirements apply to plans beginning in 2026. The rules established new requirements for implementing the nonquantitative treatment limitation (NQTL) comparative analyses requirements under MHPAEA. The rules prohibit health plans from using NQTLs that place greater restrictions on access to mental health and substance use disorder benefits as compared to medical or surgical benefits. Finally, the rules set forth the content requirements for NQTL comparative analyses and specify how plans must make these comparative analyses available to the federal agencies, state authorities, and to participants, beneficiaries, and enrollees.

Washington's Mental Health Parity Act.
In 2007 the Mental Health Parity Act was enacted and established definitions for mental health services and requirements to cover mental health services in the same manner as medical and surgical benefits for the different types of health carriers. Mental Health Services are defined as follows:

- for health benefit plans issued or renewed on or after January 1, 2021, 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 (APA), on

June 11, 2020, or such subsequent date as provided by the Insurance Commissioner (Commissioner) in rule, with the exception of the following categories, codes, and services: (i) Substance related disorders; (ii) 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 APA; (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and (iv) court-ordered treatment unless the insurer's medical director or designee determines the treatment to be medically necessary; and

- for a health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, or to be a student-only health plan issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and SUDs covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the APA, on June 11, 2020, or a subsequent date as provided by the Commissioner by rule.

The copayment or coinsurance for mental health services and prescription drugs to treat mental health conditions may be no more than the copayment or coinsurance for medical and surgical services and prescription drugs. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health plan imposes any deductible, mental health services must be included with medical and surgical services for the purpose of meeting the deductible requirement. Prescription drugs intended to treat any of the disorders covered in the mental health services definition must be covered under the same terms and conditions, as other prescription drugs covered by the health plan.

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, the Health Care Authority defines "medically necessary" as a term for describing a 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.

Utilization Management under State Law.
Health carriers that offer health plans must maintain a documented utilization review program description and written utilization review criteria that is based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. Health carriers must make clinical protocols, medical management standards, and other review criteria available upon request to participating providers.

Prohibited Utilization Management.
A health carrier may not require utilization management or review, or prior authorization for an

initial evaluation and management visit and up to six consecutive treatment visits in a new episode of care for the following types of services: chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, or speech and hearing therapy. Coverage for these visits may not be denied or limited on the basis of medical necessity or appropriateness and may not be retroactively denied.

Prescription Drug Utilization Management.
Clinical review criteria used to establish a prescription drug utilization management protocol must be evidence-based and updated on a regular basis through review of new evidence, research, and newly developed treatments. When coverage of a prescription drug for the treatment of any medical condition is subject to prescription drug utilization management, the patient and the prescribing practitioner must have access to a clear, readily accessible, and convenient process to request an exception. Once all required information is received, a health carrier or prescription drug utilization management entity must, within three business days for nonurgent requests and one business day for urgent requests, approve a request if the information provided meets the exception criteria or if deemed medically appropriate, or deny the request. If a response by a carrier or prescription drug utilization management entity is not received within the time allotted, the exception or appeal is deemed granted.

Utilization Management Review for Certain Substance Use Disorder Treatment Services.
Health plans are prohibited from requiring enrollees to obtain prior authorization before seeking withdrawal management services or inpatient or residential services in a behavioral health agency. Before conducting a utilization management review, a health carrier must provide coverage for an enrollee for: at least two days, excluding weekends and holidays, of inpatient or residential SUD treatment; and at least three days of withdrawal management services. After the initial waiting period, a health carrier may initiate a medical necessity review. If the health carrier determines within one business day from the start of the medical necessity review period that the admission to the facility was not medically necessary, the health plan is not required to pay the facility for any services that are delivered after the start of the medical necessity review period.

Prior Authorization.
A health carrier's prior authorization requirements must be described in detail and written in easily understandable language. The carrier must make its most current prior authorization requirements and restrictions, including the written clinical review criteria, available to providers and facilities. The prior authorization requirements must be based on peer-reviewed clinical review criteria that must be evidence-based and must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous people, other people of color, gender, and underserved populations. The clinical review criteria must be evaluated and updated, if necessary, at least annually.

Carriers must meet specific time frames for prior authorization determinations and notifications to providers. Standard prior authorization requests submitted electronically must be decided within three calendar days, excluding holidays if sufficient information is provided. Electronic

expediated prior authorization requests must be decided within one calendar day.

Comprehensive Grievance and Appeal Processes and Independent Review.
Each carrier and health plan must have fully operational, comprehensive grievance and appeal processes, and for plans that are not grandfathered, fully operational, comprehensive, and effective grievance and review of adverse benefit determination processes. To process an appeal, each plan that is not grandfathered and each carrier offering that plan must provide the enrollee notice when the appeal is received; assist the enrollee with the appeal process; make its decision regarding the appeal within 30 days, or for an expedited appeal within 72 hours of the date the appeal is received; and provide written notice of its resolution of the appeal to the enrollee.

An enrollee may seek review by a certified independent review organization of a health carrier's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service, or of any adverse determination made by a carrier after exhausting the carrier's grievance process and receiving a decision that is unfavorable to the enrollee, or after the carrier has exceeded the timelines for grievances, without good cause and without reaching a decision. The Commissioner must establish and use a rotational registry system for the assignment of a certified independent review organization to each dispute. The medical reviewers from a certified independent review organization must make determinations regarding the medical necessity or appropriateness of, and the application of health plan coverage provisions to, health care services for an enrollee. The medical reviewers' determinations must be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of Washington. The certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the coverage agreement. Medical reviewers may override the health plan's medical necessity or appropriateness standards if the standards are determined to be unreasonable or inconsistent with sound, evidence-based medical practice.

Carrier Overpayment Recovery.
Except in the case of fraud or other specified circumstances, a carrier may not request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within 24 months after the date that the payment was made. Any such request must specify why the carrier believes the provider owes the refund. For payments related to coordination of benefits with another carrier or responsible entity, a carrier may only request a refund from a health care provider of a payment previously made to satisfy a claim within 30 months of the payment.

Summary of Bill:

Mental Health Parity.
Washington's Mental Health Parity Act.
The Mental Health Parity Act statutes found in the chapters covering the different types of health carriers are repealed and the provisions are recodified in the health carrier chapter. The

definition of "mental health services" from the Mental Health Parity Act statutes is expanded to also include, for a health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, or to be a student-only health plan, issued or renewed on or after January 1, 2026, medically necessary outpatient services, residential care, partial hospitalization services, inpatient services, and prescription drugs provided to treat mental health or SUDs covered by:

- the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the APA on June 11, 2020, or a subsequent date as provided by the Commissioner by rule; or
- the diagnostic categories listed in the mental, behavioral, and neurodevelopmental chapters of the version available on January 13, 2025, of the International Classification of Diseases adopted by the federal HHS or any subsequent version as determined by the Commissioner in rule.

General Provisions.
A health carrier may not limit benefits or coverage for medically necessary mental health services on the basis that those services should or could be covered by a public entitlement program.

If a health carrier provides any benefits for a mental health condition or an SUD in any classification of benefits, it must provide meaningful benefits for that mental health condition or SUD in every classification in which medical or surgical benefits are provided. A health carrier does not provide meaningful benefits unless it provides benefits for a core treatment for that condition or disorder in each classification, in which the health carrier provides benefits for a core treatment for one or more medical conditions or surgical procedures.

Upon the request of a health care provider or a current or prospective covered person, a health carrier must provide the requested nonquantitative treatment limitation parity compliance analyses free of charge.

Utilization Review.
Utilization review and clinical review criteria must be consistent with generally accepted standards of mental health and SUD care. In conducting utilization reviews relating to service intensity or level of care placement, continued stay, or transfer or discharge, the health carrier must apply relevant age-appropriate patient placement criteria from nonprofit professional associations and authorize placement consistent with that criteria. If the assessed level of placement is not available, the health carrier must authorize the next higher level of care. In the event of disagreement with the provider, as part of the adverse benefit determination, the health carrier must provide its assessment to the provider and the covered person.

A health carrier may not require utilization management or review, or prior authorization for an initial evaluation and management visit, and up to six consecutive treatment visits in a new episode of care for outpatient mental health care and outpatient SUD care. Coverage for these visits may not be denied or limited on the basis of medical necessity or appropriateness and may

not be retroactively denied.

Clinical Review Criteria.
For mental health services, the documented utilization review program and written utilization review criteria carriers must maintain is modified to require health carriers to use clinical review criteria that meets the above requirements for these services.

For purposes of independent reviews regarding mental health services, medical reviewers must conduct reviews and make determinations consistent with the above requirements.

For prescription drugs prescribed to treat mental health or SUD conditions, clinical review criteria used to establish a prescription drug utilization management protocol must meet the above requirements.

Clinical review criteria used for purposes of reviewing and deciding upon prior authorization requests related to mental health services must meet the above requirements.

Utilization Management Review for Certain Mental Health and Substance Use Disorder Treatment.
The provisions prohibiting health plans from requiring enrollees to obtain prior authorization before seeking withdrawal management services or inpatient or residential services in a behavioral health agency is expanded to include mental health treatment services in a behavioral health agency. Health plans issued or renewed on or after January 1, 2026, must provide coverage for no less than two business days, excluding weekends and holidays, in a behavioral health agency that provides inpatient or residential mental health treatment prior to conducting a utilization review. Medical necessity reviews for a primary diagnosis of a mental health disorder other than an SUD must comply with the above requirements.

Mental Health Parity and Addiction Equity Act.
The requirements of the final rules issued on September 23, 2024, related to the Mental Health Parity and Addiction Equity Act are incorporated into the above requirements in their entirety.

Enforcement.
The above provisions apply to any health care benefit manager or contracted provider that performs utilization review functions on a health carrier's behalf.

The Commissioner may, after appropriate notice and opportunity for hearing, 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. The civil monetary penalties available to the Commissioner are not exclusive and may be sought and employed in combination with the Commissioner's authority to issue a cease-and-desist order or bring an action in any court of competent jurisdiction to enjoin further violations.

Violations of the above requirements are also considered violations of the state's prohibitions on

discrimination in health benefit design or implementation of health benefit design.

Other Provisions.
A health carrier may not request a refund of amounts paid to a provider from that provider for mental health services more than 180 days after the date of payment, except in cases of fraud.

A health carrier must approve coverage of mental health services that are the subject of a prescription drug exception request, an enrollee grievance, or appeal, or a prior authorization request if the health carrier does not respond to the request, grievance, or appeal within the applicable time frame.

Definitions.
"Medically necessary" means a service or product addressing the specific needs of a 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 generally accepted standards of mental health and SUD care;
- clinically appropriate in terms of type, frequency, extent, site, and duration of a service or product; and
- not primarily for the economic benefit of the insurer or for the convenience of the patient or treating provider.

"Clinical review criteria" means any criteria, standards, protocols, or guidelines used by a health carrier to conduct utilization review. "Utilization review" means the prospective, concurrent, or retrospective assessment of the medical necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

"Generally accepted standards of mental health and SUD care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence-based sources establishing generally accepted standards of care include peer reviewed scientific studies and medical literature, and recommendations of nonprofit professional associations including, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the Food and Drug Administration.

"Core treatment" means a standard treatment or course of treatment, therapy, service, or intervention indicated by generally accepted standards of mental health and SUD care for a condition or disorder.

"Nonprofit professional association" means a not-for-profit health care provider professional association or specialty society that is generally recognized by clinicians practicing in the relevant clinical specialty and issues peer-reviewed guidelines, criteria, or other clinical recommendations developed through a transparent process.

Rulemaking.
The Commissioner may adopt rules:

- administering and implementing these requirements;
- specifying data requirements to determine plan design and in-operation parity compliance for quantitative and nonquantitative treatment limitations such as prior authorization and reimbursement rates;
- specifying requirements relating to increasing in-network reimbursement rates for mental health services to remedy a health carrier's network inadequacies; and
- to ensure consistent utilization review and application of clinical review criteria to meet the requirements of the bill, including identifying clinical review criteria that are consistent with generally accepted standards of mental health and SUD care.

Appropriation: None.

Fiscal Note: Requested on January 21, 2025.

Effective Date: The bill contains multiple effective dates. Please see the bill.