HOUSE BILL REPORT
E2SHB 1432

As Amended by the Senate

Title: An act relating to improving access to appropriate mental health and substance use disorder services by updating Washington's mental health parity law and ensuring coverage of medically necessary care.

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

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Simmons, Eslick, Rule, Davis, Macri, Stearns, Reed, Goodman, Salahuddin, Pollet, Timmons and Santos).

Brief History:

Committee Activity:

Health Care & Wellness: 1/29/25, 2/18/25 [DPS];
Appropriations: 2/25/25, 2/27/25 [DP2S(w/o sub HCW)].

Floor Activity:

Passed House: 3/11/25, 72-23.
Senate Amended.
Passed Senate: 4/14/25, 48-1.

Brief Summary of Engrossed Second Substitute Bill

- Defines medically necessary for purposes of certain requirements related to a health plan's coverage of mental health services and substance use disorder (SUD) services.
- Modifies the definition of mental health services and repeals and recodifies parts of 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.

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.

- Requires health carriers to approve coverage of mental health or SUD services that are the subject of an enrollee grievance, adverse benefit determination, appeal, or a prior authorization request if the health carrier does not respond to the grievance, adverse benefit determination, appeal, or request 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 SUD conditions it covers in every classification in which medical or surgical benefits are covered.
- 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 and to ensure consistent utilization review and application of clinical review criteria.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 15 members: Representatives Bronoske, Chair; Lekanoff, Vice Chair; Rule, Vice Chair; Caldier, Assistant Ranking Minority Member; Marshall, Assistant Ranking Minority Member; Davis, Macri, Obras, Parshley, Shavers, Simmons, Stonier, Stuebe, Thai and Tharinger.

Minority Report: Do not pass. Signed by 4 members: Representatives Schmick, Ranking Minority Member; Engell, Low and Manjarrez.

Staff: Kim Weidenaar (786-7120).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Health Care & Wellness. Signed by 19 members: Representatives Ormsby, Chair; Gregerson, Vice Chair; Macri, Vice Chair; Berg, Bergquist, Callan, Cortes, Doglio, Fitzgibbon, Leavitt, Lekanoff, Peterson, Pollet, Ryu, Springer, Stonier, Street, Thai and Tharinger.

Minority Report: Do not pass. Signed by 7 members: Representatives Couture, Ranking Minority Member; Penner, Assistant Ranking Minority Member; Schmick, Assistant Ranking Minority Member; Burnett, Corry, Dye and Manjarrez.

Minority Report: Without recommendation. Signed by 5 members: Representatives Connors, Assistant Ranking Minority Member; Caldier, Keaton, Marshall and Rude.

Staff: Meghan Morris (786-7119).

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 comparative analyses requirements under MHPAEA. The rules prohibit health plans from using nonquantitative treatment limitation 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 nonquantitative treatment limitation 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.

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 expedited 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 Engrossed Second Substitute 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. For a health 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, 2027, "mental health and SUD services" are medically necessary outpatient services, residential care, partial hospitalization services, inpatient services, and prescription drugs provided to treat mental health or SUDs are 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;
- 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;

or

- DC:0-5 Diagnostic Classification of Mental Health and Developmental Disorders in Infancy and Early Childhood available on January 13, 2025, or any subsequent version as determined by the Commissioner in rule.

Each health plan, including limited duration and student-only plans, providing coverage for medical and surgical services must provide coverage for mental health and SUD services. Any cost-sharing for mental health and SUD services and any treatment limitations related to mental health and SUD services must comply with the quantitative and nonquantitative treatment limitation requirements in the MHPAEA rules issued September 23, 2024. Quantitative treatment limitations and nonquantitative treatment limitations, including any referral and prescription requirements, for mental health or SUD care must comply with the requirements of the MHPAEA, state law, and any implementing regulations.

General Provisions.
A health carrier may not limit benefits or coverage for medically necessary mental health or SUD services on the basis that those services should or could be covered by a public entitlement program. This prohibition may not be construed to require a carrier to cover benefits that have been authorized and provided for a covered person by a public entitlement program, except as otherwise required by state or federal law.

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 may not deviate from 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. The health carrier may not apply conflicting or more restrictive criteria.

If the carrier's application of the required age-appropriate patient placement criteria is not consistent with the service intensity or level of care placement requested by the covered person or their provider, any adverse benefit determination notice must include details of

the carrier's assessment under the relevant criteria to the provider and the covered person. A carrier may use patient placement criteria in addition to the required age-appropriate placement criteria only to approve requested services and may not rely on additional patient placement criteria to deny, restrict, or limit access to requested services. Carriers must comply with any oversight measures deemed appropriate by the Commissioner.

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 office visits. 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 and SUD 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 and SUD 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 and SUD services must meet the above requirements.

Mental Health Parity and Addiction Equity Act.
The requirements of the final rules issued on September 23, 2024, related to the MHPAEA 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 a 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 and SUD services more than six months after the date of payment or for payments involving coordination with another carrier or entity nine months after the date of payment, except in cases of fraud.

A health carrier must approve coverage of mental health and SUD services that are the subject of an enrollee grievance, adverse benefit determination, appeal, or a prior authorization request if the health carrier does not respond to the grievance, adverse benefit determination, appeal, or request within the applicable required 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 written guidelines, standards, protocols, or decision rules used by a health carrier, or health care benefit manager on behalf of a health carrier, during utilization review to evaluate the medical necessity of a patient's requested health care services. "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, evidence-based clinical criteria, 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; 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.

If specific funding is not provided for the bill by June 30, 2025, the bill is null and void.

EFFECT OF SENATE AMENDMENT(S):

The Senate amendment:

- removes the list of evidence-based sources that establish generally accepted standards of care for purposes of the definition of "generally accepted standards of mental health and substance use disorder care";
- makes technical changes to the definition of "utilization review";
- modifies references to the Mental Health Parity and Addiction Equity Act rules;
- specifies that a health carrier may continue to use software-based clinical decision support tools, including those developed by commercial entities, so long as the tools incorporate and apply with fidelity the required age-appropriate patient placement criteria;
- specifies that for utilization review not relating to service intensity or level of care placement, continued stay, or transfer or discharge, a carrier may use clinical review criteria from for-profit or nonprofit sources provided that the clinical review criteria meet all requirements;
- incorporates any federal agency guidance issued to implement rules published on September 23, 2024, implementing portions of the Mental Health Parity and Addiction Equity Act into Section 2 of the bill in addition to the rules;
- modifies the Insurance Commissioner's rulemaking authority by removing the authorization to adopt rules specifying data testing requirements to determine plan design and in-operation parity compliance and to ensure consistent utilization review and application of clinical review criteria and replaces it with an authorization to adopt rules necessary to implement the act, including requiring submission of

quantitative data to determine in-operation parity compliance;
- removes requirements on health carriers to approve coverage of a mental health or substance use disorder service that is the subject of a prior authorization request, grievance, appeal, or adverse benefit determination if the health carrier does not respond in the required time frame;
- specifies that outpatient mental health office visits for purposes of prohibiting utilization management or review for an initial visit and up to six office visits does not include procedures performed on an outpatient basis;
- limits the requirement to provide nonquantitative treatment limitation parity compliance analyses to only when requested following an adverse benefit determination, requires it be provided within 30 days, and removes requirements for health carriers to notify enrollees of their right to request the analysis;
- removes the civil monetary penalty the Insurance Commissioner may assess for violations of Section 2 of the bill; and
- removes the provision that provides that violations of Section 2 of the bill are also considered violations of the state's prohibitions on discrimination in health benefit design or implementation of health benefit design.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill contains multiple effective dates. Please see the bill. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) Too many people are denied mental health services because health insurers say that the services are not medically necessary. These determinations are made using an insurer's own opaque proprietary criteria, instead of the transparent, evidence-based criteria used by medical doctors. A lot of work was done to make sure this bill works in Washington, and it is evidence based. Health plans are already required to use this criteria for SUD care. This bill establishes a standard, widely used definition of what is medically necessary and requires that the criteria used by plans to make coverage decisions transparent and consistent with nationally established, evidence-based best practices developed by nonprofit clinical organizations. Many other states have adopted these provisions. This bill is about addressing the real-life consequences that Washingtonians experience when coverage is denied. The longer we take to act, the more constituents that will be cut off from the potential lifesaving care that they need.

The criteria used by health plans should be objective and informed by the best evidence. Health plans are using proprietary criteria that is inaccessible to providers and patients and developed for the sole purpose of being used by insurers. The Level of Care Utilization System (LOCUS) is the most well-regarded nonprofit clinical criteria and more states are

requiring their use. Mental health conditions should be covered like any other illness. This bill attempts to remove artificial barriers that exist for private health plans.

An untold number of families are facing distress. Mental health conditions can deteriorate and can lead to suicide. For too long mental health has not been treated in the same manner as physical health. There are life or death consequences for a system that does not value mental health. One-third of mental health providers do not accept any insurance. There is a huge lack of providers that accept insurance and there are many barriers, including claw backs of payments. This trend needs to be reversed.

Many individuals need to pay out-of-pocket or are not able to get the mental health care they need. This care is only available to people who can afford it. Mental health care should not only be for the wealthy. Many providers go into private practice for the freedom and choose not to contract with insurance to avoid the financial risk. It is the people in the community that lose out when this happens.

Under mental health parity laws, health plans must ensure than mental health services are treated comparably to other services, but this is very fact specific. Mental health parity enforcement is very complex and time consuming. This is a complex bill and there are concerns about the fast timeline.

(Opposed) This bill will add to current and future fiscal demands. The Diagnostic and Statistical Manual of Mental Disorders is fundamentally flawed and is not based on any objective laboratory measure. The state should not write a blank check without specified health improvement.

(Other) Other states that have passed a similar law have raised some concerns about how this law syncs up with the federal Mental Health Parity Act. Other states have also expressed implementation concerns. Health plans are concerned about the use of nonprofit criteria, which is often more general than needed. For instance, it might not provide the level of specificity needed on the amount of time that the person's been treated. The rulemaking authority of the Commissioner to require health plans to increase and adjust rates based on network adequacies requirements is a fundamentally new approach that does not exist elsewhere and could significantly drive up costs.

Staff Summary of Public Testimony (Appropriations):

(In support) Many people are unable to access mental health care or must end treatments early due to lacking insurance coverage. Over 60 percent of Washingtonians with commercial insurance and a diagnosed mental health condition have not received the necessary care over the past year. Without treatment, conditions deteriorate, leading to worsening mental health conditions and an increase in hospitalizations. Untreated mental health conditions add to the state's financial burden by increasing unemployment, homelessness, and incarceration.

There is not a behavioral health workforce shortage. Instead, there's a shortage of behavioral health providers accepting insurance due to barriers. Health plans are using proprietary criteria that is inaccessible to providers and patients and developed for the sole purpose of being used by insurers. These criteria lack transparency, cannot be externally validated, and can be altered to fit business needs. When Washingtonians face life or death decisions by an insurer on whether they will receive treatment, those decisions must be based on the clinical standards, not opaque cost-control tools used by insurers. This bill creates a common rulebook across insurers, doctors, and patients without a fiscal impact for the state budget. Aligning insurance coverage with standards of care will ensure timely treatment, improve mental health outcomes, and reduce long-term expenses.

(Opposed) Washington is experiencing a large budget shortfall, and this bill will only add to current and future budget demands. Our current mental health system is based on the concept that mental health conditions are caused by neurobiological factors. This concept lacks validity or proof. This bill requires that medical necessity determinations be consistent, which is not possible when diagnosis standards are fundamentally flawed.

(Other) The total premium costs of all the bills moving through this legislative session will greatly increase health care premiums for families. Even though there is not a State General Fund impact, this bill does drive costs and impacts consumer premiums.

Amendments should be considered to enhance alignment with evidence-based clinical care guidelines and promote whole person care by comprehensively integrating both behavioral health and physical health recommendations.

Persons Testifying (Health Care & Wellness): (In support) Representative Tarra Simmons, prime sponsor; Jane Beyer, Office of the Insurance Commissioner; Jake Swanton, Inseparable; Anna Nepomuceno, NAMI Washington and Patients Coalition of WA; Dr. London Breedlove, WA State Psychological Association; Eleanor Hamburger, Sirianni Youtz Spoonemore Hamburger; Jurgen Unutzer, UW Medicine; Ravi Ramasamy, Washington State Council on Child and Adolescent Psychiatry; Sharon Shadwell, Washington Mental Health Counselors Association; and Shannon Thompson, Washington Mental Health Counselor Association.

(Opposed) Kathleen Wedemeyer, Citizens Commission on Human Rights.

(Other) Jennifer Ziegler, Association of Washington Health Care Plans.

Persons Testifying (Appropriations): (In support) Anna Nepomuceno, NAMI Washington and Patients Coalition of Washington; Jake Swanton, Inseparable; Shannon Thompson, WMHCA; and Ben Packard, Washington State Society for Clinical Social Work.

(Opposed) Kathleen Wedemeyer, Citizens Commission on Human Rights.

(Other) Donna Baker-Miller, MCG Health; and Jennifer Ziegler, Association of Washington Health Care Plans.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): None.

Persons Signed In To Testify But Not Testifying (Appropriations): None.