
Health Care & Wellness Committee

HB 2658

Brief Description: Concerning the truth in mental health coverage act.

Sponsors: Representatives Stonier, Santos, Parshley, Macri, Fosse, Pollet, Hill and Davis.

Brief Summary of Bill

- Requires carriers to annually submit data to demonstrate access to and coverage of mental health and substance use disorder services and medical and surgical services by provider and facility type.
- Requires the Insurance Commissioner to develop a template for data submission and publicly post the data files submitted by carriers and develop a dashboard to allow the public to compare the data.

Hearing Date: 2/3/26

Staff: Kim Weidenaar (786-7120).

Background:

State and federal law require carriers 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 (DHHS), and the Department of the Treasury issued final rules that established new requirements for

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implementing the nonquantitative treatment limitation (NQTL) comparative analyses requirements under the MHPAEA. The rules prohibit health plans from using NQTLs that place greater restrictions on access to mental health and SUD benefits as compared to medical or surgical benefits. 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.

The Mental Health Parity Act, initially enacted in 2007, and updated in 2025, establishes definitions for mental health and SUD services and requirements to cover those services in the same manner as medical and surgical benefits.

For a health plan, including a short-term limited purpose or duration plans, and student-only health plans, 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 American Psychiatric Association on June 11, 2020, or a subsequent date as provided by the Insurance Commissioner (Commissioner) by rule;
- Mental, Behavioral, and Neurodevelopmental chapters of the version available of the International Classification of Diseases adopted by the DHHS or any subsequent version as determined by the Commissioner in rule; or
- the 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, treatment limitations, and referral and prescription requirements related to mental health and SUD services must comply with the quantitative and NQTL requirements in the MHPAEA rules, state law, and any implementing regulations.

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.

Summary of Bill:

Annually, for health plans issued or renewed on or after January 1, 2027, each carrier must submit completed templates to the Commissioner with carrier-level coverage and access data,

and coverage and access data at any subcarrier level specified by the Commissioner, that is sufficient to support an independent technical evaluation and to enable meaningful public understanding, by geographic region, of access to and coverage by facility type and professional provider type of:

- mental health disorder services;
- SUD services;
- medical and surgical services;
- youth and adult services, separately and combined; and
- in-person and telehealth services, separately and combined.

The data must also indicate whether the facility or provider is affiliated with, owned by, or under common control with the carrier.

Each carrier must report, disaggregated by facility type, professional provider type, youth services, adult services, in-person services, and telehealth services:

- utilization reviews, including the number and percentage of approvals, denials, average decision time frames, and top denial reasons;
- out-of-network utilization rates using allowed claims data;
- in-network reimbursement including average allowed amounts and allowed amounts at the fiftieth, seventy-fifth, and ninety-fifth percentiles, indexed to Medicare;
- the number of enrollees served by in-network professional providers;
- the percentage of in-network providers relative to state-licensed providers of the same type;
- network admission evaluations including the average time from completed application to network admission for each facility and professional provider type;
- psychiatric collaborative care models including number of enrollees and reimbursement indexed to Medicare;
- appeals and external reviews including counts and outcomes of adverse benefit determinations and independent review decisions; and
- additional metrics the Commissioner determines necessary for public comparison or oversight.

The Commissioner must adopt uniform templates, definitions, and protocols to ensure comparability of data submitted by carriers. The Commissioner may refine, group, stratify, or not include diagnostic categories or conditions within mental health and substance use disorder services in specified metrics or analyses to ensure meaningful, accurate, and comparable public reporting. In developing and specifying the templates, the Commissioner must consider formats that are: utilized by state insurance regulators; endorsed and utilized by one or more employer coalitions, human resources associations, or mental health nonprofit organizations; and cited by the United States Department of Labor or the DHHS.

The Commissioner must post, in a consumer-friendly manner and on a public website, all underlying data and data files submitted by carriers no later than three months after receipt. Posts must include raw data and downloadable files to permit public analysis, research, and

independent comparison.

The Commissioner must also maintain an interactive public dashboard that visually presents the posted data to allow users to view metrics for mental health services, substance use services, and medical and surgical services, which must be updated no later than nine months after receipt of the data.

Each carrier must submit a certification signed by the chief financial officer of the carrier or another officer designated by the Commissioner with responsibility for the accuracy and completeness of the reported data, stating that the reported data, to the best of the officer's knowledge and belief, is complete and accurate and follows template definitions and instructions, and that the carrier made a good-faith effort to ensure that the data was prepared and submitted in accordance with the Commissioner's instructions. The Commissioner may require a carrier to submit additional or clarifying information related to the reported data or the processes used to prepare the data.

Each carrier must retain all data relating to the information reported under this act for three years and make such records available to the Commissioner upon request.

Appropriation: None.

Fiscal Note: Requested on January 28, 2026.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.