SENATE BILL REPORT
E2SHB 1432

As Reported by Senate Committee On:
Health & Long-Term Care, March 27, 2025

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: Passed House: 3/11/25, 72-23.
Committee Activity: Health & Long-Term Care: 3/25/25, 3/27/25 [DPA-WM, DNP].

Brief Summary of Amended 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.
- Incorporates the requirements of the final rules 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

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medical or surgical benefits are covered.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Cleveland, Chair; Orwall, Vice Chair; Muzzall, Ranking Member; Bateman, Chapman, Harris, Holy, Riccelli, Robinson and Slatter.

Minority Report: Do not pass.
Signed by Senator Christian.

Staff: Greg Attanasio (786-7410)

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.

The federal 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 limitations that place greater restrictions on access to mental health and substance use disorder benefits as compared to medical or surgical benefits. 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.

In 2007, the Mental Health Parity Act was passed by the Legislature 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 (OIC) in rule, with the exception of the following

categories, codes, and services: (1) substance related disorders, (2) 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, (3) skilled nursing facility services, home health care, residential treatment, and custodial care, and (4) 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 OIC 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 OIC in 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.

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 Utilization Review 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.

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.

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. OIC 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 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: The bill as referred to committee not considered.

Summary of Amended Bill: 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 OIC 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 OIC in 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 OIC 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 OIC in rule.

General Provisions. 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.

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.

If, following an adverse benefit determination, a covered person requests one or more nonquantitative treatment limitation parity compliance analyses, the health carrier shall provide the requested analyses free of charge within 30 days.

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. A carrier may continue to use software-based clinical decision support tools, including those developed by commercial entities, so long as such tools incorporate and apply with fidelity the relevant age-appropriate patient placement criteria consistent with the requirements of this subsection.

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. 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 either for-profit or non-profit sources provided that the clinical review criteria meet the requirements of this act. Carriers must comply with any oversight measures deemed appropriate by OIC.

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 health carriers must maintain is modified to require health carriers to use clinical review criteria that meets the requirements in this act.

For purposes of independent reviews regarding mental health and SUD services and prescription drugs prescribed to treat mental health or SUD conditions, medical reviewers must conduct reviews and make determinations consistent with the requirements of this act. Clinical review criteria used for purposes of reviewing and deciding upon prior authorization requests related to mental health and SUD services must meet the

requirements of this act.

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

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.

The provisions of this act apply to any health care benefit manager that performs utilization review functions on a health carrier's behalf.

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.

"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. OIC may adopt any rules necessary to implement this act, including requiring submission of quantitative data to determine in operation parity compliance.

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

EFFECT OF HEALTH & LONG-TERM CARE COMMITTEE AMENDMENT(S):

- Clarifies the definitions of "generally accepted standards of mental health and substance use disorder care" and "utilization review."
- Removes examples of evidence-based sources from the definition of “generally accepted standards of mental health and substance use disorder care.”
- Corrects reference to the Mental Health Parity and Addiction Equity Act.
- Limits requirement to provide nonquantitative treatment limitation parity compliance analyses to only when requested following an adverse benefit determination.
- Clarifies that a carrier may use a clinical decision support tool developed by commercial entities for the purpose of utilization reviews relating to service intensity or level of care placement, continued stay, or transfer or discharge under certain conditions.
- Clarifies 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 either for-profit or nonprofit sources.
- Removes language granting OIC authority to levy civil penalties for violations of section 2 of the act.
- Removes cross-reference to existing nondiscrimination provisions of the insurance code.
- Clarifies that outpatient mental health office visits do not include procedures performed on an outpatient basis.
- Removes requirement that a health carrier must approve mental health and SUD services if the carrier fails to respond to an appeal of an adverse benefit determination within the specified time.
- Removes requirement that a health carrier must approve mental health and SUD services if the carrier fails to make a prior authorization determination within the specified time.
- Modifies OIC rule-making authority so that OIC may adopt rules necessary to implement this act, including requiring submission of quantitative data to determine in-operation parity compliance.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Proposed Striking Amendment: *The committee recommended a different version of the bill than what was heard.* PRO: Carriers use criteria for mental health care that is inconsistent with what providers view as best course of treatment. The criteria used by carriers should be transparent. Similar bills have not resulted in an increase in premiums in other states. This bill provides protections to patients from being denied necessary care. This bill will eliminate barriers to care.

CON: Medical necessity is not applicable to mental health care.

OTHER: Carriers support incorporating Federal Mental Health Parity Act in statute. Criteria designed by for-profit entities that incorporate nonprofit standards should be allowed to be used. Requirement to only use one product is problematic. Nonprofit standards are sold by a private equity firm.

Persons Testifying: PRO: Representative Tarra Simmons, Prime Sponsor; Anna Nepomuceno , NAMI WA; Delika Steele, Office of the Insurance Commissioner; Jake Swanton, Inseparable; Chetan Soni, Washington Youth Alliance Action Fund; Jürgen Unützer, UW Medicine; Shannon Thompson LMHC, CMHS, NCC, Washington Mental Health Counselors Association; Ben Packard, Washington State Society for Clinical Social Work.

CON: Anthony Holan; Kathleen Wedemeyer, Citizens Commission on Human Rights.

OTHER: Donna Baker-Miller, MCG Health; Jennifer Ziegler, Association of Washington Health Care Plans; Sasha Waring, Molina Healthcare.

Persons Signed In To Testify But Not Testifying: PRO: Madison Hultquist; Brian Allender; Terri Mosher, " I Did The time"; Samantha Mossuto, " I Did The Time"; London Breedlove, Washington State Psychological Association; Mark Griffin; Jennifer Cohen.