H-1470.1

SUBSTITUTE HOUSE BILL 1432

State of Washington 69th Legislature 2025 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Simmons, Eslick, Rule, Davis, Macri, Stearns, Reed, Goodman, Salahuddin, Pollet, Timmons, and Santos)

READ FIRST TIME 02/21/25.

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; amending RCW 48.43.016, 48.43.410, 48.43.520, 48.43.530, 48.43.535, 48.43.600, 48.43.761, and 48.43.830; adding a new section to chapter 48.43 RCW; creating new sections; repealing RCW 48.20.580, 48.21.241, 48.41.220, 48.44.341, and 48.46.291; and providing an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** (1) The legislature finds that:

(a) Access to mental health and substance use disorder treatment is critical to the health and well-being of individuals with these conditions and that access to appropriate care is important to reducing preventable emergency department visits, hospitalizations, and physical health care costs associated with significant comorbidities;

(b) Health insurance coverage is essential to ensuring that individuals can access needed mental health and substance use disorder treatment and that health carriers should make medical necessity determinations based on the objective needs of the patient; and

(c) The mental health and substance use disorder workforce faces a number of administrative barriers and undue financial risks with respect to participation in health carriers' provider networks that should be alleviated.

(2) Therefore, it is the intent of the legislature to increase access to mental health and substance use disorder treatment by updating Washington's mental health parity requirements, requiring that medical necessity determinations be consistent with generally accepted standards of care and recommendations from nonprofit health care provider associations, requiring consistent rules for both mental health and substance use disorders, and eliminating harmful barriers to care.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW to read as follows:

(1) For the purposes of this section:

(a) "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.

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

(c) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, social work, addiction medicine and counseling, and behavioral health treatment. 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, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States food and drug administration.

(d) "Health plan" or "health benefit plan" means:

(i) A health plan as defined by RCW 48.43.005; or

(ii) A plan deemed by the commissioner to have a short-term limited purpose or duration, or to be a student-only health plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution.

(e) "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:

(i) In accordance with generally accepted standards of mental health and substance use disorder care;

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration of a service or product; and

(iii) Not primarily for the economic benefit of the insurer or purchaser or for the convenience of the patient, treating physician, or other health care provider.

(f) "Mental health services" means:

(i) For health benefit plans issued or renewed before 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, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (A) Substance related disorders; (B) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (C) skilled nursing facility services, home health care, residential treatment, and custodial care; and (D) court-ordered treatment, unless the insurer's medical director or designee determines the treatment to be medically necessary;

(ii) 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 that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution, issued or

renewed on or after January 1, 2021, medically necessary outpatient services, residential care, partial hospitalization services, and inpatient services provided to treat mental health and substance use disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005; and

(iii) For a health plan issued or renewed on or after January 1, 2027, medically necessary outpatient services, residential care, partial hospitalization services, inpatient services, and prescription drugs provided to treat mental health or substance use disorders covered by:

(A) The diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005; or

(B) 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 department of health and human services through 42 C.F.R. Sec. 162.002 or any subsequent version as determined by the insurance commissioner in rule consistent with this section and the goals listed in section 1 of this act.

(g) "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.

(h) "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.

(2) Each health plan providing coverage for medical and surgical services shall provide coverage for mental health services. Any cost

sharing for mental health services and any treatment limitations related to mental health services must comply with the quantitative and nonquantitative treatment limitation requirements in the mental health parity and addiction equity act, 89 Fed. Reg. 77586 (September 23, 2024).

(3) Utilization review and clinical review criteria may not deviate from generally accepted standards of mental health and substance use disorder care.

(4) In conducting utilization reviews relating to service intensity or level of care placement, continued stay, or transfer or discharge, the health carrier shall apply relevant age-appropriate patient placement criteria from nonprofit professional associations and shall authorize placement at the service intensity and level of care consistent with that criteria. The health carrier may not apply different, additional, conflicting, or more restrictive criteria. If the assessed level of placement is not available, the health carrier shall 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 shall provide full detail of its assessment to the provider and the covered person.

(5) 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 including, but not limited to, special education or an individualized education program, medicaid, medicare, supplemental security income, or social security disability insurance, and may not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should or could be covered by a public entitlement program.

(6) This section applies to any health care benefit manager, as defined in RCW 48.200.020 or contracted provider that performs utilization review functions on a health carrier's behalf.

(7) A health carrier may not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, in a manner that undermines, alters, or conflicts with the requirements of this section.

(8) If a health carrier provides any benefits for a mental health condition or substance use disorder in any classification of benefits, it shall provide meaningful benefits for that mental health condition or substance use disorder in every classification in which

medical or surgical benefits are provided. For purposes of this subsection, whether the benefits provided are considered "meaningful benefits" is determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and requires, at a minimum, coverage of benefits for that condition or disorder in each classification in which the health carrier provides benefits for one or more medical conditions or surgical procedures. A health carrier does not provide meaningful benefits under this subsection 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 there is no core treatment for a covered mental health condition or substance use disorder with respect to a classification, the health carrier is not required to provide benefits for a core treatment for such condition or disorder in that classification, but shall provide benefits for such condition or disorder in every classification in which medical or surgical benefits are provided.

(9) The requirements related to the mental health parity and addiction equity act, 89 Fed. Reg. 77586 (September 23, 2024), are incorporated in this section in their entirety.

(10) If a health care provider or a current or prospective covered person requests one or more nonquantitative treatment limitation parity compliance analyses that the health carrier is required to have completed by 29 U.S.C. Sec. 1185a or 42 U.S.C. Sec. 300gg-26, the health carrier shall provide the requested analyses free of charge. The health carrier shall include in each of their health plan policies and mental health and substance use disorder provider contracts a notification of the right to request nonquantitative treatment limitation analyses free of charge. The notification must include information on how to request the analyses. In addition to any other action authorized under RCW 48.02.080, 48.05.185, 48.44.166, and 48.46.135, failure by a health carrier to provide the full requested analyses shall result in a penalty of $100 per day, which shall be collected by the commissioner and remitted to the requestor.

(11) If the commissioner determines that a health carrier has violated this section, the commissioner may, after appropriate notice and opportunity for hearing as required under chapters 48.04 and 34.05 RCW, by order, assess a civil monetary penalty not to exceed

$5,000 for each violation, or, if a violation was willful, a civil monetary penalty not to exceed $10,000 for each violation. The civil monetary penalties available to the commissioner pursuant to this section are not exclusive and may be sought and employed in combination with any other remedies available to the commissioner under RCW 48.02.080. Beginning January 1, 2031, and every five years thereafter, the penalty amounts specified in this section must be adjusted based on the weighted cumulative average rate of change in premium rates for the individual, small, and large group markets for the previous five years.

(12) A violation of this section shall also be considered a violation of RCW 48.43.0128.

(13) This section does not prohibit a requirement that mental health services be medically necessary, if a comparable requirement is applicable to medical and surgical services.

Sec. 3. RCW 48.43.016 and 2020 c 193 s 2 are each amended to read as follows:

(1) A health carrier or its contracted entity that imposes different prior authorization standards and criteria for a covered service among tiers of contracting providers of the same licensed profession in the same health plan shall inform an enrollee which tier an individual provider or group of providers is in by posting the information on its website in a manner accessible to both enrollees and providers.

(2)(a) A health carrier or its contracted entity may not require utilization management or review of any kind including, but not limited to, prior, concurrent, or postservice authorization for an initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care for each of the following: Chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, outpatient mental health care office visits, outpatient substance use disorder care office visits, or speech and hearing therapies. Visits for which utilization management or review is prohibited under this section are subject to any quantitative treatment limits of the health plan. Notwithstanding RCW 48.43.515(5) this section may not be interpreted to limit the ability of a health plan to require a referral or prescription for the therapies listed in this section. Quantitative treatment limitations and nonquantitative treatment

limitations, including any referral and prescription requirements, for mental health or substance use disorder care shall comply with the requirements of the mental health parity and addiction equity act, state law, and any implementing regulations.

(b) For visits for which utilization management or review is prohibited under this section, a health carrier or its contracted entity may not:

(i) Deny or limit coverage on the basis of medical necessity or appropriateness; or

(ii) Retroactively deny care or refuse payment for the visits.

(3) A health carrier shall post on its website and provide upon the request of a covered person or contracting provider any prior authorization standards, criteria, or information the carrier uses for medical necessity decisions.

(4) A health care provider with whom a health carrier consults regarding a decision to deny, limit, or terminate a person's covered health care services must hold a license, certification, or registration, in good standing and must be in the same or related health field as the health care provider being reviewed or of a specialty whose practice entails the same or similar covered health care service.

(5) A health carrier may not require a provider to provide a discount from usual and customary rates for health care services not covered under a health plan, policy, or other agreement, to which the provider is a party.

(6) Nothing in this section prevents a health carrier from denying coverage based on insurance fraud.

(7) For purposes of this section:

(a) "New episode of care" means treatment for a new condition or diagnosis for which the enrollee has not been treated by a provider of the same licensed profession within the previous ninety days and is not currently undergoing any active treatment.

(b) "Contracting provider" does not include providers employed within an integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW.

Sec. 4. RCW 48.43.410 and 2019 c 171 s 2 are each amended to read as follows:

For health plans delivered, issued for delivery, or renewed on or after January 1, 2021, 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. For prescription drugs prescribed to treat mental health or substance use disorder conditions, clinical review criteria must meet the requirements of section 2 of this act.

Sec. 5. RCW 48.43.520 and 2000 c 5 s 8 are each amended to read as follows:

(1) Carriers that offer a health plan shall maintain a documented utilization review program description and written utilization review and clinical review criteria based on reasonable medical evidence. For mental health services, as defined in section 2 of this act, clinical review criteria must meet the requirements of section 2 of this act. The program must include a method for reviewing and updating criteria. Carriers shall make clinical protocols, medical management standards, clinical review criteria as defined in section 2 of this act, and other review criteria available upon request to participating providers.

(2) The commissioner shall adopt, in rule, standards for this section after considering relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

(3) A carrier shall not be required to use medical evidence or standards in its utilization review of religious nonmedical treatment or religious nonmedical nursing care.

Sec. 6. RCW 48.43.530 and 2019 c 56 s 6 are each amended to read as follows:

(1) 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 that comply with the requirements of this section and any rules adopted by the commissioner to implement this section. For the purposes of this section, the commissioner must consider applicable grievance and appeal or review of adverse benefit determination process standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services, and for health plans that are not grandfathered health plans as approved by

the United States department of health and human services or the United States department of labor. In the case of coverage offered in connection with a group health plan, if either the carrier or the health plan complies with the requirements of this section and RCW 48.43.535, then the obligation to comply is satisfied for both the carrier and the plan with respect to the health insurance coverage.

(2) Each carrier and health plan must process as a grievance an enrollee's expression of dissatisfaction about customer service or the quality or availability of a health service. Each carrier must implement procedures for registering and responding to oral and written grievances in a timely and thorough manner.

(3) Each carrier and health plan must provide written notice to an enrollee or the enrollee's designated representative, and the enrollee's provider, of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility. Such notice must be sent directly to a protected individual receiving care when accessing sensitive health care services or when a protected individual has requested confidential communication pursuant to RCW 48.43.505(5).

(4) An enrollee's written or oral request that a carrier reconsider its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility must be processed as follows:

(a) When the request is made under a grandfathered health plan, the plan and the carrier must process it as an appeal;

(b) When the request is made under a health plan that is not grandfathered, the plan and the carrier must process it as a review of an adverse benefit determination; and

(c) Neither a carrier nor a health plan, whether grandfathered or not, may require that an enrollee file a complaint or grievance prior to seeking appeal of a decision or review of an adverse benefit determination under this subsection.

(5) To process an appeal, each plan that is not grandfathered and each carrier offering that plan must:

(a) Provide written notice to the enrollee when the appeal is received;

(b) Assist the enrollee with the appeal process;

(c) Make its decision regarding the appeal within thirty days of the date the appeal is received. An appeal must be expedited if the enrollee's provider or the carrier's medical director reasonably determines that following the appeal process response timelines could seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours of the date the appeal is received;

(d) Cooperate with a representative authorized in writing by the enrollee;

(e) Consider information submitted by the enrollee;

(f) Investigate and resolve the appeal; and

(g) Provide written notice of its resolution of the appeal to the enrollee and, with the permission of the enrollee, to the enrollee's providers. The written notice must explain the carrier's and health plan's decision and the supporting coverage or clinical reasons and the enrollee's right to request independent review of the carrier's decision under RCW 48.43.535.

(6) Written notice required by subsection (3) of this section must explain:

(a) The carrier's and health plan's decision and the supporting coverage or clinical reasons; and

(b) The carrier's and grandfathered plan's appeal or for plans that are not grandfathered, adverse benefit determination review process, including information, as appropriate, about how to exercise the enrollee's rights to obtain a second opinion, and how to continue receiving services as provided in this section.

(7) When an enrollee requests that the carrier or health plan reconsider its decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving through the health plan and the carrier's or health plan's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier and health plan must continue to provide that health service until the appeal, or for health plans that are not grandfathered, the review of an adverse benefit determination, is resolved. If the resolution of the appeal, review of an adverse benefit determination, or any review sought by the enrollee under RCW 48.43.535 affirms the carrier's or health plan's decision, the enrollee may be responsible for the cost of this continued health service.

(8) Each carrier and health plan must provide a clear explanation of the grievance and appeal, or for plans that are not grandfathered, the process for review of an adverse benefit determination process upon request, upon enrollment to new enrollees, and annually to enrollees and subcontractors.

(9) Each carrier and health plan must ensure that each grievance, appeal, and for plans that are not grandfathered, grievance and review of adverse benefit determinations, process is accessible to enrollees who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance, appeal or review of an adverse benefit determination.

(10)(a) Each plan that is not grandfathered and the carrier that offers it must: Track each appeal until final resolution; maintain, and make accessible to the commissioner for a period of three years, a log of all appeals; and identify and evaluate trends in appeals.

(b) Each grandfathered plan and the carrier that offers it must: Track each review of an adverse benefit determination until final resolution; maintain and make accessible to the commissioner, for a period of six years, a log of all such determinations; and identify and evaluate trends in requests for and resolution of review of adverse benefit determinations.

(11) In complying with this section, plans that are not grandfathered and the carriers offering them must treat a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at that time, and any decision to deny coverage in an initial eligibility determination as an adverse benefit determination.

(12) A health carrier shall approve coverage of the mental health services that are the subject of the grievance, appeal, or adverse benefit determination if the health carrier does not respond to the grievance, appeal, or adverse benefit determination within the time frames required in this section.

Sec. 7. RCW 48.43.535 and 2022 c 263 s 4 are each amended to read as follows:

(1) There is a need for a process for the fair consideration of disputes relating to decisions by carriers that offer a health plan to deny, modify, reduce, or terminate coverage of or payment for health care services for an enrollee. For purposes of this section,

"carrier" also applies to a health plan if the health plan administers the appeal process directly or through a third party.

(2) An enrollee may seek review by a certified independent review organization of a 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 under RCW 48.49.020, 48.49.030, or sections 2799A-1 or 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 or 300gg-112) and implementing federal regulations in effect as of March 31, 2022, 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 provided in RCW 48.43.530, without good cause and without reaching a decision.

(3) The commissioner must establish and use a rotational registry system for the assignment of a certified independent review organization to each dispute. The system should be flexible enough to ensure that an independent review organization has the expertise necessary to review the particular medical condition or service at issue in the dispute, and that any approved independent review organization does not have a conflict of interest that will influence its independence.

(4) Carriers must provide to the appropriate certified independent review organization, not later than the third business day after the date the carrier receives a request for review, a copy of:

(a) Any medical records of the enrollee that are relevant to the review;

(b) Any documents used by the carrier in making the determination to be reviewed by the certified independent review organization;

(c) Any documentation and written information submitted to the carrier in support of the appeal; and

(d) A list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal. Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to rules adopted by the commissioner.

(5) Enrollees must be provided with at least five business days to submit to the independent review organization in writing additional information that the independent review organization must

consider when conducting the external review. The independent review organization must forward any additional information submitted by an enrollee to the plan or carrier within one business day of receipt by the independent review organization.

(6) The medical reviewers from a certified independent review organization will 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. Except as provided in this subsection, the certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the medical coverage agreement. Medical reviewers may override the health plan's medical necessity or appropriateness standards if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice. For reviews of mental health services, as defined in section 2 of this act, the medical reviewers must conduct reviews and make determinations in a manner consistent with the requirements of section 2 of this act.

(7) Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both the carrier and the enrollee or the enrollee's representative.

(a) An enrollee or carrier may request an expedited external review if the adverse benefit determination or internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services but has not been discharged from a facility; or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum function. The independent review organization must make its decision to uphold or reverse the adverse benefit determination or final internal adverse benefit determination and notify the enrollee and the carrier or health plan of the determination as expeditiously as possible but within not more than seventy-two hours after the receipt of the request for expedited external review. If the notice

is not in writing, the independent review organization must provide written confirmation of the decision within forty-eight hours after the date of the notice of the decision.

(b) For claims involving experimental or investigational treatments, the independent review organization must ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.

(8) Carriers must timely implement the certified independent review organization's determination, and must pay the certified independent review organization's charges.

(9) When an enrollee requests independent review of a dispute under this section, and the dispute involves a carrier's decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving at the time the request for review is submitted and the carrier's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier must continue to provide the health service if requested by the enrollee until a determination is made under this section. If the determination affirms the carrier's decision, the enrollee may be responsible for the cost of the continued health service.

(10) Each certified independent review organization must maintain written records and make them available upon request to the commissioner.

(11) A certified independent review organization may notify the office of the insurance commissioner if, based upon its review of disputes under this section, it finds a pattern of substandard or egregious conduct by a carrier.

(12)(a) The commissioner shall adopt rules to implement this section after considering relevant standards adopted by national managed care accreditation organizations and the national association of insurance commissioners.

(b) This section is not intended to supplant any existing authority of the office of the insurance commissioner under this title to oversee and enforce carrier compliance with applicable statutes and rules.

Sec. 8. RCW 48.43.600 and 2005 c 278 s 1 are each amended to read as follows:

(1) Except in the case of fraud, or as provided in subsections (2) and (3) of this section, a carrier may not: (a) 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 twenty-four months after the date that the payment was made or, in the case of mental health services as defined in section 2 of this act, within six months after the date the payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

(2) A carrier may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (a) 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 thirty months after the date that the payment was made or, in the case of mental health services as defined in section 2 of this act, within nine months after the date the payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

(3) A carrier may at any time request a refund from a health care provider of a payment previously made to satisfy a claim if: (a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (b) the carrier is unable to recover directly from the third party because the third party has either already paid or will pay the provider for the health services covered by the claim.

(4) If a contract between a carrier and a health care provider conflicts with this section, this section shall prevail. However, nothing in this section prohibits a health care provider from choosing at any time to refund to a carrier any payment previously made to satisfy a claim.

(5) For purposes of this section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

(6) This section neither permits nor precludes a carrier from recovering from a subscriber, enrollee, or beneficiary any amounts paid to a health care provider for benefits to which the subscriber, enrollee, or beneficiary was not entitled under the terms and conditions of the health plan, insurance policy, or other benefit agreement.

(7) This section does not apply to claims for health care services provided through dental only health carriers, health care services provided under Title XVIII (medicare) of the social security act, or medicare supplemental plans regulated under chapter 48.66 RCW.

Sec. 9. RCW 48.43.761 and 2024 c 366 s 7 are each amended to read as follows:

(1) Except as provided in subsection (2) of this section, a health plan issued or renewed on or after January 1, ((~~2021~~)) 2027, may not require an enrollee to obtain prior authorization for withdrawal management services or inpatient or residential substance use disorder or mental health treatment services in a behavioral health agency licensed or certified under RCW 71.24.037.

(2)(a) A health plan issued or renewed on or after January 1, ((~~2021~~)) 2027, must:

(i) 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 or substance use disorder treatment prior to conducting a utilization review; and

(ii) Provide coverage for no less than three days in a behavioral health agency that provides withdrawal management services prior to conducting a utilization review.

(b)(i) The health plan may not require an enrollee to obtain prior authorization for the services specified in (a) of this subsection as a condition for payment of services prior to the times specified in (a) of this subsection.

(ii) Once the times specified in (a) of this subsection have passed, the health plan may initiate utilization management review procedures if the behavioral health agency continues to provide services or is in the process of arranging for a seamless transfer to

an appropriate facility or lower level of care under subsection (6) of this section. For a health plan issued or renewed on or after January 1, ((~~2025~~)) 2027, if a health plan authorizes inpatient or residential mental health or substance use disorder treatment services pursuant to (a)(i) of this subsection following the initial medical necessity review process under (c)(iii) of this subsection, the length of the initial authorization may not be less than 14 days from the date that the patient was admitted to the behavioral health agency. Any subsequent reauthorization that the health plan approves after the first 14 days must continue for no less than seven days prior to requiring further reauthorization. Nothing prohibits a health plan from requesting information to assist with a seamless transfer under this subsection.

(c)(i) The behavioral health agency under (a) of this subsection must notify an enrollee's health plan as soon as practicable after admitting the enrollee, but not later than ((~~twenty-four~~)) 24 hours after admitting the enrollee. The time of notification does not reduce the requirements established in (a) of this subsection.

(ii) The behavioral health agency under (a) of this subsection must provide the health plan with its initial assessment and initial treatment plan for the enrollee within two business days of admission, excluding weekends and holidays, or within three days in the case of a behavioral health agency that provides withdrawal management services.

(iii) After the time period in (a) of this subsection and receipt of the material provided under (c)(ii) of this subsection, the plan may initiate a medical necessity review process. Medical necessity ((~~review~~)) reviews for a primary diagnosis of substance use disorder must be based on the standard set of criteria established under RCW 41.05.528. Medical necessity reviews for a primary diagnosis of a mental health disorder other than a substance use disorder must comply with the requirements of section 2 of this act. In a review for inpatient or residential substance use disorder treatment services, a health plan may not make a determination that a patient does not meet medical necessity criteria based primarily on the patient's length of abstinence. If the patient's abstinence from substance use was due to incarceration, hospitalization, or inpatient treatment, a health plan may not consider the patient's length of abstinence in determining medical necessity. If the health plan determines within one business day from the start of the medical

necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the health plan's medical necessity review is completed more than one business day after the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection, the health plan must pay for the services delivered from the time of admission until the time at which the medical necessity review is completed and the agency is advised of the decision in writing.

(3)(a) The behavioral health agency shall document to the health plan the patient's need for continuing care and justification for level of care placement following the current treatment period, based on the standard set of criteria established under RCW 41.05.528, with documentation recorded in the patient's medical record.

(b) For a health plan issued or renewed on or after January 1, 2025, for inpatient or residential mental health or substance use disorder treatment services, the health plan may not consider the patient's length of stay at the behavioral health agency when making decisions regarding the authorization to continue care at the behavioral health agency.

(4) Nothing in this section prevents a health carrier from denying coverage based on insurance fraud.

(5) If the behavioral health agency under subsection (2)(a) of this section is not in the enrollee's network:

(a) The health plan is not responsible for reimbursing the behavioral health agency at a greater rate than would be paid had the agency been in the enrollee's network; and

(b) The behavioral health agency may not balance bill, as defined in RCW 48.43.005.

(6) When the treatment plan approved by the health plan involves transfer of the enrollee to a different facility or to a lower level of care, the care coordination unit of the health plan shall work with the current agency to make arrangements for a seamless transfer as soon as possible to an appropriate and available facility or level of care. The health plan shall pay the agency for the cost of care at the current facility until the seamless transfer to the different

facility or lower level of care is complete. A seamless transfer to a lower level of care may include same day or next day appointments for outpatient care, and does not include payment for nontreatment services, such as housing services. If placement with an agency in the health plan's network is not available, the health plan shall pay the current agency until a seamless transfer arrangement is made.

(7) The requirements of this section do not apply to treatment provided in out-of-state facilities.

(8) For the purposes of this section "withdrawal management services" means twenty-four hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery.

Sec. 10. RCW 48.43.830 and 2023 c 382 s 1 are each amended to read as follows:

(1) Each carrier offering a health plan issued or renewed on or after January 1, 2024, shall comply with the following standards related to prior authorization for health care services and prescription drugs:

(a) The carrier shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior authorization request through an electronic prior authorization process, as designated by each carrier:

(i) For electronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within three calendar days, excluding holidays, of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within one calendar day of submission of the electronic prior authorization request.

(ii) For electronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within one calendar day of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If

insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within one calendar day of submission of the electronic prior authorization request.

(b) The carrier shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior authorization request through a process other than an electronic prior authorization process:

(i) For nonelectronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within five calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within five calendar days of submission of the nonelectronic prior authorization request.

(ii) For nonelectronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within two calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within one calendar day of submission of the nonelectronic prior authorization request.

(c) In any instance in which a carrier has determined that a provider or facility has not provided sufficient information for making a determination under (a) and (b) of this subsection, a carrier may establish a specific reasonable time frame for submission of the additional information. This time frame must be communicated to the provider and enrollee with a carrier's request for additional information.

(d) The carrier's prior authorization requirements must be described in detail and written in easily understandable language. The carrier shall make its most current prior authorization requirements and restrictions, including the written clinical review criteria, available to providers and facilities in an electronic format upon request. The prior authorization requirements must be

based on peer-reviewed clinical review criteria. The clinical review criteria must be evidence-based criteria 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. Clinical review criteria used for purposes of reviewing and decided upon prior authorization requests related to mental health services, as defined in section 2 of this act, must meet the requirements of section 2 of this act.

(2)(a) Each carrier shall build and maintain a prior authorization application programming interface that automates the process for in-network providers to determine whether a prior authorization is required for health care services, identify prior authorization information and documentation requirements, and facilitate the exchange of prior authorization requests and determinations from its electronic health records or practice management system. The application programming interface must support the exchange of prior authorization requests and determinations for health care services beginning January 1, 2025, and must:

(i) Use health level 7 fast health care interoperability resources in accordance with standards and provisions defined in 45 C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);

(ii) Automate the process to determine whether a prior authorization is required for durable medical equipment or a health care service;

(iii) Allow providers to query the carrier's prior authorization documentation requirements;

(iv) Support an automated approach using nonproprietary open workflows to compile and exchange the necessary data elements to populate the prior authorization requirements that are compliant with the federal health insurance portability and accountability act of 1996 or have an exception from the federal centers for medicare and medicaid services; and

(v) Indicate that a prior authorization denial or authorization of a service less intensive than that included in the original request is an adverse benefit determination and is subject to the carrier's grievance and appeal process under RCW 48.43.535.

(b) Each carrier shall establish and maintain an interoperable electronic process or application programming interface that

automates the process for in-network providers to determine whether a prior authorization is required for a covered prescription drug. The application programming interface must support the exchange of prior authorization requests and determinations for prescription drugs, including information on covered alternative prescription drugs, beginning January 1, 2027, and must:

(i) Allow providers to identify prior authorization information and documentation requirements;

(ii) Facilitate the exchange of prior authorization requests and determinations from its electronic health records or practice management system, and may include the necessary data elements to populate the prior authorization requirements that are compliant with the federal health insurance portability and accountability act of 1996 or have an exception from the federal centers for medicare and medicaid services; and

(iii) Indicate that a prior authorization denial or authorization of a drug other than the one included in the original prior authorization request is an adverse benefit determination and is subject to the carrier's grievance and appeal process under RCW 48.43.535.

(c) If federal rules related to standards for using an application programming interface to communicate prior authorization status to providers are not finalized by the federal centers for medicare and medicaid services by September 13, 2023, the requirements of (a) of this subsection may not be enforced until January 1, 2026.

(d)(i) If a carrier determines that it will not be able to satisfy the requirements of (a) of this subsection by January 1, 2025, the carrier shall submit a narrative justification to the commissioner on or before September 1, 2024, describing:

(A) The reasons that the carrier cannot reasonably satisfy the requirements;

(B) The impact of noncompliance upon providers and enrollees;

(C) The current or proposed means of providing health information to the providers; and

(D) A timeline and implementation plan to achieve compliance with the requirements.

(ii) The commissioner may grant a one-year delay in enforcement of the requirements of (a) of this subsection (2) if the commissioner

determines that the carrier has made a good faith effort to comply with the requirements.

(iii) This subsection (2)(d) shall not apply if the delay in enforcement in (c) of this subsection takes effect because the federal centers for medicare and medicaid services did not finalize the applicable regulations by September 13, 2023.

(e) By September 13, 2023, and at least every six months thereafter until September 13, 2026, the commissioner shall provide an update to the health care policy committees of the legislature on the development of rules and implementation guidance from the federal centers for medicare and medicaid services regarding the standards for development of application programming interfaces and interoperable electronic processes related to prior authorization functions. The updates should include recommendations, as appropriate, on whether the status of the federal rule development aligns with the provisions of chapter 382, Laws of 2023. The commissioner also shall report on any actions by the federal centers for medicare and medicaid services to exercise enforcement discretion related to the implementation and maintenance of an application programming interface for prior authorization functions. The commissioner shall consult with the health care authority, carriers, providers, and consumers on the development of these updates and any recommendations.

(3) A health carrier shall approve coverage of the mental health services that are the subject of the prior authorization request if the health carrier does not respond to the prior authorization request within the time frames required in this section.

(4) Nothing in this section applies to prior authorization determinations made pursuant to RCW 48.43.761.

((~~(4)~~)) (5) For the purposes of this section:

(a) "Expedited prior authorization request" means a request by a provider or facility for approval of a health care service or prescription drug where:

(i) The passage of time:

(A) Could seriously jeopardize the life or health of the enrollee;

(B) Could seriously jeopardize the enrollee's ability to regain maximum function; or

(C) In the opinion of a provider or facility with knowledge of the enrollee's medical condition, would subject the enrollee to

severe pain that cannot be adequately managed without the health care service or prescription drug that is the subject of the request; or

(ii) The enrollee is undergoing a current course of treatment using a nonformulary drug.

(b) "Standard prior authorization request" means a request by a provider or facility for approval of a health care service or prescription drug where the request is made in advance of the enrollee obtaining a health care service or prescription drug that is not required to be expedited.

NEW SECTION. **Sec. 11.** The insurance commissioner may adopt rules:

(1) Necessary to administer and implement this act;

(2) Specifying data testing requirements to determine plan design and in-operation parity compliance for quantitative and nonquantitative treatment limitations, including but not limited to prior authorization, concurrent review, retrospective review, credentialing standards, and reimbursement rates. Such data testing requirements may utilize independent generally recognized benchmarks to determine parity compliance; and

(3) To ensure consistent utilization review and application of clinical review criteria to meet the requirements of this act, including identification of clinical review criteria that are consistent with generally accepted standards of mental health and substance use disorder care.

NEW SECTION. **Sec. 12.** Sections 1 through 10 of this act take effect January 1, 2027.

NEW SECTION. **Sec. 13.** The following acts or parts of acts, as now existing or hereafter amended, are each repealed, effective January 1, 2027:

(1) RCW 48.20.580 (Mental health services—Definition—Coverage required, when) and 2020 c 228 s 2 & 2007 c 8 s 1;

(2) RCW 48.21.241 (Mental health services—Group health plans—Definition—Coverage required, when) and 2020 c 228 s 3, 2007 c 8 s 2, 2006 c 74 s 1, & 2005 c 6 s 3;

(3) RCW 48.41.220 (Mental health services—Definition—Coverage required, when) and 2020 c 228 s 4 & 2007 c 8 s 6;

(4) RCW 48.44.341 (Mental health services—Health plans—Definition—Coverage required, when) and 2020 c 228 s 5, 2007 c 8 s 3, 2006 c 74 s 2, & 2005 c 6 s 4; and

(5) RCW 48.46.291 (Mental health services—Health plans—Definition—Coverage required, when) and 2020 c 228 s 6, 2007 c 8 s 4, 2006 c 74 s 3, & 2005 c 6 s 5.

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