
HOUSE BILL 2658

State of Washington

69th Legislature

2026 Regular Session

By Representatives Stonier, Santos, Parshley, Macri, Fosse, Pollet, Hill, and Davis

Read first time 01/26/26. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to the truth in mental health coverage act;
2 adding a new section to chapter 48.43 RCW; and creating a new
3 section.

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

5 NEW SECTION. **Sec. 1.** The legislature finds:

6 (1) Analyses by Milliman in 2017 and 2019 and RTI International
7 in 2024 demonstrate that, over multiple years, Washington residents
8 have experienced substantially greater difficulty accessing in-
9 network mental health and substance use services than accessing
10 medical and surgical services.

11 (2) In 2021, Washington residents were 7.1 times more likely to
12 receive outpatient behavioral health services out-of-network than
13 outpatient medical and surgical services; 12.1 times more likely for
14 outpatient facility services; and 16.7 times more likely for
15 inpatient behavioral health services.

16 (3) In Washington, average in-network reimbursement in 2021 for
17 medical and surgical clinicians was 41 percent higher than for
18 behavioral health clinicians, indexed to medicare reimbursement. This
19 gap discourages behavioral health clinicians from joining insurance
20 networks and further limits access to care for enrollees. More recent

1 Washington-specific data is unavailable due to the absence of
2 standardized public reporting requirements.

3 (4) Federal regulators have cited the RTI data as evidence of the
4 need for greater accountability and transparency by health plans and
5 issuers.

6 (5) Youth face even greater barriers to access due to health
7 benefit plans' narrow networks that lack sufficient child and
8 adolescent behavioral health providers.

9 (6) Independent economic analyses by McKinsey and Company show
10 that individuals with behavioral health diagnoses incur two to four
11 times higher total medical costs than those without such diagnoses,
12 largely because untreated behavioral health conditions worsen
13 physical health outcomes. The same analyses by Milliman show that
14 individuals with behavioral health diagnoses incur between 3.2 and
15 6.2 times higher medical costs. Earlier access to effective treatment
16 reduces these downstream costs.

17 (7) Transparent, comparable information on coverage and access,
18 including information maintained on a public dashboard, is an
19 essential regulatory function necessary to effectuate compliance with
20 state insurance laws, protect consumers and employers as informed
21 purchasers, and reduce the higher downstream medical costs associated
22 with untreated mental health and substance use disorders.

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

25 (1)(a) Each carrier shall annually submit completed templates to
26 the commissioner, as specified by the commissioner pursuant to this
27 section, with carrier-level coverage and access data, and coverage
28 and access data at any subcarrier level specified by the commissioner
29 in rule, in the form, manner, and time prescribed by the
30 commissioner, but no later than July 1st of each year for data from
31 the previous calendar year.

32 (b) The data submitted by the carrier must be sufficient to
33 support an independent technical evaluation and to enable meaningful
34 public understanding, by geographic area as specified by the
35 commissioner, of access to and coverage by facility type and
36 professional provider type of:

- 37 (i) Mental health disorder services;
38 (ii) Substance use disorder services;
39 (iii) Medical and surgical services;

1 (iv) Youth and adult services, separately and combined; and

2 (v) In-person and telehealth services, separately and combined.

3 (c) The data submitted by the carrier must indicate whether the
4 facility or professional provider is affiliated with, owned by, or
5 under common control with the carrier, as specified by the
6 commissioner.

7 (2) The commissioner shall adopt uniform templates, definitions,
8 audit procedures, and correction protocols to ensure comparability of
9 data submitted by carriers under this section across carriers and
10 over time. In specifying reporting templates and data elements for
11 purposes of this section, the commissioner may refine, group,
12 stratify, or not include diagnostic categories or conditions within
13 mental health and substance use disorder services in specified
14 metrics or analyses to ensure meaningful, accurate, and comparable
15 public reporting.

16 (3)(a) Each carrier shall report, disaggregated by facility type,
17 professional provider type, youth services, adult services, in-person
18 services, and telehealth services:

19 (i) Utilization reviews, including the number and percentage of
20 approvals, modified approvals, denials, and partial denials, using
21 both utilization review and claims data, average decision time
22 frames, top denial reasons, and other measures specified by the
23 commissioner to assess the effects of utilization review on access to
24 timely, clinically appropriate care;

25 (ii) Out-of-network utilization rates using allowed claims data;

26 (iii) In-network reimbursement including average allowed amounts
27 and allowed amounts at the 50th, 75th, and 95th percentiles, each
28 indexed to medicare;

29 (iv) The number of unique enrollees served by listed in-network
30 professional providers;

31 (v) The percentage of listed in-network providers relative to
32 state-licensed providers of the same type;

33 (vi) Network admission evaluations including the average time
34 from completed application to network admission for each facility and
35 professional provider type;

36 (vii) Psychiatric collaborative care models including number of
37 enrollees, including pediatric and adult collaborative care
38 separately, penetration rate per 100,000 covered lives with a
39 behavioral health diagnosis, and reimbursement indexed to medicare;

1 (viii) Appeals and external reviews including counts and outcomes
2 of adverse benefit determinations and independent review decisions;
3 and

4 (ix) Additional metrics the commissioner determines necessary for
5 public comparison or oversight.

6 (b) Any data cell containing fewer than 11 enrollees must be
7 suppressed consistent with centers for medicare and medicaid services
8 cell suppression standards.

9 (4) In developing and specifying the templates, the commissioner
10 shall consider formats that are:

11 (a) Utilized by state insurance regulators;

12 (b) Endorsed and utilized by one or more employer coalitions,
13 human resources associations, or mental health nonprofit
14 organizations; and

15 (c) Cited by the United States department of labor or the United
16 States department of health and human services.

17 (5)(a) The commissioner shall post, in an easily accessible,
18 consumer-friendly manner and on a public website, all underlying data
19 and data files reported under this section no later than three months
20 after receipt.

21 (b) Posts must include raw data and downloadable files to permit
22 public analysis, research, and independent comparison.

23 (c) Data must be posted separately at the carrier level and any
24 subcarrier level specified by the commissioner in rule.

25 (d) Information collected under this section is not considered to
26 be proprietary or confidential and must be publicly disclosed,
27 subject only to cell suppression standards.

28 (6)(a) The commissioner shall maintain an interactive public
29 dashboard that visually presents the posted data, including separate
30 displays of youth and adult outcomes, and allows comparison across
31 carriers and any subcarrier level specified by the commissioner.

32 (b) The dashboard must allow users to view metrics for mental
33 health services, substance use services, and medical and surgical
34 services.

35 (c) The dashboard must be updated no later than nine months after
36 receipt of the data.

37 (7) Each carrier shall submit a certification, in a form and
38 manner specified by the commissioner, signed by the chief financial
39 officer of the carrier or another officer designated by the
40 commissioner with responsibility for the accuracy and completeness of

1 the reported data, stating that the reported data, to the best of the
2 officer's knowledge and belief, is complete and accurate and follows
3 template definitions and instructions, and that the carrier made a
4 good-faith effort, through reasonable policies, procedures, and
5 oversight, to ensure that the data was prepared and submitted in
6 accordance with this section and the commissioner's instructions. The
7 commissioner may require a carrier to submit additional or clarifying
8 information related to the reported data or the processes used to
9 prepare the data.

10 (8) The commissioner may adopt rules necessary to implement this
11 section.

12 (9) Each carrier shall retain all data relating to the
13 information reported under this section for three years and make such
14 records available to the commissioner upon request.

15 (10) This section applies to health plans issued or renewed on or
16 after January 1, 2027.

17 (11) For purposes of this section:

18 (a) "Adult" means individuals age 18 and older.

19 (b) "Facility type" means a category of facilities and levels of
20 care in which mental health disorder services, substance use disorder
21 services, or medical and surgical services are delivered.

22 (c) "Medical and surgical services" means all other health care
23 services or benefits that are not mental health and substance use
24 disorder services as defined in RCW 48.43.766.

25 (d) "Mental health disorder services" are services or benefits
26 for the diagnosis or treatment of mental disorders other than
27 substance use disorders, as classified in the mental and behavioral
28 disorders chapters of the international classification of diseases
29 and the mental disorder diagnostic categories of the diagnostic and
30 statistical manual of mental disorders.

31 (e) "Out-of-network allowed claims" means claims which are
32 allowed at the out-of-network plan benefits level, with corresponding
33 enrollee out-of-pocket expenses, rather than the in-network plan
34 benefits level.

35 (f) "Professional provider type" means categories of health care
36 professionals that furnish mental health disorder services, substance
37 use disorder services, or medical and surgical services in an office
38 setting.

39 (g) "Substance use disorder services" are services or benefits
40 for the diagnosis or treatment of substance use disorders as

1 classified in the substance-related and addictive disorders chapters
2 of the most current version of the international classification of
3 diseases and the substance-related and addictive disorders diagnostic
4 categories of the most current version of the diagnostic and
5 statistical manual of mental disorders.

6 (h) "Templates" means documents containing embedded formulae for
7 quantitative data using definitions and instructions specified by the
8 commissioner.

9 (i) "Youth" means individuals under age 18.

10 NEW SECTION. **Sec. 3.** If any provision of this act or its
11 application to any person or circumstance is held invalid, the
12 remainder of the act or the application of the provision to other
13 persons or circumstances is not affected.

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