H-2304.2

HOUSE BILL 2145

State of Washington 68th Legislature 2024 Regular Session

By Representatives Simmons, Senn, Callan, Reeves, and Kloba

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AN ACT Relating to medically necessary treatment of a mental health or substance use disorder; amending RCW 48.43.005; reenacting and amending RCW 41.05.017; adding new sections to chapter 48.43 RCW; prescribing penalties; and providing an effective date.

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

Sec. 1. RCW 48.43.005 and 2023 c 433 s 20 are each amended to read as follows:

Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Adjusted community rate" means the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities.

(2) "Adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to

provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(3) "Air ambulance service" has the same meaning as defined in section 2799A-2 of the public health service act (42 U.S.C. Sec. 300gg-112) and implementing federal regulations in effect on March 31, 2022.

(4) "Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable enrollee cost-sharing responsibility, for a covered health care service or item rendered by a participating provider or facility or by a nonparticipating provider or facility.

(5) "Applicant" means a person who applies for enrollment in an individual health plan as the subscriber or an enrollee, or the dependent or spouse of a subscriber or enrollee.

(6) "Balance bill" means a bill sent to an enrollee by a nonparticipating provider or facility for health care services provided to the enrollee after the provider or facility's billed amount is not fully reimbursed by the carrier, exclusive of permitted cost-sharing.

(7) "Basic health plan" means the plan described under chapter 70.47 RCW, as revised from time to time.

(8) "Basic health plan model plan" means a health plan as required in RCW 70.47.060(2)(e).

(9) "Basic health plan services" means that schedule of covered health services, including the description of how those benefits are to be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

(10) "Behavioral health emergency services provider" means emergency services provided in the following settings:

(a) A crisis stabilization unit as defined in RCW 71.05.020;

(b) A 23-hour crisis relief center as defined in RCW 71.24.025;

(c) An evaluation and treatment facility that can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the department of health;

(d) An agency certified by the department of health under chapter 71.24 RCW to provide outpatient crisis services;

(e) An agency certified by the department of health under chapter 71.24 RCW to provide medically managed or medically monitored withdrawal management services; or

(f) A mobile rapid response crisis team as defined in RCW 71.24.025 that is contracted with a behavioral health administrative services organization operating under RCW 71.24.045 to provide crisis response services in the behavioral health administrative services organization's service area.

(11) "Board" means the governing board of the Washington health benefit exchange established in chapter 43.71 RCW.

(12)(a) For grandfathered health benefit plans issued before January 1, 2014, and renewed thereafter, "catastrophic health plan" means:

(i) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand seven hundred fifty dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand five hundred dollars, both amounts to be adjusted annually by the insurance commissioner; and

(ii) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least six thousand dollars, both amounts to be adjusted annually by the insurance commissioner.

(b) In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding twelve months, as determined by the United States department of labor. For a plan year beginning in 2014, the out-of-pocket limits must be adjusted as specified in section 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount shall apply on the following January 1st.

(c) For health benefit plans issued on or after January 1, 2014, "catastrophic health plan" means:

(i) A health benefit plan that meets the definition of catastrophic plan set forth in section 1302(e) of P.L. 111-148 of 2010, as amended; or

(ii) A health benefit plan offered outside the exchange marketplace that requires a calendar year deductible or out-of-pocket expenses under the plan, other than for premiums, for covered benefits, that meets or exceeds the commissioner's annual adjustment under (b) of this subsection.

(13) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

(14) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(15) "Covered person" or "enrollee" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

(16) "Dependent" means, at a minimum, the enrollee's legal spouse and dependent children who qualify for coverage under the enrollee's health benefit plan.

(17) "Emergency medical condition" means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment attention to result in a condition (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

(18) "Emergency services" means:

(a)(i) A medical screening examination, as required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition;

(ii) Medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. Sec. 1395dd(e)(3)); and

(iii) Covered services provided by staff or facilities of a hospital after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Poststabilization services relate to medical, mental health, or substance use disorder treatment necessary in the short term to avoid placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or

(b)(i) A screening examination that is within the capability of a behavioral health emergency services provider including ancillary services routinely available to the behavioral health emergency services provider to evaluate that emergency medical condition;

(ii) Examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the behavioral health emergency services provider, as are required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd) or as would be required under such section if such section applied to behavioral health emergency services providers, to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. Sec. 1395dd(e)(3)); and

(iii) Covered behavioral health services provided by staff or facilities of a behavioral health emergency services provider after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Poststabilization services relate to mental health or substance use disorder treatment necessary in the short term to avoid placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious

impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(19) "Employee" has the same meaning given to the term, as of January 1, 2008, under section 3(6) of the federal employee retirement income security act of 1974.

(20) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(21) "Essential health benefit categories" means:

(a) Ambulatory patient services;

(b) Emergency services;

(c) Hospitalization;

(d) Maternity and newborn care;

(e) Mental health and substance use disorder services, including behavioral health treatment;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and chronic disease management; and

(j) Pediatric services, including oral and vision care.

(22) "Exchange" means the Washington health benefit exchange established under chapter 43.71 RCW.

(23) "Final external review decision" means a determination by an independent review organization at the conclusion of an external review.

(24) "Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a health plan or carrier at the completion of the internal appeals process, or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the exhaustion rules described in RCW 48.43.530 and 48.43.535.

(25) "Grandfathered health plan" means a group health plan or an individual health plan that under section 1251 of the patient protection and affordable care act, P.L. 111-148 (2010) and as amended by the health care and education reconciliation act, P.L. 111-152 (2010) is not subject to subtitles A or C of the act as amended.

(26) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

(27) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 or 70.230 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

(28) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(29) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(30) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the patient protection and affordable care act (P.L. 111-148).

(31) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

(a) Long-term care insurance governed by chapter 48.84 or 48.83 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Coverage supplemental to the coverage provided under chapter 55, Title 10, United States Code;

(d) Limited health care services offered by limited health care service contractors in accordance with RCW 48.44.035;

(e) Disability income;

(f) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(g) Workers' compensation coverage;

(h) Accident only coverage;

(i) Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit;

(j) Employer-sponsored self-funded health plans;

(k) Dental only and vision only coverage;

(l) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner;

(m) Civilian health and medical program for the veterans affairs administration (CHAMPVA); and

(n) Stand-alone prescription drug coverage that exclusively supplements medicare part D coverage provided through an employer group waiver plan under federal social security act regulation 42 C.F.R. Sec. 423.458(c).

(32) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(33) "In-network" or "participating" means a provider or facility that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for

the health care services, including applicable cost-sharing obligations.

(34) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

(35) "Nonemergency health care services performed by nonparticipating providers at certain participating facilities" means covered items or services other than emergency services with respect to a visit at a participating health care facility, as provided in section 2799A-1(b) of the public health service act (42 U.S.C. Sec. 300gg-111(b)), 45 C.F.R. Sec. 149.30, and 45 C.F.R. Sec. 149.120 as in effect on March 31, 2022.

(36) "Open enrollment" means a period of time as defined in rule to be held at the same time each year, during which applicants may enroll in a carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(37) "Out-of-network" or "nonparticipating" means a provider or facility that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

(38) "Out-of-pocket maximum" or "maximum out-of-pocket" means the maximum amount an enrollee is required to pay in the form of cost-sharing for covered benefits in a plan year, after which the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

(39) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(40) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(41)(a) "Protected individual" means:

(i) An adult covered as a dependent on the enrollee's health benefit plan, including an individual enrolled on the health benefit plan of the individual's registered domestic partner; or

(ii) A minor who may obtain health care without the consent of a parent or legal guardian, pursuant to state or federal law.

(b) "Protected individual" does not include an individual deemed not competent to provide informed consent for care under RCW 11.88.010(1)(e).

(42) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

(43) "Sensitive health care services" means health services related to reproductive health, sexually transmitted diseases, substance use disorder, gender dysphoria, gender-affirming care, domestic violence, and mental health.

(44) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least one but no more than fifty employees, during the previous calendar year and employed at least one employee on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year,

except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year.

(45) "Special enrollment" means a defined period of time of not less than thirty-one days, triggered by a specific qualifying event experienced by the applicant, during which applicants may enroll in the carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(46) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

(47) "Utilization review" means the prospective, concurrent, or retrospective assessment of the 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.

(48) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

(49) "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, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature; recommendations of nonprofit health care provider professional associations and specialty societies, 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.

(50) "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that 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:

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

(b) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

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

(51) "Mental health and substance use disorders" means mental health conditions or substance use disorders that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the world health organization's international statistical classification of diseases and related health problems, or that is listed in the most recent version of the American psychiatric association's diagnostic and statistical manual of mental disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American psychiatric association's diagnostic and statistical manual of mental disorders or the world health organization's international statistical classification of diseases and related health problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(52) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a health carrier to conduct utilization review.

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

(1) Every health plan issued or renewed on or after January 1, 2025, that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders.

(2) A health carrier shall not limit benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment at any level of care placement.

(3) All medical necessity determinations made by the health carrier concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of section 3 of this act.

(4) A health carrier that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason including, but not limited to, the health carrier's subsequent rescission, cancellation, or modification of the enrollee's contract, or the health carrier's subsequent determination that it did not make an accurate determination of the enrollee's eligibility. This section shall not be construed to expand or alter the benefits available to the enrollee under a health plan.

(5) A health carrier shall not limit benefits or coverage for medically necessary services on the basis that those services should be 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 shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(6) A health carrier shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(7) 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 this chapter.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43 RCW to read as follows:

(1) A health carrier that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the health carrier, and any entity acting on the carrier's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

(2) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a health carrier shall apply the criteria and practice guidelines set forth in the most recent versions of such criteria and practice guidelines, developed by the nonprofit professional association for the relevant clinical specialty.

(3) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subsection (2) of this section, a health carrier shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources.

(4) To ensure the proper use of the criteria described in subsection (2) of this section, every health carrier shall:

(a) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health carrier's staff, including any third parties contracted with the health carrier to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria;

(b) Make the education program available to other stakeholders, including the health carrier's participating providers and covered lives;

(c) Provide, at no cost, the clinical review criteria and any training material or resources to providers and enrollees;

(d) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process;

(e) Conduct interrater reliability testing to ensure consistency in utilization review decision making covering how medical necessity

decisions are made. This assessment shall cover all aspects of utilization review;

(f) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities; and

(g) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(5) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by a health plan, including prescription drugs.

(6) This section applies to a health carrier that covers hospital, medical, or surgical expenses and conducts utilization review, and any entity or contracting provider that performs utilization review or utilization management functions on a health carrier's behalf.

(7) 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 this chapter.

(8) A carrier may not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

NEW SECTION. **Sec. 4.** A new section is added to chapter 48.43 RCW to read as follows:

(1) If a health carrier contract issued or renewed on or after January 1, 2025, contains a provision that reserves discretionary authority to the carrier, or an agent of the carrier, to determine eligibility for benefits or coverage, interpret the terms of the contract, or provide standards of interpretation or review that are

inconsistent with the laws of this state, that provision is void and unenforceable.

(2) For purposes of this section, the term "discretionary authority" means a contract provision that has the effect of conferring discretion on a health carrier or other claims administrator to determine entitlement to benefits or interpret contract language related to mental health and substance use disorders that, in turn, could lead to a deferential standard of review by a reviewing court.

(3) This section does not prohibit a health carrier from including a provision in a contract that informs an enrollee that, as part of its routine operations, the plan applies the terms of its contracts for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes, so long as the provision could not give rise to a deferential standard of review by a reviewing court.

Sec. 5. RCW 41.05.017 and 2022 c 236 s 3, 2022 c 228 s 2, and 2022 c 10 s 2 are each reenacted and amended to read as follows:

Each health plan that provides medical insurance offered under this chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, are subject to the provisions of RCW 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545, 48.43.550, 70.02.110, 70.02.900, 48.43.190, 48.43.083, 48.43.0128, 48.43.780, 48.43.435, 48.43.815, sections 2 through 4 of this act, and chapter 48.49 RCW.

NEW SECTION. **Sec. 6.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 7.** This act takes effect January 1, 2025.

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