Initiative Measure No. IL26-282

Filed July 10, 2025

AN ACT Relating to mandatory health insurance coverage of medically necessary health care services; adding a new chapter to Title 48 RCW; creating new sections; and prescribing penalties.

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

NEW SECTION. **Sec.** The people of Washington find and declare the following:

(1) Access to medically necessary health care services is a fundamental necessity for the health and welfare of Washington residents. Insurance coverage denials for medically necessary treatments or prescriptions cause significant hardship for patients and undermine the patient-provider relationship. Existing dispute processes often leave patients financially responsible during coverage disputes, creating barriers to essential care.

(2) Washington state has authority under RCW 48.02.060 and the federal McCarran-Ferguson act to regulate insurance practices in order to protect consumers and patients. This act is intended to supplement and work in harmony with existing patient protections, including Washington's balance billing protection act, chapter 48.49 RCW, and the federal no surprises act, by providing stronger safeguards where necessary.

(3) The intent of this act is to ensure that all medical treatments and medications deemed medically necessary by a licensed health care provider are promptly covered by insurance without prior authorization barriers or denials, and that patients are held harmless from costs when such care is provided. This act explicitly targets the practices of insurance carriers and claims administrators, including third-party administrators and pharmacy benefit managers, rather than directly regulating the benefits of self-funded employer health plans, consistent with state regulatory authority and federal law. The people note that the United States

supreme court has affirmed state authority to regulate entities like pharmacy benefit managers that administer health benefits, see *Rutledge v. Pharmaceutical Care Management Ass'n*, 141 S.Ct. 474 (2020), and it is intended that this act be applied to the fullest extent permitted by the employee retirement income security act savings clause and other applicable law.

NEW SECTION. **Sec.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

(1) "Medically necessary" or "medical necessity" means health care services or supplies needed to prevent, diagnose, treat, or cure an illness, injury, condition, disease, or its symptoms, in a manner that is consistent with generally accepted standards of medical practice. In determining medical necessity, a provider's clinical judgment should align with the standards of care that a prudent, evidence-based medical professional would apply to similar circumstances.

(2) "Health care provider" means any individual who is licensed under RCW 18.57.020, 18.71.021, 18.71A.020, 18.79.030, 18.83.020, 18.225.020, or other applicable sections of Title 18 RCW and who is authorized to provide or prescribe health care services within the scope of their professional license. This includes, but is not limited to, physicians, osteopathic physicians, nurse practitioners, physician assistants, dentists, podiatrists, optometrists, mental health counselors, psychologists, and other licensed practitioners legally permitted to order treatments or medications for patients.

(3) "Insurance carrier" or "carrier" means any person or entity that provides, administers, or pays for health insurance coverage or health benefits in Washington state. This term includes health insurers, health care service contractors, and health maintenance organizations authorized under chapters 48.43, 48.44, and 48.46 RCW, as well as any third-party administrators, pharmacy benefit managers, managed care organizations, including medicaid managed care plans, or other entities that make coverage or payment decisions for health care services for Washington residents.

(4) "Enrollee" or "patient" means an individual who is enrolled in or covered by a health plan or health insurance policy issued or administered by an insurance carrier.

(5) "Health plan" means any policy, contract, or agreement entered into by a carrier to provide, reimburse, or administer payment for health care services. This includes plans offered by employers or unions, plans offered directly to individuals or groups, and government-sponsored health coverage programs to the extent permitted by law. For the purposes of this act, health plans include self-funded employer plans only to the extent that carriers or administrators of such plans are subject to state regulation as provided in section 8 of this act.

NEW SECTION. **Sec.** (1) A carrier may not deny or refuse to cover any service or prescription drug that a licensed health care provider, acting within their scope of practice, has determined to be medically necessary for the patient. The carrier must honor the provider's determination of medical necessity for coverage purposes. There is a presumption that any service ordered by a licensed provider for their patient meets the criteria of medical necessity under the terms of the health plan.

(2) Carriers may not require prior authorization, concurrent review, or any other form of preservice or intraservice utilization review for the coverage of services under this act. If a provider orders or prescribes a treatment, the carrier must authorize and cover the service without imposing waiting periods, medical management criteria, or administrative hurdles before the patient can receive care. Reviews of medical necessity, if any, may only occur after the claim is paid, as provided in section 5 of this act.

(3) For purposes of patient cost-sharing and benefits, all health care providers licensed in Washington state must be treated as in-network or participating providers under the patient's health plan when providing medically necessary services covered by this act. An enrollee's financial obligation, including copayments, deductibles, and coinsurance, for such services may be no greater

than if a provider under contract with the carrier had provided the service. Patients shall not incur any additional out-of-network charges for receiving necessary care from any licensed provider in the state.

(4) A carrier's obligation to cover medically necessary services extends to services delivered by providers who are not contracted with the carrier. The carrier shall ensure that medically necessary care is accessible to the enrollee without delay. If a needed service is not reasonably available from an in-network provider or if the patient chooses a noncontracted provider, the carrier remains responsible for coverage under this chapter. In all cases, the patient's cost-sharing is limited by subsection (3) of this section, and balance billing is prohibited per section 4 of this act.

(5) This chapter does not require coverage of services that are purely cosmetic or not related to the treatment of an illness or health condition. For the purposes of this subsection, "cosmetic procedure" means a surgery or treatment primarily aimed at improving appearance and not needed for diagnosis or treatment of a medical or psychological condition. However, if a licensed health care provider certifies that a normally cosmetic procedure is medically necessary for the patient's physical or mental health, then the carrier shall cover that procedure as medically necessary on the same basis as other covered services.

(6) There shall be no distinction in coverage requirements between emergency and nonemergency medical services under this chapter. All medically necessary services are covered regardless of whether the care is delivered in an emergency situation or a nonemergency setting. Nonemergency but medically necessary treatments such as ongoing therapies or elective yet necessary surgeries may not be denied or subjected to additional requirements by virtue of not being emergency care.

NEW SECTION. **Sec.** (1) An enrollee may not be held responsible for paying any costs for medically necessary services covered by their health plan under section 3 of this act, except for the

ordinary cost-sharing, such as copayments, deductibles, or coinsurance, that would apply if the services were provided in-network under the terms of their health plan. If the patient has already met applicable deductibles or out-of-pocket maximums, the patient shall not be charged anything for the service.

(2) A health care provider who provides services to a patient covered under this chapter may not bill or collect any amount from the patient above the amount of the patient's in-network cost-sharing obligation for that service. Balance billing is prohibited. Providers shall accept the insurance payment, plus the patient's in-network cost-share, if any, as payment in full for the services. If a provider is not satisfied with the payment received, they may use the dispute resolution process described in section 7 of this act but may not pursue the patient for additional payment.

(3) Any health care provider that accepts an insurance plan shall hold the patient harmless from charges for any service that is covered under this chapter. If an insurance carrier for any reason fails to timely pay for a service, or if a dispute arises between the provider and the carrier about a service, the provider may not request or require the patient to pay the amount in dispute. The patient is explicitly insulated from any billing or collection attempts related to the services in question.

(4) Insurance carriers may not engage in any practice that would shift costs to patients for services covered under this chapter. Specifically, a carrier may not: (a) Require or pressure a patient to pay any portion of the service cost beyond their normal plan cost-sharing; (b) seek reimbursement or restitution from a patient for any amount paid to a provider, even if a claim is later disputed; or (c) report a patient to credit agencies or initiate any debt collection for amounts related to services covered under this chapter.

(5) To further protect patients from indirect financial harm such as being charged by providers due to delayed insurance payments, carriers shall pay providers promptly. Each carrier shall pay the owed amount on any claim for services under this chapter

within 30 days of receiving a clean claim from the provider. For the purposes of this subsection "clean claim" means a claim that has no material defect or impropriety and that includes all information needed for processing.

NEW SECTION. **Sec.** (1) A carrier may conduct a retrospective review or audit of claims only for the following purposes:

(a) To identify billing errors, administrative errors, or duplicate claims;

(b) To confirm that services billed were actually rendered to the patient;

(c) To detect fraudulent or abusive billing practices, such as upcoding or submitting claims for services not provided; or

(d) To verify that the services provided were within the scope of practice of the provider.

(2) Under no circumstances may a carrier use a post-payment review to question or deny the medical necessity of a service that a licensed provider ordered. If a service was covered and paid under section 3 of this act, the carrier cannot later rescind or reclaim payment on the grounds that it deems the service was not medically necessary. The clinical appropriateness of care, as determined by the treating provider, is not subject to second review through retrospective utilization review.

(3) If a carrier's legitimate post-payment audit under subsection (1) of this section finds that a claim was paid in error or due to fraud, the carrier may seek recoupment of the paid amount directly from the provider who was paid for the service. The provider shall refund any improperly paid amounts to the carrier upon a valid determination. The carrier may not, in any case, attempt to recover money from the patient for any claim that was paid and later determined to be improper. Patients are not parties to disputes over payments between carriers and providers.

(4) If a carrier suspects that a provider has engaged in fraud or intentional misrepresentation in billing, the carrier may refer the matter to the office of the insurance commissioner for

investigation under the insurance fraud program, chapter 48.135 RCW, or to other appropriate law enforcement or regulatory authorities. Likewise, patterns of abusive billing or potential malpractice by a provider may be referred to the provider's licensing board. Such referrals do not relieve the carrier from its obligation to hold patients harmless under this chapter.

(5) To prevent abuse of the audit process, carriers shall conduct any post-payment reviews in good faith and in a manner that does not harass or needlessly burden providers who are complying with this chapter. The insurance commissioner shall adopt rules establishing reasonable limits on the frequency and scope of carriers' post-payment audits. These rules may include safe harbors or thresholds, such as focusing audits on statistical outliers, large claims, or suspicious billing patterns, and limits on how often a carrier can audit the same provider within a given time frame.

NEW SECTION. **Sec.** (1)(a) If a carrier believes that a service or prescription, although already paid, was not medically necessary or was inappropriate, the carrier may initiate an independent medical review only after it has paid the claim in question in full to the provider. The carrier shall notify the provider, and the patient for informational purposes, that it is challenging the medical necessity of the service.

(b) The carrier may not withhold or delay payment pending the outcome of the review; payment must be made first, in accordance with sections 3 and 4 of this act. Patients shall have no financial responsibilities related to such disputes at any time.

(2) Disputes over medical necessity shall be decided by an impartial independent review. The review may be conducted under the authority of the Washington medical commission or by an independent review organization certified by the office of the insurance commissioner to perform external medical reviews. The reviewing entity shall assign one or more qualified, independent health care

professionals in the same or similar specialty as the service in question to evaluate the case.

(3) In conducting the independent review, the reviewer or reviewers shall give substantial deference to the medical judgment of the treating provider who prescribed or provided the service. The service should be deemed medically necessary unless the reviewer concludes that there was a clear and significant deviation from the normal standard of care or that the provider's decision lacked any reasonable medical justification.

(4) For nonurgent disputes, the reviewer shall issue a final determination within 30 days of the carrier's initiation of the dispute review. For an urgent or time-sensitive treatment, such as ongoing therapy that the carrier is questioning, the reviewer shall issue a final determination within 72 hours of initiation.

(5)(a) If the independent review upholds the provider's determination and finds that the service was medically necessary, the carrier has no further recourse and the provider's claim must stand as paid. The carrier may not attempt to recover the payment, and shall reimburse the provider for any reasonable costs or fees the provider incurred in defending the necessity of the service during the review. Additionally, the carrier shall bear the costs of the independent review process itself, including any fees charged by the independent review organization or review panel.

(b) If the independent review determines that the service was not medically necessary under the applicable standards, the carrier may seek to recoup the payment for that service from the provider, but not from the patient. The provider shall refund the amount to the carrier if such a determination is made. A finding that a provider administered a treatment that was not medically necessary may be referred to the provider's licensing board such as the Washington medical commission or other relevant board under Title 18 RCW for further evaluation and possible disciplinary action or remedial education, consistent with the uniform disciplinary act, chapter 18.130 RCW. However, such a referral or finding does not by itself create any right for the patient to be billed.

(6) Under no circumstances shall the patient be billed or charged for any service that is undergoing or has undergone independent review under this section. Whether the outcome favors the provider or the carrier, the patient's financial obligation is unchanged from what it was prior to the dispute.

(7) Patterns of abuse in the dispute process are subject to enforcement by the office of the insurance commissioner and the Washington medical commission. If an insurance carrier is found to routinely challenge claims that are ultimately deemed medically necessary, the insurance commissioner may treat this as a violation of this chapter and impose penalties as outlined in section 9 of this act. Conversely, if a particular provider is found through multiple independent reviews to be regularly prescribing or performing services that are not medically necessary, the medical commission or relevant licensing board shall investigate and take appropriate action under their authority, which may include fines, required training, or license sanctions.

NEW SECTION. **Sec.** (1) Except for the patient's applicable cost-sharing, such as copay, deductible, or coinsurance, as would apply in-network, a payment made by a carrier to a provider for a service under this chapter is payment in full for that service. Providers may not attempt to collect any additional amount from the patient beyond the cost-sharing.

(2) For services covered under this chapter that are provided by a health care provider who is not in the carrier's network, the carrier shall pay the provider a reasonable rate for the service. The reasonable rate is the greater of: (a) The carrier's average contracted rate for the same or comparable service in the geographic area; or (b) 125 percent of the medicare rate for the same or comparable service in that area; or (c) for services without a medicare rate, 150 percent of the carrier's average contracted rate or the 80th percentile of billed charges in the geographic area, whichever is less.

(3) Each carrier shall annually report to the office of the insurance commissioner the average contracted rates it paid for common health care services, categorized by service code. The office of the insurance commissioner shall compile and publish a reference list of these rates alongside corresponding medicare rates. The office of the insurance commissioner's published information shall serve as a reference for reasonable out-of-network rates. Carriers and providers may refer to this public data when negotiating or disputing payments. Patient identifying information may not be included in any such reporting, and data may be aggregated to protect confidential rate information as necessary.

(4) If a health care provider believes that the amount paid by the carrier for a service is below the amount required by subsection (2) of this section or is otherwise unjust, the provider may notify the carrier of a payment dispute. The provider and carrier shall attempt to resolve the payment discrepancy through good faith negotiation. The carrier shall respond to the provider's notice of dispute within 30 days. If no resolution is reached within 30 days of the provider's initial complaint, the provider may escalate the dispute by requesting arbitration under subsection (5) of this section.

(5) Unresolved disputes over the appropriate payment amount for a service under this chapter shall be settled by binding arbitration, administered or overseen by the office of the insurance commissioner. The insurance commissioner may establish an arbitration program or approve independent arbitration organizations to handle these disputes. The arbitration shall be "baseball style," or conducted in another format consistent with the dispute resolution methods in Washington's balance billing protection act, chapter 48.49 RCW, and the federal no surprises act, to the extent applicable.

(6) In deciding the appropriate payment, the arbitrator shall consider the standard in subsection (2) of this section as a primary factor, as well as any other relevant information presented by the parties. Such information may include the provider's level of

training or experience, the patient's acuity, the complexity of providing the service, the effort made by each party to reach a network contract, and other equitable factors. The arbitrator's decision is final and binds both parties. The carrier shall pay any additional amount required by the decision within 30 days. If the decision lowers the payment, the provider shall refund the excess to the carrier.

(7) The party that does not prevail in the arbitration shall pay the costs of the arbitration process. The insurance commissioner may establish rules for apportioning costs in cases of split decisions, or to cap fee amounts to keep the process accessible. In no event shall any arbitration costs be passed on to the patient.

NEW SECTION. **Sec.** (1) This chapter exercises Washington state's regulatory authority over insurance and related entities, consistent with the federal McCarran-Ferguson act and the employee retirement income security act savings clause. These requirements regulate the business of insurance, including practices of claims administration and benefit management, and are intended to be saved from employee retirement income security act preemption under 29 U.S.C. Sec. 1144(b)(2)(A). This chapter does not mandate the content of any self-funded employee benefit plan, nor require an employer to provide any specific benefit, except insofar as such plans choose to use third-party entities that are subject to state insurance regulation to administer benefits.

(2) All persons and organizations engaged in administering, managing, or insuring health benefits for Washington residents are required to comply with this chapter. This includes third-party administrators of self-funded employer health plans and pharmacy benefit managers with respect to their activities in Washington. If a third-party administrator or pharmacy benefit manager makes coverage decisions or manages claims for an employer plan covering Washington-based enrollees, it shall adhere to the same standards as an insurer under this chapter, even if the underlying plan is not subject to state law for its benefit terms. A third-party

administrator or pharmacy benefit manager that violates these requirements shall be subject to enforcement by the insurance commissioner just as an insurer would be.

(3) Any insurer issuing stop-loss insurance policies in Washington shall comply with this chapter in the administration of stop-loss claims. The insurance commissioner shall review and approve stop-loss policy forms to ensure they do not circumvent the intent of this chapter. The insurance commissioner may set minimum attachment points or other policy standards to prevent inappropriate self-insurance, such as extremely low attachment points that effectively create an uninsured plan in name only.

(4) The state may implement an assessment or fee on large employers that do not provide health coverage meeting the requirements of this chapter, with proceeds dedicated to public health programs or to an assistance fund for uncompensated care. Employers who do provide compliant coverage or who purchase fully insured plans subject to this chapter may receive exemptions or credits offsetting such fees.

(5) This chapter does not regulate benefit design. No requirement in this chapter requires any employer to provide specific benefits or modify plan terms. If any provision of this chapter is found to impermissibly conflict with the employee retirement income security act for a particular plan or circumstance, that provision shall be construed and applied in a way that avoids the conflict or, if necessary, shall be deemed severable to the minimum extent needed so that the remainder of the law is not affected.

NEW SECTION. **Sec.** (1) The office of the insurance commissioner is charged with administering and enforcing the provisions of this chapter. The insurance commissioner may promulgate rules in accordance with the administrative procedure act, chapter 34.05 RCW, to implement this chapter. The insurance commissioner shall utilize all powers provided under Title 48 RCW to oversee carriers and other regulated entities, including the power

to conduct market conduct examinations, investigate consumer complaints, and require reports and data from carriers to monitor compliance.

(2) Insurance carriers shall submit periodic reports to the office of the insurance commissioner on relevant metrics. Relevant metrics may include the number of claims submitted and paid under this chapter, instances of any post-payment reviews or disputes initiated, average time to payment on claims, and summaries of the outcomes of any independent reviews or arbitrations conducted. The insurance commissioner shall specify the format and frequency of such reports and may require inclusion of data on any prior authorization requests to verify that such practices have ceased for services covered under this chapter. The commissioner shall make summary data from these reports available to the public, while protecting confidential or proprietary information as appropriate.

(3)(a) If an insurance carrier, or any third-party administrator or pharmacy benefit manager acting in the capacity of a carrier, fails to comply with any requirement of this chapter, it is subject to enforcement actions and penalties. The insurance commissioner may issue cease-and-desist orders against unlawful practices and may impose fines for violations. For willful or repeat violations, the commissioner may suspend or revoke the carrier's certificate of authority or license to operate in Washington. The following penalty structure is provided as guidance for violations of the core coverage requirements or patient protections of this chapter:

(i) For the first offense, a fine of up to $25,000 per violation.

(ii) For subsequent offenses, a fine of up to $50,000 per violation.

(iii) If the commissioner finds a pattern of deliberate noncompliance, each instance in the pattern may be fined up to $100,000, and additional remedies such as license suspension or required corrective action plans may be imposed.

(b) Each denied claim or each patient improperly billed in contravention of this chapter may be considered a separate

violation. The fines described in this subsection are in addition to any other remedies available under law.

(4) A third-party administrator or pharmacy benefit manager that violates the provisions of this chapter shall be subject to similar penalties as outlined for insurance carriers. Stop-loss insurers that violate section 8(3) of this chapter are also subject to enforcement under this chapter, including fines or revocation of approval for their policies in Washington.

(5) If a provider is found to be abusing the protections of this chapter, the provider's licensing board, such as the Washington medical commission for physicians, may take disciplinary action. The insurance commissioner may refer suspected provider misconduct to the appropriate board. Sanctions may include fines, required training or monitoring, or, in extreme cases of fraud or incompetence, suspension or revocation of the provider's license. All such actions shall be taken in accordance with the due process procedures of the uniform disciplinary act, chapter 18.130 RCW.

(6) A violation of this chapter by an insurer may be deemed an unreasonable denial of a claim for benefits or an unfair practice under RCW 48.30.015.

(7) The office of the insurance commissioner shall ensure that consumers are informed of their rights under this chapter and have accessible means to report potential violations. The office of the insurance commissioner's consumer protection division shall receive and handle complaints related to wrongful denials, improper balance billing attempts, or other issues under this chapter, and shall assist in promptly resolving such issues. This may include ordering carriers to pay claims or refund money to patients as needed. The existence of the independent review and arbitration processes established by this chapter does not preclude a patient or provider from also seeking assistance from the office of the insurance commissioner or pursuing any other lawful remedies if a carrier is not following the law.

(8) The office of the insurance commissioner, in coordination with the department of health, shall provide an annual report to the

governor, the legislature, and the public on the implementation of this chapter. The report should summarize data such as the number of claims affected, the number of disputes and their outcomes under sections 6 and 7 of this act, any observed impacts on insurance premiums or health care costs, and recommendations for improvements. Beginning in 2028, the office of the insurance commissioner shall report annually on premium changes attributable to this chapter, with comparison to national trends.

(9) This chapter is intended to complement, and not conflict with, existing state and federal laws.

(a) If any state law would permit practices that are prohibited by this chapter or otherwise conflict with the provisions of this chapter, then this chapter shall supersede and govern. Any state rules or contracts executed or taking effect after this chapter must conform to the mandates of this chapter.

(b) Nothing in this chapter is intended to diminish or eliminate any protections under federal law. This chapter shall be implemented in a manner consistent with all applicable federal requirements. If any portion of this chapter would result in loss of federal funding, the insurance commissioner may temporarily suspend only those specific provisions necessary to maintain federal compliance, with immediate notice to the legislature.

NEW SECTION. **Sec.** (1) Within 180 days of the effective date of this section, the insurance commissioner shall adopt any rules necessary for the implementation and administration of this act, including establishing processes for independent reviews, arbitration of payment disputes, data reporting, and any other regulatory details needed to carry out the provisions of this act. In developing rules, the commissioner may consult with stakeholders including patient advocates, health care providers, and carriers to ensure the rules are clear and workable.

(2) All systems and procedures required by this act must be in place no later than one year after the effective date of this section. This includes the designation by the medical commission or

office of the insurance commissioner of independent review organizations or panels for medical necessity disputes, the establishment of arbitration systems for payment disputes, and the dissemination of information to carriers, providers, and consumers about the new rights and obligations under this act.

(3)(a) The provisions of sections 3 and 4 of this act shall take effect for health care services delivered on or after January 1st of the year following one full calendar year after enactment of this act.

(b) Any health plan contract issued or renewed on or after the effective date specified in (a) of this subsection shall comply with the requirements of this act. Any provision in a health plan contract or agreement that is inconsistent with this act is void and unenforceable as of the date specified in (a) of this subsection, including any plan term that purports to allow denial of medically necessary services or requires prior authorization for coverage, or any term that would permit a provider to balance bill a patient.

(4) If an insurance claim or prior authorization request is pending or under dispute as of the effective date of sections 3 and 4 of this act, the provisions of this act shall apply. If a service was denied before the effective date of sections 3 and 4 of this act but is still under appeal or reconsideration when this act takes effect, the carrier shall reassess the claim under the new rules and make any required payment to the provider, with no cost to the patient going forward.

(5) If any part of this act is found to jeopardize the state's receipt of federal funds due to a conflict with federal laws or regulations, the governor may, with the approval of the attorney general, suspend the minimum necessary portion of this act to avoid the loss of federal funds. Any such suspension shall be promptly reported to the legislature. The suspension shall only last as long as the conflict exists and shall only apply to the specific provisions necessary to avoid the loss of federal funds.

NEW SECTION. **Sec.** 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. The people declare that they would have adopted the remaining provisions of this act even if any portion of it is later declared unconstitutional or preempted. To this end, the provisions of this act are severable.

NEW SECTION. **Sec.** Sections 2 through 9 of this act constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec.** This act may be known and cited as the "Washington state mandatory health care coverage act."

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