S-0054.5

SENATE BILL 5995

State of Washington 55th Legislature 1997 Regular Session

By Senators Thibaudeau, Winsley, Fairley, Long and Kohl

Read first time 02/25/97. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to health plan coverage for serious mental illness; amending RCW 48.21.240, 48.41.110, 48.44.340, and 48.46.290; and reenacting and amending RCW 70.47.020 and 70.47.060.

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

Sec. 1. RCW 70.47.020 and 1995 c 266 s 2 and 1995 c 2 s 3 are each reenacted and amended to read as follows:

As used in this chapter:

(1) "Washington basic health plan" or "plan" means the system of enrollment and payment on a prepaid capitated basis for basic health care services, administered by the plan administrator through participating managed health care systems, created by this chapter.

(2) "Administrator" means the Washington basic health plan administrator, who also holds the position of administrator of the Washington state health care authority.

(3) "Managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the administrator and rendered by duly

licensed providers, on a prepaid capitated basis to a defined patient population enrolled in the plan and in the managed health care system.

(4) "Subsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children, not eligible for medicare, who resides in an area of the state served by a managed health care system participating in the plan, whose gross family income at the time of enrollment does not exceed twice the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services, and who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan.

(5) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children, not eligible for medicare, who resides in an area of the state served by a managed health care system participating in the plan, and who chooses to obtain basic health care coverage from a particular managed health care system, and who pays or on whose behalf is paid the full costs for participation in the plan, without any subsidy from the plan.

(6) "Subsidy" means the difference between the amount of periodic payment the administrator makes to a managed health care system on behalf of a subsidized enrollee plus the administrative cost to the plan of providing the plan to that subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

(7) "Premium" means a periodic payment, based upon gross family income which an individual, their employer or another financial sponsor makes to the plan as consideration for enrollment in the plan as a subsidized enrollee or a nonsubsidized enrollee.

(8) "Rate" means the per capita amount, negotiated by the administrator with and paid to a participating managed health care system, that is based upon the enrollment of subsidized and nonsubsidized enrollees in the plan and in that system.

(9) "Serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the diagnostic and statistical manual (DSM) IV-R.

(a) Schizophrenia;

(b) Paranoid and other psychotic disorders;

(c) Bipolar disorders (mixed, manic, and depressive);

(d) Major depressive disorders (single episode or recurrent); and

(e) Schizo-affective disorders (bipolar or depressive).

Sec. 2. RCW 70.47.060 and 1995 c 266 s 1 and 1995 c 2 s 4 are each reenacted and amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, prescription drugs and medications, mental health services, and other services that may be necessary for basic health care. In addition, the administrator may offer as basic health plan services chemical dependency services((~~, mental health services~~)) and organ transplant services; however, no one service or any combination of these ((~~three~~)) two services shall increase the actuarial value of the basic health plan benefits by more than five percent excluding inflation, as determined by the office of financial management. All subsidized and nonsubsidized enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive covered basic health care services in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care and shall include all services necessary for prenatal, postnatal, and well-child care. However, with respect to coverage for groups of subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider. The schedule of services for the condition of serious mental illness must be at least as favorable as the coverage made available for services and benefits for other major illnesses and must include the same durational limits, amount limits, deductibles, and coinsurance factors. The schedule of services shall also include a separate schedule of basic health care services for children, eighteen years of age and younger, for those subsidized or nonsubsidized enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984,

RCW 48.42.080, and such other factors as the administrator deems appropriate.

However, with respect to coverage for subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that the services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider.

(2)(a) To design and implement a structure of periodic premiums due the administrator from subsidized enrollees that is based upon gross family income, giving appropriate consideration to family size and the ages of all family members. The enrollment of children shall not require the enrollment of their parent or parents who are eligible for the plan. The structure of periodic premiums shall be applied to subsidized enrollees entering the plan as individuals pursuant to subsection (9) of this section and to the share of the cost of the plan due from subsidized enrollees entering the plan as employees pursuant to subsection (10) of this section.

(b) To determine the periodic premiums due the administrator from nonsubsidized enrollees. Premiums due from nonsubsidized enrollees shall be in an amount equal to the cost charged by the managed health care system provider to the state for the plan plus the administrative cost of providing the plan to those enrollees and the premium tax under RCW 48.14.0201.

(c) An employer or other financial sponsor may, with the prior approval of the administrator, pay the premium, rate, or any other amount on behalf of a subsidized or nonsubsidized enrollee, by arrangement with the enrollee and through a mechanism acceptable to the administrator, but in no case shall the payment made on behalf of the enrollee exceed the total premiums due from the enrollee.

(d) To develop, as an offering by all health carriers providing coverage identical to the basic health plan, a model plan benefits package with uniformity in enrollee cost-sharing requirements.

(3) To design and implement a structure of enrollee cost sharing due a managed health care system from subsidized and nonsubsidized enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, and may utilize copayments, deductibles, and other cost-sharing mechanisms, but shall not be so

costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(4) To limit enrollment of persons who qualify for subsidies so as to prevent an overexpenditure of appropriations for such purposes. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment until the administrator finds the danger no longer exists.

(5) To limit the payment of subsidies to subsidized enrollees, as defined in RCW 70.47.020. The level of subsidy provided to persons who qualify may be based on the lowest cost plans, as defined by the administrator.

(6) To adopt a schedule for the orderly development of the delivery of services and availability of the plan to residents of the state, subject to the limitations contained in RCW 70.47.080 or any act appropriating funds for the plan.

(7) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state. Contracts with participating managed health care systems shall ensure that basic health plan enrollees who become eligible for medical assistance may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

(8) To receive periodic premiums from or on behalf of subsidized and nonsubsidized enrollees, deposit them in the basic health plan operating account, keep records of enrollee status, and authorize periodic payments to managed health care systems on the basis of the number of enrollees participating in the respective managed health care systems.

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan as subsidized or nonsubsidized enrollees, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and on a reasonable schedule defined by the authority, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If, as a result of an eligibility review, the administrator determines that a subsidized enrollee's income exceeds twice the federal poverty level and that the enrollee knowingly failed to inform the plan of such increase in income, the administrator may bill the enrollee for the subsidy paid on the enrollee's behalf during the period of time that the enrollee's income exceeded twice the federal poverty level. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to reenroll in the plan.

(10) To accept applications from business owners on behalf of themselves and their employees, spouses, and dependent children, as subsidized or nonsubsidized enrollees, who reside in an area served by the plan. The administrator may require all or the substantial majority of the eligible employees of such businesses to enroll in the plan and establish those procedures necessary to facilitate the orderly enrollment of groups in the plan and into a managed health care system. The administrator may require that a business owner pay at least an amount equal to what the employee pays after the state pays its portion of the subsidized premium cost of the plan on behalf of each employee enrolled in the plan. Enrollment is limited to those not eligible for medicare who wish to enroll in the plan and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. The administrator shall adjust the amount determined to be due on behalf of or from all such enrollees whenever the amount negotiated by the administrator with the participating managed health care system or systems is modified or the administrative cost of providing the plan to such enrollees changes.

(11) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the administrator shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant.

(12) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed health care systems and to the plan. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

(13) To evaluate the effects this chapter has on private employer-based health care coverage and to take appropriate measures consistent with state and federal statutes that will discourage the reduction of such coverage in the state.

(14) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

(15) To provide, consistent with available funding, assistance for rural residents, underserved populations, and persons of color.

Sec. 3. RCW 48.21.240 and 1987 c 283 s 3 are each amended to read as follows:

(1)(a) Each group insurer providing disability insurance coverage in this state for hospital or medical care under contracts which are

issued, delivered, or renewed in this state on or after July 1, 1986, shall offer optional supplemental coverage for mental health treatment for the insured and the insured's covered dependents.

((~~(2)~~)) (b) Benefits shall be provided under the optional supplemental coverage for mental health treatment whether treatment is rendered by: ((~~(a)~~)) (i) A physician licensed under chapter 18.71 or 18.57 RCW; ((~~(b)~~)) (ii) a psychologist licensed under chapter 18.83 RCW; ((~~(c)~~)) (iii) a community mental health agency licensed by the department of social and health services pursuant to chapter 71.24 RCW; or ((~~(d)~~)) (iv) a state hospital as defined in RCW 72.23.010. The treatment shall be covered at the usual and customary rates for such treatment. The insurer, health care service contractor, or health maintenance organization providing optional coverage under the provisions of this ((~~section~~)) subsection for mental health services may establish separate usual and customary rates for services rendered by physicians licensed under chapter 18.71 or 18.57 RCW, psychologists licensed under chapter 18.83 RCW, and community mental health centers licensed under chapter 71.24 RCW and state hospitals as defined in RCW 72.23.010. However, the treatment may be subject to contract provisions with respect to reasonable deductible amounts or copayments. In order to qualify for coverage under this ((~~section~~)) subsection, a licensed community mental health agency shall have in effect a plan for quality assurance and peer review, and the treatment shall be supervised by a physician licensed under chapter 18.71 or 18.57 RCW or by a psychologist licensed under chapter 18.83 RCW.

((~~(3)~~)) (c) The group disability insurance contract may provide that all the coverage for mental health treatment is waived for all covered members if the contract holder so states in advance in writing to the insurer.

((~~(4)~~)) (d) This ((~~section~~)) subsection shall not apply to a group disability insurance contract that has been entered into in accordance with a collective bargaining agreement between management and labor representatives prior to March 1, 1987.

(2) The schedule of services for the condition of serious mental illness for each group insurer providing disability insurance coverage in this state for hospital or medical care under contracts that are issued, delivered, or renewed in this state on or after the effective date of this act must be at least as favorable as the coverage made available for services and benefits for other major illnesses and must

include the same durational limits, amount limits, deductibles, and coinsurance factors. For the purposes of this subsection, "serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the diagnostic and statistical manual (DSM) IV-R.

(a) Schizophrenia;

(b) Paranoid and other psychotic disorders;

(c) Bipolar disorders (mixed, manic, and depressive);

(d) Major depressive disorders (single episode or recurrent); and

(e) Schizo-affective disorders (bipolar or depressive).

Sec. 4. RCW 48.41.110 and 1987 c 431 s 11 are each amended to read as follows:

(1) The administrator shall prepare a brochure outlining the benefits and exclusions of the pool policy in plain language. After approval by the board of directors, such brochure shall be made reasonably available to participants or potential participants. The health insurance policy issued by the pool shall pay only usual, customary, and reasonable charges for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of illnesses, injuries, and conditions which are not otherwise limited or excluded. Eligible expenses are the usual, customary, and reasonable charges for the health care services and items for which benefits are extended under the pool policy. Such benefits shall at minimum include, but not be limited to, the following services or related items:

(a) Hospital services including serious mental illnesses covered under (r) of this subsection, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, but limited to a total of one hundred eighty inpatient days in a calendar year, and limited to thirty days inpatient care for other mental and nervous conditions, or alcohol, drug, or chemical dependency or abuse per calendar year;

(b) Professional services including surgery for the treatment of injuries, illnesses, or conditions, other than dental, which are rendered by a health care provider, or at the direction of a health care provider, by a staff of registered or licensed practical nurses, or other health care providers;

(c) The first twenty outpatient professional visits for the diagnosis or treatment of one or more mental or nervous conditions or alcohol, drug, or chemical dependency or abuse rendered during a calendar year by one or more physicians, psychologists, or community mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners;

(d) Drugs and contraceptive devices requiring a prescription;

(e) Services of a skilled nursing facility, excluding custodial and convalescent care, for not more than one hundred days in a calendar year as prescribed by a physician;

(f) Services of a home health agency;

(g) Chemotherapy, radioisotope, radiation, and nuclear medicine therapy;

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

(k) Durable medical equipment which has no personal use in the absence of the condition for which prescribed;

(l) Diagnostic x-rays and laboratory tests;

(m) Oral surgery limited to the following: Fractures of facial bones; excisions of mandibular joints, lesions of the mouth, lip, or tongue, tumors, or cysts excluding treatment for temporomandibular joints; incision of accessory sinuses, mouth salivary glands or ducts; dislocations of the jaw; plastic reconstruction or repair of traumatic injuries occurring while covered under the pool; and excision of impacted wisdom teeth;

(n) Services of a physical therapist and services of a speech therapist;

(o) Hospice services;

(p) Professional ambulance service to the nearest health care facility qualified to treat the illness or injury; ((~~and~~))

(q) Other medical equipment, services, or supplies required by physician's orders and medically necessary and consistent with the diagnosis, treatment, and condition; and

(r) On and after the effective date of this act, the schedule of services for the condition of serious mental illness must be at least as favorable as the coverage made available for services and benefits for other major illnesses and must include the same durational limits, amount limits, deductibles, and coinsurance factors. For the purposes

of this subsection, "serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the diagnostic and statistical manual (DSM) IV-R.

(i) Schizophrenia;

(ii) Paranoid and other psychotic disorders;

(iii) Bipolar disorders (mixed, manic, and depressive);

(iv) Major depressive disorders (single episode or recurrent); and

(v) Schizo-affective disorders (bipolar or depressive).

(2) The board shall design and employ cost containment measures and requirements such as, but not limited to, preadmission certification and concurrent inpatient review which may make the pool more cost-effective.

(3) The pool benefit policy may contain benefit limitations, exceptions, and reductions that are generally included in health insurance plans and are approved by the insurance commissioner; however, no limitation, exception, or reduction may be approved that would exclude coverage for any disease, illness, or injury.

Sec. 5. RCW 48.44.340 and 1987 c 283 s 4 are each amended to read as follows:

(1)(a) Each health care service contractor providing hospital or medical services or benefits in this state under group contracts for health care services under this chapter which are issued, delivered, or renewed in this state on or after July 1, 1986, shall offer optional supplemental coverage for mental health treatment for the insured and the insured’s covered dependents.

((~~(2)~~)) (b) Benefits shall be provided under the optional supplemental coverage for mental health treatment whether treatment is rendered by: ((~~(a)~~)) (i) A physician licensed under chapter 18.71 or 18.57 RCW; ((~~(b)~~)) (ii) a psychologist licensed under chapter 18.83 RCW; ((~~(c)~~)) (iii) a community mental health agency licensed by the department of social and health services pursuant to chapter 71.24 RCW; or ((~~(d)~~)) (iv) a state hospital as defined in RCW 72.23.010. The treatment shall be covered at the usual and customary rates for such treatment. The insurer, health care service contractor, or health maintenance organization providing optional coverage under the provisions of this ((~~section~~)) subsection for mental health services may establish separate usual and customary rates for services rendered by physicians licensed under chapter 18.71 or 18.57 RCW, psychologists

licensed under chapter 18.83 RCW, and community mental health centers licensed under chapter 71.24 RCW and state hospitals as defined in RCW 72.23.010. However, the treatment may be subject to contract provisions with respect to reasonable deductible amounts or copayments. In order to qualify for coverage under this ((~~section~~)) subsection, a licensed community mental health agency shall have in effect a plan for quality assurance and peer review, and the treatment shall be supervised by a physician licensed under chapter 18.71 or 18.57 RCW or by a psychologist licensed under chapter 18.83 RCW.

((~~(3)~~)) (c) The group contract for health care services may provide that all the coverage for mental health treatment is waived for all covered members if the contract holder so states in advance in writing to the health care service contractor.

((~~(4)~~)) (d) This ((~~section~~)) subsection shall not apply to a group health care service contract that has been entered into in accordance with a collective bargaining agreement between management and labor representatives prior to March 1, 1987.

(2) The schedule of services for the condition of serious mental illness for each health care service contractor providing disability insurance coverage in this state for hospital or medical care under contracts that are issued, delivered, or renewed in this state on or after the effective date of this act must be at least as favorable as the coverage made available for services and benefits for other major illnesses and must include the same durational limits, amount limits, deductibles, and coinsurance factors. For the purposes of this subsection, "serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the diagnostic and statistical manual (DSM) IV-R.

(a) Schizophrenia;

(b) Paranoid and other psychotic disorders;

(c) Bipolar disorders (mixed, manic, and depressive);

(d) Major depressive disorders (single episode or recurrent); and

(e) Schizo-affective disorders (bipolar or depressive).

Sec. 6. RCW 48.46.290 and 1987 c 283 s 5 are each amended to read as follows:

(1)(a) Each health maintenance organization providing services or benefits for hospital or medical care coverage in this state under group health maintenance agreements which are issued, delivered, or

renewed in this state on or after July 1, 1986, shall offer optional supplemental coverage for mental health treatment to the enrolled participant and the enrolled participant's covered dependents.

((~~(2)~~)) (b) Benefits shall be provided under the optional supplemental coverage for mental health treatment whether treatment is rendered by the health maintenance organization or the health maintenance organization refers the enrolled participant or the enrolled participant's covered dependents for treatment to: ((~~(a)~~)) (i) A physician licensed under chapter 18.71 or 18.57 RCW; ((~~(b)~~)) (ii) a psychologist licensed under chapter 18.83 RCW; ((~~(c)~~)) (iii) a community mental health agency licensed by the department of social and health services pursuant to chapter 71.24 RCW; or ((~~(d)~~)) (iv) a state hospital as defined in RCW 72.23.010. The treatment shall be covered at the usual and customary rates for such treatment. The insurer, health care service contractor, or health maintenance organization providing optional coverage under the provisions of this ((~~section~~)) subsection for mental health services may establish separate usual and customary rates for services rendered by physicians licensed under chapter 18.71 or 18.57 RCW, psychologists licensed under chapter 18.83 RCW, and community mental health centers licensed under chapter 71.24 RCW and state hospitals as defined in RCW 72.23.010. However, the treatment may be subject to contract provisions with respect to reasonable deductible amounts or copayments. In order to qualify for coverage under this ((~~section~~)) subsection, a licensed community mental health agency shall have in effect a plan for quality assurance and peer review, and the treatment shall be supervised by a physician licensed under chapter 18.71 or 18.57 RCW or by a psychologist licensed under chapter 18.83 RCW.

((~~(3)~~)) (c) The group health maintenance agreement may provide that all the coverage for mental health treatment is waived for all covered members if the contract holder so states in advance in writing to the health maintenance organization.

((~~(4)~~)) (d) This ((~~section~~)) subsection shall not apply to a group health maintenance agreement that has been entered into in accordance with a collective bargaining agreement between management and labor representatives prior to March 1, 1987.

(2) The schedule of services for the condition of serious mental illness for each health maintenance organization providing disability insurance coverage in this state for hospital or medical care under

contracts that are issued, delivered, or renewed in this state on or after the effective date of this act must be at least as favorable as the coverage made available for services and benefits for other major illnesses and must include the same durational limits, amount limits, deductibles, and coinsurance factors. For the purposes of this subsection, "serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the diagnostic and statistical manual (DSM) IV-R.

(a) Schizophrenia;

(b) Paranoid and other psychotic disorders;

(c) Bipolar disorders (mixed, manic, and depressive);

(d) Major depressive disorders (single episode or recurrent); and

(e) Schizo-affective disorders (bipolar or depressive).

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