S-0420.3

SENATE BILL 5211

State of Washington 57th Legislature 2001 Regular Session

By Senators Thibaudeau, Long, Spanel, Winsley, B. Sheldon, Swecker, Fraser, Kohl-Welles, Kline, Carlson, Eide, Rasmussen, Fairley, McCaslin, Franklin, Haugen, Oke, Costa, McAuliffe, Prentice, Jacobsen, Constantine and Regala

Read first time 01/16/2001. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to comparable mental health benefits; amending RCW 48.21.240, 48.44.340, and 48.46.290; adding a new section to chapter 41.05 RCW; adding a new section to chapter 48.21 RCW; adding a new section to chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; adding a new section to chapter 70.47 RCW; creating a new section; and repealing RCW 48.21.240, 48.44.340, and 48.46.290.

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

NEW SECTION. **Sec. 1.** Children are our future. We spend millions of dollars educating Washington state children to ensure that their future is as bright as possible. But, in order for our children to learn, they must be healthy. They need strong minds as well as strong bodies. According to Washington state data, one or two children in every Washington classroom is suffering from serious emotional and behavioral problems. Suicide is the second leading cause of death among adolescents.

The legislature finds that without comparable mental health benefits for children, families are often unable to pay for needed services. As a result, many children do without the treatment they

need, which significantly impacts their ability to learn, and their opportunities for a productive future.

For adults national data suggest that in any given year one in ten Americans experiences a mental disorder, and one in five Americans will have a mental disorder during his or her lifetime that requires treatment.

The current disparity between coverage of mental health services and coverage for medical/surgical services places Washington state citizens at unreasonable financial risk. Most insurance policies have no stop loss for mental health costs. Not only does this create a significant barrier to appropriate treatment, it can also lead to severe financial loss.

The legislature finds that the costs for leaving mental disorders untreated or undertreated are enormous, and often include: Decreased job productivity, increased job turnover, loss of employment, increased disability costs, deteriorating school performance, increased use of other health care services, treatment delays leading to more costly treatments, suicide, family breakdown and impoverishment, and institutionalization, whether in hospitals, juvenile detention, jails, or prisons.

Therefore, the legislature intends to require comparable mental health coverage for children and catastrophic mental health coverage for adults under the terms of this act.

NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05 RCW to read as follows:

(1) For the purpose of this section, "mental health services" means: (a) Outpatient and inpatient services provided to treat any of the mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders on the effective date of this section, or such subsequent date as may be provided by the authority by rule, consistent with the purposes of chapter . . ., Laws of 2001 (this act), except V codes and those codes defining substance abuse disorders, 291.0 through 292.9 and 303.0 through 305.9 as of the effective date of this section; and (b) prescription drugs, if the plan contract otherwise includes coverage for prescription drugs.

(2) Each health plan offered to public employees and their covered dependents under this chapter that is not subject to the provisions of

Title 48 RCW and is established or renewed after July 1, 2002, and that provides coverage for hospital or medical care, shall provide coverage for mental health services as follows:

(a) For children, as that term is defined in the policy, the health plan shall only impose treatment limitations or financial requirements on coverage for mental health services, if the same limitations or requirements are imposed on coverage for medical and surgical services. This includes but is not limited to copays, cost sharing, annual or lifetime dollar limits, outpatient visit limits, outpatient day limits, and inpatient limits. Wellness and preventive services that are reimbursed at one hundred percent without deductible, coinsurance, or other cost sharing are excluded from this comparison.

(i) If a plan requires annual deductibles, a separate deductible for mental health services is allowed. The annual deductible for mental health services may not be greater than the annual deductible for medical and surgical services. This does not preclude a plan with pharmacy benefits from establishing a separate deductible for those benefits if it applies to all prescription drugs.

(ii) If a plan has maximum out-of-pocket limits, one single annual maximum out-of-pocket limit for medical and surgical and mental health services is required. This subsection (2)(a)(ii) does not preclude a plan with pharmacy benefits from excluding prescription drugs from the out-of-pocket limit as long as all prescription drugs are treated equivalently.

(b) For adults, the provisions of subsection (1)(a)(i) and (ii) of this section apply, except that plans are allowed to have differential copays or coinsurance requirements, which means that plans may have a greater copay or coinsurance for mental health services than for medical and surgical services. However, the copay or coinsurance for mental health services may be no greater than as of January 1, 2001.

(3) Each health plan is required to use those managed care tools necessary for the cost-effective management of this act to include but not be limited to the use of preauthorization screening prior to authorizing the delivery of mental health services or the requirement that mental health services must be medically necessary as determined by its medical director or his or her designee. Managed care requirements for mental health services may be different from those for medical and surgical services.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.21 RCW to read as follows:

(1) For the purpose of this section, "mental health services" means: (a) Outpatient and inpatient services provided to treat any of the mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders on the effective date of this section or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter . . ., Laws of 2001 (this act), except V codes and those codes defining substance abuse disorders, 291.0 through 292.9 and 303.0 through 305.9 as of the effective date of this section; and (b) prescription drugs, if the insurance contract otherwise includes coverage for prescription drugs.

(2) All group disability insurance contracts and blanket disability insurance contracts providing health care services to groups with fifty or more persons, issued or renewed after July 1, 2002, and for groups with at least twenty-five persons but fewer than fifty persons, issued or renewed after July 1, 2003, that provide coverage for hospital or medical care shall provide coverage for mental health services as follows:

(a) For children as that term is defined in the policy, the contracts shall only impose treatment limitations or financial requirements on coverage for mental health services, if the same limitations or requirements are imposed on coverage for medical and surgical services. This includes but is not limited to copays, cost sharing, annual or lifetime dollar limits, outpatient visit limits, outpatient day limits, and inpatient limits. Wellness and preventive services that are reimbursed at one hundred percent without deductible, coinsurance, or other cost sharing are excluded from this comparison.

(i) If a contract requires annual deductibles, a separate annual deductible for mental health services is allowed. The annual deductible for mental health services may not be greater than the annual deductible for medical and surgical services. This does not preclude a plan with pharmacy benefits from establishing a separate deductible for those benefits if it applies to all prescription drugs.

(ii) If a plan has maximum out-of-pocket limits, one single annual maximum out-of-pocket limit for medical and surgical and mental health services is required. This subsection (2)(a)(ii) does not preclude a plan with pharmacy benefits from excluding prescription drugs from the

out-of-pocket limit as long as all prescription drugs are treated equivalently.

(b) For adults, subsection (1)(a)(i) and (ii) of this section apply, except that insurance contracts are allowed to have differential copays or coinsurance requirements, which means that contracts may have a greater copay or coinsurance for mental health services than for medical and surgical services. However, the copay or coinsurance for mental health services may be no greater than as of January 1, 2001.

(3) This section does not prohibit an insurer from requiring the use of preauthorization screening prior to authorizing the delivery of mental health services or the requirement that mental health services must be medically necessary as determined by its medical director or his or her designee or other managed care tools. Managed care requirements for mental health services may be different from those for medical and surgical services.

NEW SECTION. **Sec. 4.** A new section is added to chapter 48.44 RCW to read as follows:

(1) For the purpose of this section, "mental health services" means: (a) Outpatient and inpatient services provided to treat any of the mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders on the effective date of this section, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter . . ., Laws of 2001 (this act), except V codes and those codes defining substance abuse disorders, 291.0 through 292.9 and 303.0 through 305.9 as of the effective date of this section; and (b) prescription drugs, if the contract otherwise includes coverage for prescription drugs.

(2) All health care service contracts for groups with fifty or more persons, issued or renewed after July 1, 2002, and for groups with at least twenty-five persons but fewer than fifty persons, issued or renewed after July 1, 2003, that provide coverage for hospital or medical care shall provide coverage for mental health services as follows:

(a) For children as that term is defined in the contract, the contract shall only impose treatment limitations or financial requirements on coverage for mental health services, if the same limitations or requirements are imposed on coverage for medical and

surgical services. This includes but is not limited to copays, cost sharing, annual or lifetime dollar limits, outpatient visit limits, outpatient day limits, and inpatient limits. Wellness and preventive services that are reimbursed at one hundred percent without deductible, coinsurance, or other cost sharing are excluded from this comparison.

(i) If a contract requires annual deductibles, a separate deductible for mental health services is allowed. The annual deductible for mental health services may not be greater than the annual deductible for medical and surgical services. This does not preclude a plan with pharmacy benefits from establishing a separate deductible for those benefits if it applies to all prescription drugs.

(ii) If a plan has maximum out-of-pocket limits, one single annual maximum out-of-pocket limit for medical and surgical and mental health services is required. This subsection (2)(a)(ii) does not preclude a plan with pharmacy benefits from excluding prescription drugs from the out-of-pocket limit as long as all prescription drugs are treated equivalently.

(b) For adults, the provisions of subsection (1)(a)(i) and (ii) of this section apply, except that contracts are allowed to have differential copays or coinsurance requirements, which means that contracts may have a greater copay or coinsurance for mental health services than for medical and surgical services. However, the copay or coinsurance for mental health services may be no greater than as of January 1, 2001.

(3) This section does not prohibit a health care service contractor from requiring the use of preauthorization screening prior to authorizing the delivery of mental health services or the requirement that mental health services must be medically necessary as determined by its medical director or his or her designee or other managed care tools. Managed care requirements for mental health services may be different from those for medical and surgical services.

NEW SECTION. **Sec. 5.** A new section is added to chapter 48.46 RCW to read as follows:

(1) For the purpose of this section, "mental health services" means: (a) Outpatient and inpatient services provided to treat any of the mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders on the effective date of this section, or such subsequent

date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter . . ., Laws of 2001 (this act), except V codes and those codes defining substance abuse disorders, 291.0 through 292.9 and 303.0 through 305.9 as of the effective date of this section; and (b) prescription drugs, if the plan contract otherwise includes coverage for prescription drugs.

(2) All health benefit plans offered by health maintenance organizations to groups with fifty or more persons, issued or renewed after July 1, 2002, and for groups with at least twenty-five persons but fewer than fifty persons, issued or renewed after July 1, 2003, that provide coverage for hospital or medical care shall provide coverage for mental health services as follows:

(a) For children as that term is defined in the plan, the plan shall only impose treatment limitations or financial requirements on coverage for mental health services, if the same limitations or requirements are imposed on coverage for medical and surgical services. This includes but is not limited to copays, cost sharing, annual or lifetime dollar limits, outpatient visit limits, outpatient day limits, and inpatient limits. Wellness and preventive services that are reimbursed at one hundred percent without deductible, coinsurance, or other cost sharing are excluded from this comparison.

(i) If a contract requires annual deductibles, a separate deductible for mental health services is allowed. The annual deductible for mental health services may not be greater than the annual deductible for medical and surgical services. This does not preclude a plan with pharmacy benefits from establishing a separate deductible for those benefits if it applies to all prescription drugs.

(ii) If a plan has maximum out-of-pocket limits, one single annual maximum out-of-pocket limit for medical and surgical and mental health services is required. This subsection (2)(a)(ii) does not preclude a plan with pharmacy benefits from excluding prescription drugs from the out-of-pocket limit as long as all prescription drugs are treated equivalently.

(b) For adults, subsection (1)(a)(i) and (ii) of this section apply, except that health maintenance organizations are allowed to have differential copays or coinsurance requirements, which means that they may have a greater copay or coinsurance for mental health services than for medical/surgical services. However, the copay or coinsurance for

mental health services may be no greater than what was in existence on January 1, 2001.

(3) This section does not prohibit a health maintenance organization from requiring the use of preauthorization screening prior to authorizing the delivery of mental health services or the requirement that mental health services must be medically necessary as determined by its medical director or his or her designee or other managed care tools. Managed care requirements for mental health services may be different from those for medical/surgical services.

NEW SECTION. **Sec. 6.** A new section is added to chapter 70.47 RCW to read as follows:

Notwithstanding the provisions of RCW 70.47.060, this section governs the provision of mental health services to subsidized enrollees in the basic health plan.

(1) For the purpose of this section, "mental health services" means: (a) Outpatient and inpatient services provided to treat any of the mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders on the effective date of this section, or such subsequent date as may be provided by the Washington state health care authority by rule, consistent with the purposes of chapter . . ., Laws of 2001 (this act), except V codes and those codes defining substance abuse disorders, 291.0 through 292.9 and 303.0 through 305.9 as of the effective date of this section; and (b) prescription drugs, if the plan contract otherwise includes coverage for prescription drugs.

(2) After July 1, 2003, the basic health plan shall provide coverage for mental health services to subsidized children and adults as follows:

(a) For children as that term is defined by the basic health plan, the plan shall only impose treatment limitations or financial requirements on coverage for mental health services, if the same limitations or requirements are imposed on coverage for medical and surgical services. This includes but is not limited to copays, cost sharing, annual or lifetime dollar limits, outpatient visit limits, outpatient day limits, and inpatient limits. Wellness and preventive services that are reimbursed at one hundred percent without deductible, coinsurance, or other cost sharing are excluded from this comparison.

(i) If a contract requires annual deductibles, a separate deductible for mental health services is allowed. The annual deductible for mental health services may not be greater than the annual deductible for medical and surgical services. This does not preclude a plan with pharmacy benefits from establishing a separate deductible for those benefits if it applies to all prescription drugs.

(ii) If a plan has maximum out-of-pocket limits, one single annual maximum out-of-pocket limit for medical and surgical and mental health services is required. This subsection (2)(a)(ii) does not preclude a plan with pharmacy benefits from excluding prescription drugs from the out-of-pocket limit as long as all prescription drugs are treated equivalently.

(b) For adults, subsection (1)(a)(i) and (ii) of this section apply, except the plan is allowed to have differential copays or coinsurance requirements, which means that contracts may have a greater copay or coinsurance for mental health services than for medical and surgical services. However, the copay or coinsurance for mental health services may be no greater than as of January 1, 2001.

(3) The plan is required to use those managed care tools necessary for the cost-effective management of this act to include but not be limited to the use of preauthorization screening prior to authorizing the delivery of mental health services and the requirement that mental health services must be medically necessary as determined by its medical director or his or her designee. Managed care requirements for mental health services may be different from those for medical and surgical services.

Sec. 7. RCW 48.21.240 and 1987 c 283 s 3 are each amended to read as follows:

(1) 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) Benefits shall be provided under the optional supplemental coverage for mental health treatment whether treatment is rendered by: (a) A physician licensed under chapter 18.71 or 18.57 RCW; (b) a psychologist licensed under chapter 18.83 RCW; (c) a community mental health agency licensed by the department of social and health services

pursuant to chapter 71.24 RCW; or (d) 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 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, 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) 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) This section 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.

(5) This section does not apply to groups with fifty or more persons beginning July 1, 2002.

Sec. 8. RCW 48.44.340 and 1987 c 283 s 4 are each amended to read as follows:

(1) 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) Benefits shall be provided under the optional supplemental coverage for mental health treatment whether treatment is rendered by: (a) A physician licensed under chapter 18.71 or 18.57 RCW; (b) a psychologist licensed under chapter 18.83 RCW; (c) a community mental

health agency licensed by the department of social and health services pursuant to chapter 71.24 RCW; or (d) 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 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, 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) 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) This section 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.

(5) This section does not apply to groups with fifty or more persons beginning July 1, 2002.

Sec. 9. RCW 48.46.290 and 1987 c 283 s 5 are each amended to read as follows:

(1) 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) 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) A physician licensed under chapter 18.71 or 18.57 RCW; (b) a psychologist licensed under chapter 18.83 RCW; (c) a community mental health agency licensed by the department of social and health services pursuant to chapter 71.24 RCW; or (d) 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 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, 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) 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) This section 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.

(5) This section does not apply to groups with fifty or more persons beginning July 1, 2002.

NEW SECTION. **Sec. 10.** The following acts or parts of acts are each repealed, effective July 1, 2003:

(1) RCW 48.21.240 (Mental health treatment, optional supplemental coverage--Waiver) and 1987 c 283 s 3, 1986 c 184 s 2, & 1983 c 35 s 1;

(2) RCW 48.44.340 (Mental health treatment, optional supplemental coverage--Waiver) and 1987 c 283 s 4, 1986 c 184 s 3, & 1983 c 35 s 2; and

(3) RCW 48.46.290 (Mental health treatment, optional supplemental coverage--Waiver) and 1987 c 283 s 5, 1986 c 184 s 4, & 1983 c 35 s 3.

NEW SECTION. **Sec. 11.** 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.

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