HOUSE BILL REPORT
HB 1828

As Reported by House Committee On:
Financial Institutions & Insurance
Appropriations

Title: An act relating to mental health parity.

Brief Description: Requiring that insurance coverage for mental health services be at parity with medical and surgical services.

Sponsors: Representatives Schual-Berke, Pflug, Cody, Hankins, Linville, Skinner, Cooper, Alexander, Ruderman, Delvin, McDermott, Ericksen, Campbell, Santos, Haigh, Quall, Upthegrove, Simpson, Hatfield, Kessler, Conway and Kenney.

Brief History:
Committee Activity:
Financial Institutions & Insurance: 2/21/03, 3/3/03 [DPS];
Appropriations: 2/3/04, 2/10/04 [DP2S(w/o sub FII)].

Brief Summary of Second Substitute Bill

- Requires group health insurance plans to provide the same coverage for mental health services as that provided for medical and surgical services.
- Allows the mental health parity requirements to be gradually phased in over a five-year period.
- Exempts certain types of mental health services from mandatory coverage provisions.
- Allows health plans to utilize managed care with respect to mental health services.
- Exempts small businesses with 50 employees or less from mental health parity requirements.

HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS & INSURANCE

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 7 members: Representatives Schual-Berke, Chair; Simpson, Vice Chair; Cairnes, Cooper, Hatfield, Hunter and Santos.

Minority Report: Do not pass. Signed by 4 members: Representatives Benson, Ranking Minority Member; Newhouse, Assistant Ranking Minority Member; Carrell and Roach.

Staff: Thamas Osborn (786-7129).

Background:

State law does not require health insurers to provide mental health coverage, nor does it impose specific mandates on the level of coverage that must be provided by those insurers who do offer such coverage. The law does require, however, that health carriers providing group coverage to employers with more than 25 employees offer optional supplemental coverage for mental health treatment, which can be waived at the request of the employer.

The administrator of the Basic Health Plan (BHP) is authorized to offer mental health services under the BHP as long as those services, along with chemical dependency and organ transplant services, do not increase the actuarial value of BHP benefits by more than 5 percent.

Washington State Health Care Authority (Chapter 41.05 RCW): The Washington State Health Care Authority (HCA) is the state agency that administers health care benefits for state employees, as well as for low income residents through the BHP. The HCA oversees state employee health insurance programs provided by various private health plans (e.g., Group Health, Premera Blue Cross, Regence, etc.) as well as the Uniform Medical Plan.

Group and blanket disability insurance carriers (Chapter 48.21 RCW): This category of insurers encompasses most of the traditional private insurance companies, such as Prudential, Mutual of Omaha, and Aetna, to name a few. They typically provide "fee for service" coverage as opposed to managed care. Group and blanket disability insurance carriers are regulated by the Office of the Insurance Commissioner (OIC).

Health care services contractors (Chapter 48.44 RCW): Health care services contractors provide managed health care coverage via contractual arrangements with a network of selected providers. Premera Blue Cross and Regence are examples of health care service contractors that are doing business in Washington and are regulated by the OIC.

Health maintenance organizations (Chapter 48.46 RCW): A health maintenance organization (HMO), such as Group Health, is another type of managed health care provider that is regulated by the OIC. HMOs employ their own health care professionals and operate their own clinics.

Optional supplemental mental health coverage: Group and blanket disability insurance plans, health care services contractors, and HMOs are all required to *offer* optional, supplemental mental health treatment coverage for insureds and covered dependents. The coverage must be offered at the "usual and customary rates for such treatment" and is subject to other specified requirements and conditions.

Diagnostic and Statistical Manual of Mental Disorders (DSM): The DSM is a manual published by the American Psychiatric Association that covers all recognized mental health

disorders affecting both children and adults. It lists the factors known to cause these disorders, presents pertinent statistics, and cites research concerning optimal treatment approaches. The DSM is considered to be the standard reference for mental health professionals who make psychiatric diagnoses.

Summary of Substitute Bill:

I. Introduction

Overview: Using a gradual five-year phase-in, the bill requires specified categories of group health insurance plans to provide a level of coverage for mental health services that is equal to the coverage provided for medical and surgical services. Once the mental health parity requirements are fully implemented in 2008, limitations on mental health services may be imposed by an insurance plan only if the same limitations are imposed on medical and surgical services.

This mental health parity requirement applies to five categories of group health insurance plans:

- plans administered by the HCA on behalf of state employees;
- group and blanket disability plans;
- coverage provided by health care services contractors;
- coverage provided by health maintenance organizations; and
- Washington Basic Health Plan.

Small business exemption: The mental health parity requirements for each type of plan are largely identical and are subject to the same structured phase-in. However, the insurance coverage provided to owners of small businesses with 50 employees or less is exempt from the mental health parity requirements set forth in the bill.

II. Covered Mental Health Services

"Mental health services" defined: The required mental health services include "medically necessary inpatient and outpatient services provided to treat mental disorders" as listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is published by the American Psychiatric Association. The determination of whether or not a mental health service is "medically necessary" in a particular case is subject to the discretion of the medical director of the health plan. However, this discretion is not unbridled, insofar as health plans are required to apply a medical necessity standard for mental health care that is comparable to that applied for medical and surgical services.

Exempted mental health services: Certain types of mental health treatment and related services are exempted from the bill, including:

- treatment for sexual dysfunction disorders;
- treatment for disorders related to substance abuse;

- treatment for life transition problems (family/marital issues, occupational/academic problems, etc.);
- residential treatment and custodial care;
- court ordered treatment (unless medically necessary); and
- skilled nursing facility services and home health care.

Managed care: The HCA and health benefit plans may utilize managed care techniques in providing the mental health services required under the bill.

III. Five-Year Phase-in

Overview of phase-in: Parity between mental health, medical, and surgical services is achieved in three phases that occur over a five-year period, beginning on July 1, 2003. The phases are both gradual and cumulative. Each succeeding phase incorporates the coverage requirements of the preceding phase and, thus, incrementally adds coverage requirements until January 1, 2008, when all of the parity provisions will be in effect.

Phase 1 – For health benefit plans established or renewed on or after July 1, 2003: (1) The copayment for mental health services may not exceed the copayment for medical/surgical services provided under the plan. (2) Parity must also be provided with respect to prescription drug coverage.

Phase 2 – For health benefit plans established or renewed on or after January 1, 2006: If the health insurance plan imposes a maximum out of pocket limit or stop loss, the same limit or stop loss must apply to medical, surgical, and mental health services. (Phase 2 also incorporates the parity requirements implemented in phase 1.)

Phase 3 – For health benefit plans established or renewed on or after July 1, 2008: (1) If the health insurance plan imposes a deductible, it must be a *single* deductible covering medical, surgical, and mental health services. (2) Any treatment limitations or financial requirements must be the same for mental health, medical, or surgical services. (Phase 3 also incorporates the parity requirements implemented in phase 1 and phase 2.)

IV. Other Provisions

Optional supplemental mental health coverage: Health insurance plans are not required to offer optional supplemental mental health coverage to groups that are covered by the mental health parity provisions set forth in the act.

Rule-making authority: The Insurance Commissioner, the administrator of the State Health Care Authority, and the administrator of the Basic Health Plan are each granted authority to adopt rules necessary to implement the act.

Substitute Bill Compared to Original Bill:

The substitute makes the following changes to the original bill:

- Certain types of mental health treatment and related services are exempted from the bill, including: (1) treatment for sexual dysfunction disorders; (2) skilled nursing facility services; and (3) home health care.
- Court ordered mental health treatment may be covered by the parity provisions in the bill, but only if the health plan determines such treatment to be medically necessary.
- Clarifies that on or after July 1, 2008, mental health services shall be included with medical or surgical services for the purpose of meeting any deductible requirement.
- A new section is added authorizing the Health Care Authority to manage the delivery of mental health services and requiring the administrator to consider specified care management techniques.
- Health benefit plans are given the authority to *manage* mental health services.
- The small business exemption is revised so that it applies to businesses with 50 employees or less throughout all three parts of the parity implementation phase-in. The third phase, beginning on July 1, 2008, is changed from applying to businesses with more than 25 employees, to businesses with more than 50 employees.
- The types of mental health providers authorized to provide optional supplemental mental health coverage is expanded and updated.

Appropriation: None.

Fiscal Note: Requested on February 13, 2003.

Effective Date of Substitute Bill: The bill contains an emergency clause and takes effect immediately.

Testimony For: (Original Bill) There is a great unmet need for mental health services that are not covered by most health plans. Financial barriers prevent millions of persons from receiving needed treatment. Low-income persons are particularly vulnerable, since many with serious mental health problems are completely untreated. Even those with some insurance coverage have difficulty getting the services they need, due to treatment restrictions and high copays. Many elderly persons have untreated mental illnesses, which creates problems in finding residential placements for them. A large percentage of incarcerated persons have untreated mental illnesses, thus affordable treatment services would certainly reduce the populations of our jails. Mental health problems are the leading cause of hospitalization of young children, and suicide accounts for a large percentage of teenage deaths. One in five persons experience a degree of anxiety or depression that interferes with daily functioning. In the vast majority of cases, mental illness stems from physiological disorders of the brain and, these individuals should be provided with treatment on a par with any other type of physical problem.

The costs of implementing a mental health parity requirement would be more than offset by the savings it would create and would also improve the lives of millions of people. Many large, self-insured corporations have implemented mental health parity and have discovered that it saves money by decreasing absenteeism and increasing productivity. Such corporations

have also experienced a reduction in their insurance costs after introducing mental health parity. Historical experience in other states indicates that parity typically increases insurance premiums by very little. When Maryland introduced a mental health parity requirement, insurance rates increased by only .6 percent, whereas New Hampshire experienced no increase in insurance costs. Mental health disorders are more prevalent than cancer or heart disease and the cost of hospitalization is huge. Improving access to treatment would greatly reduce such costs.

Testimony Against: The bill creates a mandate that will unduly burden small businesses. Large increases in insurance costs are already a huge problem for many businesses, and the bill will only add to the problem. There are already 88 sections in Washington law that mandate what must be included in employer health insurance policies. This bill will only add to what is already a huge regulatory burden that threatens the ability of some businesses to provide employee health insurance. Furthermore, mandated benefits are inherently unfair, because they force people to pay for them whether they want them or not. What the public wants is better access to basic health care, and this bill will decrease such access because the mandate will make basic insurance more expensive. If mental health parity is truly a cost effective option, then let people freely choose whether they want it and let the marketplace decide if this is the direction we should go. The cost of mental health parity may harm businesses and cause lower wages.

The bill has technical problems insofar as it is inconsistent with federal law with respect to how small employers are treated under the provisions of the bill. Furthermore, federal law prohibits the state regulation of employers or unions with self-insurance programs. Accordingly, due to federal preemption, 50 percent of the employees in Washington would not be covered by the bill.

(With concerns) (Original bill) The Insurance Commissioner is committed to the comprehensive reform of entire health insurance system. While this bill is well-intentioned, it is inconsistent with the goal of comprehensive reform. Furthermore, the bill creates a mandate.

Testified: (In support) Representative Schual-Berke, prime sponsor; Randy Revelle, Washington Coalition for Insurance Parity; Lucy Homans, Washington State Psychological Association; Heidi Grimes, Farrell Adrian, and Frank Jose, National Association for Mental Illness of Greater Seattle; Douglas Green, M.D., Washington State Medical Association; Len McComb, Washington State Hospital Association; Brad Boswell, National Association for Mental Illness of Washington; Donna Obermeyer, Washington State Special Education Coalition; Phil Jordan, Washington Protection & Advocacy System; Sherry Appleton, League of Women Voters of Washington; Kristen Rogers, National Association of Social Work; Jim Legaz, Washington Catholic Conference; Peter Lukevich, Washington Partners in Crisis; Jim Goche and Christos Dagadakis, Washington State Psychiatric Association; Eleanor Owen, Older Women's League; Sherwin Cotler, M.D.; Ellie Menzies, Service Employee's International Union; Delight Roberts, The Children's Alliance; Scott Edwards, Washington Association of Marriage and Family Therapy; Herb Larson, National Association for Mental

Illness of Thurston and Mason Counties; and Jesus Rodriguez, Consejo Counseling and Referral Service.

(Opposed) Mel Sorenson, Employer Healthcare Coalition; Richard Warner, Citizens' Commission on Human Rights; Gary Smith, Independent Businesses Association; and Carolyn Logue, National Federation of Independent Businesses.

(With concerns) Bill Daley, Office of the Insurance Commissioner.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Financial Institutions & Insurance. Signed by 15 members: Representatives Sommers, Chair; Fromhold, Vice Chair; Cody, Conway, Dunshee, Grant, Hunter, Kagi, Kenney, Kessler, Linville, McIntire, Miloscia, Ruderman and Schual-Berke.

Minority Report: Do not pass. Signed by 12 members: Representatives Sehlin, Ranking Minority Member; Pearson, Assistant Ranking Minority Member; Alexander, Anderson, Boldt, Buck, Chandler, Clements, Cox, McDonald, Sump and Talcott.

Staff: David Pringle (786-7310).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Financial Institutions & Insurance:

The effective dates for the phase in of mental health parity requirements for new or renewed plans are moved forward one year in the Appropriations substitute bill. The date that mental health co-payments or co-insurance requirements may be no more than for medical services is changed from July 1, 2003, to July 1, 2004. The date for mental health maximum out-of-pocket limits to be no more than for medical services is changed from July 1, 2006, to July 1, 2007. The date for treatment limitations or any other financial requirements on coverage to be no different for mental health than for other medical services is changed from July 1, 2008, to July 1, 2009.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Second Substitute Bill: The bill contains an emergency clause and takes effect immediately.

Testimony For: The time has come for this kind of coverage. The fiscal note does not encapsulate the social benefits of this bill. Many companies already offer these benefits at parity. State workers already enjoy most of these benefits, and so should everyone else. The cost of the bill has been limited by excluding some benefit coverage, and permitting management techniques. The lack of parity affects the state, particularly children. It will reduce costs to the state and business, such as imprisonment. Parity requirements have already

been passed in 33 states and have found the change cost-effective. Jail costs are avoidable with more treatment of mental illness. Crisis and loss of life can be avoided with proper treatment. This benefit must be mandated because no individual carrier will offer this unless all are required to do so. As a parent of a mentally ill 10-year old who became suicidal, I had great trouble finding a doctor. With coverage limited to 12 outpatient days, and only nine in-hospital days, there were $100,000 in uncovered expenses. We were advised to deplete our assets and go on Medicaid. I would rather just have insurance coverage.

Testimony Against: These are valuable benefits, but the cost in addition to the other 88 sections of mandates already required is too much. We can only get premiums down by increasing, not decreasing copays, deductibles, etc. Employers need maximum flexibility in choosing benefits - not to have more mandated onto employee plans. The result too often is that employees get nothing. Costs in this bill are deferred a long time, creating an enormous bow wave into the future. If this is important, pay for it now. The state costs alone understate the total costs of the change. Many of the small businesses of the state are outside of the scope of the bill, but we don't think that this can be done outside of a consideration of other state coverage mandates. In 2003 an additional 2 percent of Washington employers dropped health insurance coverage for their employees. This will also discourage other insurers from coming into the state. This will cost business $250 million per year. The underlying assumptions about social benefits from this are unsubstantiated, and less than 1 percent of mental health patients in treatment are recovering.

Persons Testifying: (In support) Representative Schual-Berke, prime sponsor; Sean Corry, Washington State Partners in Crisis; Stacy Shown; Peter Lukevich, Washington State Partners in Crisis; Greg Simon, Washington Mental Health Parity Coalition; Lucy Homans, Washington State Psychological Association; Len McComb, Washington State Hospital Association; Eleanor Owen, King County Mental Health Board; Randy Revelle, Washington Coalition for Insurance Parity; and Jim Goche, Washington State Psychiatric Association.

(Opposed) Richard Warner, Citizens Commission on Human Rights; Gary Smith, Independent Business Association; Carolyn Logue, National Federation of Independent Business; and Mel Sorensen, Employer Healthcare Coalition.

Persons Signed In To Testify But Not Testifying: None.