H-3987.1

SECOND SUBSTITUTE HOUSE BILL 1828

State of Washington 58th Legislature 2004 Regular Session

By House Committee on Appropriations (originally sponsored by Representatives Schual-Berke, Pflug, Cody, Hankins, Linville, Skinner, Cooper, Alexander, Ruderman, Delvin, McDermott, Ericksen, Campbell, Santos, Haigh, Quall, Upthegrove, G. Simpson, Hatfield, Kessler, Conway and Kenney)

READ FIRST TIME 02/10/04.

AN ACT Relating to mental health parity; amending RCW 48.21.240, 48.44.340, and 48.46.290; adding new sections 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 new sections to chapter 70.47 RCW; adding a new section to chapter 48.02 RCW; creating a new section; and declaring an emergency.

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

NEW SECTION. **Sec. 1.** The legislature finds that the costs of leaving mental disorders untreated or undertreated are significant, and often include: Decreased job productivity, loss of employment, increased disability costs, deteriorating school performance, increased use of other health services, treatment delays leading to more costly treatments, suicide, family breakdown and impoverishment, and institutionalization, whether in hospitals, juvenile detention, jails, or prisons.

Treatable mental disorders are prevalent and often have a high impact on health and productive life. The legislature finds that the potential benefits of improved access to mental health services are

significant. Additionally, the legislature declares that it is not cost-effective to treat persons with mental disorders differently than persons with medical and surgical disorders.

Therefore, the legislature intends to require that insurance coverage be at parity for mental health services, which means this coverage be delivered under the same terms and conditions as medical and surgical services.

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

(1) For the purposes of this section, "mental health services" means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on the effective date of this section, or such subsequent date as may be provided by the administrator by rule, consistent with the purposes of this act, with the exception of the following categories, codes, and services: (a) Substance related disorders; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care; and (d) court ordered treatment unless the authority's or contracted insuring entity's medical director determines the treatment to be medically necessary.

(2) All health benefit plans offered to public employees and their covered dependents under this chapter that provide coverage for medical and surgical services shall provide:

(a) For all health benefit plans established or renewed on or after July 1, 2004, coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(b) For all health benefit plans established or renewed on or after January 1, 2007, coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(c) For all health benefit plans established or renewed on or after July 1, 2009, coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and

(ii) Prescription drugs intended to treat any of the disorders

covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(3) In meeting the requirements of subsection (2)(a) and (b) of this section, health benefit plans may not reduce the number of mental health outpatient visits or mental health inpatient days below the level in effect on July 1, 2002.

(4) This section does not prohibit a requirement that mental health services be medically necessary as determined by the medical director or designee, if a comparable requirement is applicable to medical and surgical services.

(5) Nothing in this section shall be construed to prevent the management of mental health services.

(6) The administrator will consider care management techniques for mental health services, including but not limited to: (a) Authorized treatment plans; (b) preauthorization requirements based on the type of service; (c) concurrent and retrospective utilization review; (d) utilization management practices; (e) discharge coordination and planning; and (f) contracting with and using a network of participating providers.

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

(1) For the purposes of this section, "mental health services" means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, 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 this act, with the exception of the following categories, codes, and services: (a) Substance related disorders; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care; and (d) court

ordered treatment unless the insurer's medical director or designee determines the treatment to be medically necessary.

(2) All group disability insurance contracts and blanket disability insurance contracts providing health benefit plans that provide coverage for medical and surgical services shall provide:

(a) For all health benefit plans established or renewed on or after July 1, 2004, for groups of more than fifty employees coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(b) For all health benefit plans established or renewed on or after January 1, 2007, for groups of more than fifty employees coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(c) For all health benefit plans established or renewed on or after July 1, 2009, for groups of more than fifty employees coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health

benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(3) In meeting the requirements of subsection (2)(a) and (b) of this section, health benefit plans may not reduce the number of mental health outpatient visits or mental health inpatient days below the level in effect on July 1, 2002.

(4) This section does not prohibit a requirement that mental health services be medically necessary as determined by the medical director or designee, if a comparable requirement is applicable to medical and surgical services.

(5) Nothing in this section shall be construed to prevent the management of mental health services.

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

(1) For the purposes of this section, "mental health services" means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, 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 this act, with the exception of the following categories, codes, and services: (a) Substance related disorders; (b) life

transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care; and (d) court ordered treatment unless the health care service contractor's medical director or designee determines the treatment to be medically necessary.

(2) All health service contracts providing health benefit plans that provide coverage for medical and surgical services shall provide:

(a) For all health benefit plans established or renewed on or after July 1, 2004, for groups of more than fifty employees coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(b) For all health benefit plans established or renewed on or after January 1, 2007, for groups of more than fifty employees coverage for:

(i) Mental health services. The copayment or coinsurance for these mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(c) For all health benefit plans established or renewed on or after July 1, 2009, for groups of more than fifty employees coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(3) In meeting the requirements of subsection (2)(a) and (b) of this section, health benefit plans may not reduce the number of mental health outpatient visits or mental health inpatient days below the level in effect on July 1, 2002.

(4) This section does not prohibit a requirement that mental health services be medically necessary as determined by the medical director or designee, if a comparable requirement is applicable to medical and surgical services.

(5) Nothing in this section shall be construed to prevent the management of mental health services.

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

(1) For the purposes of this section, "mental health services" means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of

mental disorders, published by the American psychiatric association, 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 this act, with the exception of the following categories, codes, and services: (a) Substance related disorders; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care; and (d) court ordered treatment unless the health maintenance organization's medical director or designee determines the treatment to be medically necessary.

(2) All health benefit plans offered by health maintenance organizations that provide coverage for medical and surgical services shall provide:

(a) For all health benefit plans established or renewed on or after July 1, 2004, for groups of more than fifty employees coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(b) For all health benefit plans established or renewed on or after January 1, 2007, for groups of more than fifty employees coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this

comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(c) For all health benefit plans established or renewed on or after July 1, 2009, for groups of more than fifty employees coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(3) In meeting the requirements of subsection (2)(a) and (b) of this section, health benefit plans may not reduce the number of mental health outpatient visits or mental health inpatient days below the level in effect on July 1, 2002.

(4) This section does not prohibit a requirement that mental health services be medically necessary as determined by the medical director or designee, if a comparable requirement is applicable to medical and surgical services.

(5) Nothing in this section shall be construed to prevent the management of mental health services.

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

(1) For the purposes of this section, "mental health services" means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on the effective date of this section, or such subsequent date as may be determined by the administrator, by rule, consistent with the purposes of this act, with the exception of the following categories, codes, and services: (a) Substance related disorders; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care; and (d) court ordered treatment, unless the Washington basic health plan's or contracted managed health care system's medical director or designee determines the treatment to be medically necessary.

(2)(a) Any schedule of benefits established or renewed by the Washington basic health plan on or after July 1, 2004, shall provide coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the schedule of benefits. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered under the schedule of benefits.

(b) Any schedule of benefits established or renewed by the Washington basic health plan on or after January 1, 2007, shall provide coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance

for medical and surgical services otherwise provided under the schedule of benefits. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the schedule of benefits imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered under the schedule of benefits.

(c) Any schedule of benefits established or renewed by the Washington basic health plan on or after July 1, 2009, shall include coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the schedule of benefits. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the schedule of benefits imposes a maximum out-of pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the schedule of benefits imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered under the schedule of benefits.

(3) In meeting the requirements of subsection (2)(a) and (b) of this section, the Washington basic health plan may not reduce the number of mental health outpatient visits or mental health inpatient days below the level in effect on July 1, 2002.

(4) This section does not prohibit a requirement that mental health services be medically necessary as determined by the medical director or designee, if a comparable requirement is applicable to medical and surgical services.

(5) Nothing in this section shall be construed to prevent the management of mental health services.

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

(1) For groups not covered by section 3 of this act, 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~~)) licensed mental health provider regulated under chapter 18.57, 18.71, 18.79, 18.83, or 18.225 RCW; ((~~(c)~~)) (b) a community mental health agency licensed by the department of social and health services pursuant to chapter 71.24 RCW; or ((~~(d)~~)) (c) 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~~)) the different categories of providers listed in (a) through (c) of this subsection. 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~~)) one of the categories of providers listed in (a) of this subsection.

(3) For groups not covered by section 3 of this act, 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.

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

(1) For groups not covered by section 4 of this act, 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~~)) licensed mental health provider regulated under chapter 18.57, 18.71, 18.79, 18.83, or 18.225 RCW; ((~~(c)~~)) (b) a community mental health agency licensed by the department of social and health services pursuant to chapter 71.24 RCW; or ((~~(d)~~)) (c) 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~~)) the different categories of providers listed in (a) through

(c) of this subsection. 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~~)) one of the categories of providers listed in (a) of this subsection.

(3) For groups not covered by section 4 of this act, 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.

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

(1) For groups not covered by section 5 of this act, 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~~)) by: (a) A ((~~physician licensed under chapter 18.71 or 18.57 RCW; (b) a psychologist licensed under chapter 18.83~~)) licensed mental health provider regulated under chapter 18.57, 18.71, 18.79, 18.83, or 18.225 RCW; ((~~(c)~~)) (b) a community mental health agency licensed by the department of social and health services pursuant to chapter 71.24 RCW; or ((~~(d)~~)) (c) 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~~)) the different categories of providers listed in (a) through (c) of this subsection. 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~~)) one of the categories of providers listed in (a) of this subsection.

(3) For groups not covered by section 5 of this act, 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.

NEW SECTION. **Sec. 10.** A new section is added to chapter 48.02 RCW to read as follows:

The insurance commissioner may adopt rules to implement sections 3 through 5 of this act, except that the rules do not apply to health benefit plans administered or operated under chapter 41.05 or 70.47 RCW.

NEW SECTION. **Sec. 11.** A new section is added to chapter 70.47 RCW to read as follows:

The administrator may adopt rules to implement section 6 of this act.

NEW SECTION. **Sec. 12.** A new section is added to chapter 41.05 RCW to read as follows:

The administrator may adopt rules to implement section 2 of this act.

NEW SECTION. **Sec. 13.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 14.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately.

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