Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Financial Institutions & Insurance Committee

HB 1154

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

Sponsors: Representatives Schual-Berke, Campbell, Kirby and Jarrett.

Brief Summary of Bill

- Requires group health insurance plans to provide the same amounts and terms of coverage for mental health services as is provided for medical and surgical services.
- Allows the mental health parity requirements to be phased-in over a five year period.
- Exempts certain types of mental health services from mandatory coverage provisions.
- Exempts groups with 50 of fewer employees from mandatory coverage. Insurers must offer optional mental health coverage to those groups.

Hearing Date: 1/18/05

Staff: Jon Hedegard (786-7127).

Background:

State law does not require health carriers to provide mental health coverage. Health carriers providing group coverage to employers are required to offer optional supplemental coverage for mental health treatment, which can be waived at the request of the employer. If a health carrier does provide mental health coverage there is no specific mandates on the level of coverage that must be provided under the group coverage.

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. Currently, inpatient care is covered in full up to 10 days per calendar year, and outpatient care is covered in full up to 12 visits per year. These limits are not found on other hospital inpatient services. The coinsurance rate, applicability of a deductible, and maximum facility charges for mental health benefits are generally consistent with hospital inpatient service charges.

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

The Office of the Insurance Commissioner (OIC) is the state agency that oversees private health insurance. There are three main categories of insuring entities or "health carriers" that offer health plans that fall under the jurisdiction of the OIC:

- Disability insurers (Chapter 48.21 RCW). An example is Aetna.
- Health care services contractors (Chapter 48.44 RCW): Examples include Premera and Regence.
- Health maintenance organizations (Chapter 48.46 RCW): An example is Group Health.

Optional supplemental mental health coverage: Generally, health carriers are required to offer optional, supplemental mental health treatment coverage to group purchasers. The coverage extends to insureds and covered dependents. The contract holder for the group can waive coverage for the group. 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 Bill:

I. OVERVIEW

The bill requires group health insurance plans with over 50 employees to provide a level of coverage for mental health services that is equal to the coverage provided for medical and surgical services. The requirements are imposed in three increments over five years. Once the mental health parity requirements are fully implemented in 2010, limitations on mental health services may be imposed by an insurance plan only if the same limitations are imposed on medical and surgical services.

The mental health parity requirements for each type of plan are largely identical and are subject to the same structured phase-in. This mental health parity requirement applies to five categories of group health insurance coverages:

1) Plans administered by the HCA on behalf of state employees;
2) Plans provided by disability insurers;
3) Plans provided by health care services contractors;
4) Plans provided by health maintenance organizations; and
5) Benefits provided by Washington Basic Health Plan.

Small business exemption: Health carriers do not have to provide mental health coverage to small businesses with 50 or fewer employees. As a general rule, health carriers must make an offer of optional coverage to any group other than a group of more than 50 employees.

II. COVERED MENTAL HEATH SERVICES

"Mental health services" defined: The required mental health services include medically necessary inpatient and outpatient services provided to treat mental disorders listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), 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: There are specified types of mental health disorders and treatment categories that are exempted from coverage, including:

Disorders related to substance abuse;
Life transition problems (family/marital issues, occupational/academic problems, etc.);
Residential treatment and custodial care; and
Court ordered treatment (unless medically necessary).

III. FIVE YEAR PHASE-IN

Health coverage is generally offered for one year periods. Parity between mental health, medical, and surgical services is achieved in three phases that occur over a five year period. Phase One begins on July 1, 2005. Phase Two begins on January 1, 2008. Phase Three begins on July 1, 2010. The phases are cumulative. The second phase incorporates the coverage requirements of the first phase. The third phase incorporates the coverage requirements of the first two phases. On July 1, 2010, all of the parity provisions will effective.

Phase One - For health benefit plans established or renewed on or after July 1, 2005:

1) The copayment or coinsurance for mental health services may not exceed the copayment or coinsurance for medical/surgical services provided under the plan. *Begun in Phase One.*

2) Prescription drug coverage for mental health services must be covered to the same extent and under the same conditions as other prescription drug coverage in the health benefit plan. *Begun in Phase One.*

Phase Two - For health benefit plans established or renewed on or after January 1, 2008:

1) The copayment or coinsurance for mental health services may not exceed the copayment or coinsurance for medical/surgical services provided under the plan. *Begun in Phase One. Maintained in Phase Two.*

2) Prescription drug coverage for mental health services must be covered to the same extent and under the same conditions as other prescription drug coverage in the health benefit plan. *Begun in Phase One. Maintained in Phase Two.*

3) 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. *Begun in Phase Two.*

Phase Three - For health benefit plans established or renewed on or after July 1, 2010:

1) The copayment or coinsurance for mental health services may not exceed the copayment or coinsurance for medical/surgical services provided under the plan. *Begun in Phase One. Maintained in Phases Two and Three.*

2) Prescription drug coverage for mental health services must be covered to the same extent and under the same conditions as other prescription drug coverage in the health benefit plan. *Begun in Phase One. Maintained in Phases Two and Three*.

3) 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. *Begun in Phase Two. Maintained in Phase Three*.

4) If the health insurance plan imposes a deductible, it must be a single deductible covering medical, surgical, and mental health services. *Begun in Phase Three*.

5) Any treatment limitations or financial requirements must be the same for mental health, medical, or surgical services. *Begun in Phase Three*.

IV. OTHER PROVISIONS

Groups with 50 or fewer employees – Health carriers are not required to offer the mental health parity provisions set forth in the act to groups with 50 or fewer employees. Generally, health carriers must offer optional supplemental mental health coverage to these groups. The group contract holder may waive the optional coverage for all insureds.

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.

Appropriation: None.

Fiscal Note: Requested on January 14, 2005.

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