

CERTIFICATION OF ENROLLMENT

ENGROSSED HOUSE BILL 1460

60th Legislature
2007 Regular Session

Passed by the House February 28, 2007
Yeas 75 Nays 22

Speaker of the House of Representatives

Passed by the Senate March 23, 2007
Yeas 41 Nays 3

President of the Senate

Approved

Governor of the State of Washington

CERTIFICATE

I, Richard Nafziger, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED HOUSE BILL 1460** as passed by the House of Representatives and the Senate on the dates hereon set forth.

Chief Clerk

FILED

**Secretary of State
State of Washington**

ENGROSSED HOUSE BILL 1460

Passed Legislature - 2007 Regular Session

State of Washington 60th Legislature 2007 Regular Session

By Representatives Schual-Berke, Hankins, Cody, Campbell, Morrell, Green, Dickerson, Darneille, McDermott, Jarrett, Hudgins, Moeller, Kagi, Rodne, Williams, Ormsby, Haigh, Linville, Wood, Conway, O'Brien, Hasegawa, Santos and Lantz

Read first time 01/19/2007. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to extending existing mental health parity
2 requirements to individual and small group plans; amending RCW
3 48.21.241, 48.44.341, 48.46.291, and 48.41.110; adding a new section to
4 chapter 48.20 RCW; adding a new section to chapter 48.41 RCW; repealing
5 RCW 48.21.240, 48.44.340, and 48.46.290; and providing an effective
6 date.

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

8 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.20 RCW
9 to read as follows:

10 (1) For the purposes of this section, "mental health services"
11 means medically necessary outpatient and inpatient services provided to
12 treat mental disorders covered by the diagnostic categories listed in
13 the most current version of the diagnostic and statistical manual of
14 mental disorders, published by the American psychiatric association, on
15 July 24, 2005, or such subsequent date as may be provided by the
16 insurance commissioner by rule, consistent with the purposes of chapter
17 6, Laws of 2005, with the exception of the following categories, codes,
18 and services: (a) Substance related disorders; (b) life transition
19 problems, currently referred to as "V" codes, and diagnostic codes 302

1 through 302.9 as found in the diagnostic and statistical manual of
2 mental disorders, 4th edition, published by the American psychiatric
3 association; (c) skilled nursing facility services, home health care,
4 residential treatment, and custodial care; and (d) court-ordered
5 treatment unless the insurer's medical director or designee determines
6 the treatment to be medically necessary.

7 (2) Each disability insurance contract delivered, issued for
8 delivery, or renewed on or after January 1, 2008, providing coverage
9 for medical and surgical services shall provide coverage for:

10 (a) Mental health services. The copayment or coinsurance for
11 mental health services may be no more than the copayment or coinsurance
12 for medical and surgical services otherwise provided under the
13 disability insurance contract. Wellness and preventive services that
14 are provided or reimbursed at a lesser copayment, coinsurance, or other
15 cost sharing than other medical and surgical services are excluded from
16 this comparison. If the disability insurance contract imposes a
17 maximum out-of-pocket limit or stop loss, it shall be a single limit or
18 stop loss for medical, surgical, and mental health services; and

19 (b) Prescription drugs intended to treat any of the disorders
20 covered in subsection (1) of this section to the same extent, and under
21 the same terms and conditions, as other prescription drugs covered by
22 the disability insurance contract.

23 (3) Each disability insurance contract delivered, issued for
24 delivery, or renewed on or after July 1, 2010, providing coverage for
25 medical and surgical services shall provide coverage for:

26 (a) Mental health services. The copayment or coinsurance for
27 mental health services may be no more than the copayment or coinsurance
28 for medical and surgical services otherwise provided under the
29 disability insurance contract. Wellness and preventive services that
30 are provided or reimbursed at a lesser copayment, coinsurance, or other
31 cost sharing than other medical and surgical services are excluded from
32 this comparison. If the disability insurance contract imposes a
33 maximum out-of-pocket limit or stop loss, it shall be a single limit or
34 stop loss for medical, surgical, and mental health services. If the
35 disability insurance contract imposes any deductible, mental health
36 services shall be included with medical and surgical services for the
37 purpose of meeting the deductible requirement. Treatment limitations

1 or any other financial requirements on coverage for mental health
2 services are only allowed if the same limitations or requirements are
3 imposed on coverage for medical and surgical services; and

4 (b) Prescription drugs intended to treat any of the disorders
5 covered in subsection (1) of this section to the same extent, and under
6 the same terms and conditions, as other prescription drugs covered by
7 the disability insurance contract.

8 (4) In meeting the requirements of this section, disability
9 insurance contracts may not reduce the number of mental health
10 outpatient visits or mental health inpatient days below the level in
11 effect on July 1, 2002.

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

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

18 **Sec. 2.** RCW 48.21.241 and 2006 c 74 s 1 are each amended to read
19 as follows:

20 (1) For the purposes of this section, "mental health services"
21 means medically necessary outpatient and inpatient services provided to
22 treat mental disorders covered by the diagnostic categories listed in
23 the most current version of the diagnostic and statistical manual of
24 mental disorders, published by the American psychiatric association, on
25 July 24, 2005, or such subsequent date as may be provided by the
26 insurance commissioner by rule, consistent with the purposes of chapter
27 6, Laws of 2005, with the exception of the following categories, codes,
28 and services: (a) Substance related disorders; (b) life transition
29 problems, currently referred to as "V" codes, and diagnostic codes 302
30 through 302.9 as found in the diagnostic and statistical manual of
31 mental disorders, 4th edition, published by the American psychiatric
32 association; (c) skilled nursing facility services, home health care,
33 residential treatment, and custodial care; and (d) court ordered
34 treatment unless the insurer's medical director or designee determines
35 the treatment to be medically necessary.

36 (2) All group disability insurance contracts and blanket disability

1 insurance contracts providing health benefit plans that provide
2 coverage for medical and surgical services shall provide:

3 (a) For all group health benefit plans for groups other than small
4 groups, as defined in RCW 48.43.005 delivered, issued for delivery, or
5 renewed on or after January 1, 2006, coverage for:

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

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

17 (b) For all group health benefit plans (~~((for groups other than~~
18 ~~small groups, as defined in RCW 48.43.005))~~) delivered, issued for
19 delivery, or renewed on or after January 1, 2008, coverage for:

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

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

33 (c) For all group health benefit plans (~~((for groups other than~~
34 ~~small groups, as defined in RCW 48.43.005))~~) delivered, issued for
35 delivery, or renewed on or after July 1, 2010, coverage for:

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

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

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

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

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

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

27 **Sec. 3.** RCW 48.44.341 and 2006 c 74 s 2 are each amended to read
28 as follows:

29 (1) For the purposes of this section, "mental health services"
30 means medically necessary outpatient and inpatient services provided to
31 treat mental disorders covered by the diagnostic categories listed in
32 the most current version of the diagnostic and statistical manual of
33 mental disorders, published by the American psychiatric association, on
34 July 24, 2005, or such subsequent date as may be provided by the
35 insurance commissioner by rule, consistent with the purposes of chapter
36 6, Laws of 2005, with the exception of the following categories, codes,
37 and services: (a) Substance related disorders; (b) life transition

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

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

10 (a) For all group health benefit plans for groups other than small
11 groups, as defined in RCW 48.43.005 delivered, issued for delivery, or
12 renewed on or after January 1, 2006, coverage for:

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

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

24 (b) For all (~~group~~) health benefit plans (~~for groups other than~~
25 ~~small groups, as defined in RCW 48.43.005~~) delivered, issued for
26 delivery, or renewed on or after January 1, 2008, coverage for:

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

36 (ii) Prescription drugs intended to treat any of the disorders
37 covered in subsection (1) of this section to the same extent, and under

1 the same terms and conditions, as other prescription drugs covered by
2 the health benefit plan.

3 (c) For all (~~group~~) health benefit plans (~~for groups other than~~
4 ~~small groups, as defined in RCW 48.43.005~~) delivered, issued for
5 delivery, or renewed on or after July 1, 2010, coverage for:

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

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

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

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

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

35 **Sec. 4.** RCW 48.46.291 and 2006 c 74 s 3 are each amended to read
36 as follows:

37 (1) For the purposes of this section, "mental health services"

1 means medically necessary outpatient and inpatient services provided to
2 treat mental disorders covered by the diagnostic categories listed in
3 the most current version of the diagnostic and statistical manual of
4 mental disorders, published by the American psychiatric association, on
5 July 24, 2005, or such subsequent date as may be provided by the
6 insurance commissioner by rule, consistent with the purposes of chapter
7 6, Laws of 2005, with the exception of the following categories, codes,
8 and services: (a) Substance related disorders; (b) life transition
9 problems, currently referred to as "V" codes, and diagnostic codes 302
10 through 302.9 as found in the diagnostic and statistical manual of
11 mental disorders, 4th edition, published by the American psychiatric
12 association; (c) skilled nursing facility services, home health care,
13 residential treatment, and custodial care; and (d) court ordered
14 treatment unless the health maintenance organization's medical director
15 or designee determines the treatment to be medically necessary.

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

19 (a) For all group health benefit plans for groups other than small
20 groups, as defined in RCW 48.43.005 delivered, issued for delivery, or
21 renewed on or after January 1, 2006, coverage for:

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

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

33 (b) For all (~~group~~) health benefit plans (~~for groups other than~~
34 ~~small groups, as defined in RCW 48.43.005~~) delivered, issued for
35 delivery, or renewed on or after January 1, 2008, coverage for:

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

1 benefit plan. Wellness and preventive services that are provided or
2 reimbursed at a lesser copayment, coinsurance, or other cost sharing
3 than other medical and surgical services are excluded from this
4 comparison. If the health benefit plan imposes a maximum out-of-pocket
5 limit or stop loss, it shall be a single limit or stop loss for
6 medical, surgical, and mental health services; and

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

11 (c) For all (~~group~~) health benefit plans (~~for groups other than~~
12 ~~small groups, as defined in RCW 48.43.005~~) delivered, issued for
13 delivery, or renewed on or after July 1, 2010, coverage for:

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

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

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

37 (4) This section does not prohibit a requirement that mental health

1 services be medically necessary as determined by the medical director
2 or designee, if a comparable requirement is applicable to medical and
3 surgical services.

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

6 **Sec. 5.** RCW 48.41.110 and 2001 c 196 s 4 are each amended to read
7 as follows:

8 (1) The pool shall offer one or more care management plans of
9 coverage. Such plans may, but are not required to, include point of
10 service features that permit participants to receive in-network
11 benefits or out-of-network benefits subject to differential cost
12 shares. Covered persons enrolled in the pool on January 1, 2001, may
13 continue coverage under the pool plan in which they are enrolled on
14 that date. However, the pool may incorporate managed care features
15 into such existing plans.

16 (2) The administrator shall prepare a brochure outlining the
17 benefits and exclusions of the pool policy in plain language. After
18 approval by the board, such brochure shall be made reasonably available
19 to participants or potential participants.

20 (3) The health insurance policy issued by the pool shall pay only
21 reasonable amounts for medically necessary eligible health care
22 services rendered or furnished for the diagnosis or treatment of
23 illnesses, injuries, and conditions which are not otherwise limited or
24 excluded. Eligible expenses are the reasonable amounts for the health
25 care services and items for which benefits are extended under the pool
26 policy. Such benefits shall at minimum include, but not be limited to,
27 the following services or related items:

28 (a) Hospital services, including charges for the most common
29 semiprivate room, for the most common private room if semiprivate rooms
30 do not exist in the health care facility, or for the private room if
31 medically necessary, but limited to a total of one hundred eighty
32 inpatient days in a calendar year, and limited to thirty days inpatient
33 care for (~~mental and nervous conditions, or~~) alcohol, drug, or
34 chemical dependency or abuse per calendar year;

35 (b) Professional services including surgery for the treatment of
36 injuries, illnesses, or conditions, other than dental, which are

1 rendered by a health care provider, or at the direction of a health
2 care provider, by a staff of registered or licensed practical nurses,
3 or other health care providers;

4 (c) The first twenty outpatient professional visits for the
5 diagnosis or treatment of (~~one or more mental or nervous conditions~~
6 ~~or~~) alcohol, drug, or chemical dependency or abuse rendered during a
7 calendar year by a state-certified chemical dependency program approved
8 under chapter 70.96A RCW, or by one or more physicians, psychologists,
9 or community mental health professionals, or, at the direction of a
10 physician, by other qualified licensed health care practitioners(~~, in~~
11 ~~the case of mental or nervous conditions, and rendered by a state~~
12 ~~certified chemical dependency program approved under chapter 70.96A~~
13 ~~RCW, in the case of alcohol, drug, or chemical dependency or abuse));~~

14 (d) Drugs and contraceptive devices requiring a prescription;

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

18 (f) Services of a home health agency;

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

21 (h) Oxygen;

22 (i) Anesthesia services;

23 (j) Prostheses, other than dental;

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

26 (l) Diagnostic x-rays and laboratory tests;

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

34 (n) Maternity care services;

35 (o) Services of a physical therapist and services of a speech
36 therapist;

37 (p) Hospice services;

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

3 (r) Mental health services pursuant to section 6 of this act; and
4 (s) Other medical equipment, services, or supplies required by
5 physician's orders and medically necessary and consistent with the
6 diagnosis, treatment, and condition.

7 (4) The board shall design and employ cost containment measures and
8 requirements such as, but not limited to, care coordination, provider
9 network limitations, preadmission certification, and concurrent
10 inpatient review which may make the pool more cost-effective.

11 (5) The pool benefit policy may contain benefit limitations,
12 exceptions, and cost shares such as copayments, coinsurance, and
13 deductibles that are consistent with managed care products, except that
14 differential cost shares may be adopted by the board for nonnetwork
15 providers under point of service plans. The pool benefit policy cost
16 shares and limitations must be consistent with those that are generally
17 included in health plans approved by the insurance commissioner;
18 however, no limitation, exception, or reduction may be used that would
19 exclude coverage for any disease, illness, or injury.

20 (6) The pool may not reject an individual for health plan coverage
21 based upon preexisting conditions of the individual or deny, exclude,
22 or otherwise limit coverage for an individual's preexisting health
23 conditions; except that it shall impose a six-month benefit waiting
24 period for preexisting conditions for which medical advice was given,
25 for which a health care provider recommended or provided treatment, or
26 for which a prudent layperson would have sought advice or treatment,
27 within six months before the effective date of coverage. The
28 preexisting condition waiting period shall not apply to prenatal care
29 services. The pool may not avoid the requirements of this section
30 through the creation of a new rate classification or the modification
31 of an existing rate classification. Credit against the waiting period
32 shall be as provided in subsection (7) of this section.

33 (7)(a) Except as provided in (b) of this subsection, the pool shall
34 credit any preexisting condition waiting period in its plans for a
35 person who was enrolled at any time during the sixty-three day period
36 immediately preceding the date of application for the new pool plan.
37 For the person previously enrolled in a group health benefit plan, the
38 pool must credit the aggregate of all periods of preceding coverage not

1 separated by more than sixty-three days toward the waiting period of
2 the new health plan. For the person previously enrolled in an
3 individual health benefit plan other than a catastrophic health plan,
4 the pool must credit the period of coverage the person was continuously
5 covered under the immediately preceding health plan toward the waiting
6 period of the new health plan. For the purposes of this subsection, a
7 preceding health plan includes an employer-provided self-funded health
8 plan.

9 (b) The pool shall waive any preexisting condition waiting period
10 for a person who is an eligible individual as defined in section
11 2741(b) of the federal health insurance portability and accountability
12 act of 1996 (42 U.S.C. 300gg-41(b)).

13 (8) If an application is made for the pool policy as a result of
14 rejection by a carrier, then the date of application to the carrier,
15 rather than to the pool, should govern for purposes of determining
16 preexisting condition credit.

17 NEW SECTION. **Sec. 6.** A new section is added to chapter 48.41 RCW
18 to read as follows:

19 (1) For the purposes of this section, "mental health services"
20 means medically necessary outpatient and inpatient services provided to
21 treat mental disorders covered by the diagnostic categories listed in
22 the most current version of the diagnostic and statistical manual of
23 mental disorders, published by the American psychiatric association, on
24 July 24, 2005, or such subsequent date as may be provided by the
25 insurance commissioner by rule, consistent with the purposes of chapter
26 6, Laws of 2005, with the exception of the following categories, codes,
27 and services: (a) Substance related disorders; (b) life transition
28 problems, currently referred to as "V" codes, and diagnostic codes 302
29 through 302.9 as found in the diagnostic and statistical manual of
30 mental disorders, 4th edition, published by the American psychiatric
31 association; (c) skilled nursing facility services, home health care,
32 residential treatment, and custodial care; and (d) court-ordered
33 treatment unless the insurer's medical director or designee determines
34 the treatment to be medically necessary.

35 (2) Each health insurance policy issued by the pool on or after
36 January 1, 2008, shall provide coverage for:

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

10 (b) Prescription drugs intended to treat any of the disorders
11 covered in subsection (1) of this section to the same extent, and under
12 the same terms and conditions, as other prescription drugs covered by
13 the policy.

14 (3) Each health insurance policy issued by the pool on or after
15 July 1, 2010, shall provide coverage for:

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

30 (b) Prescription drugs intended to treat any of the disorders
31 covered in subsection (1) of this section to the same extent, and under
32 the same terms and conditions, as other prescription drugs covered by
33 the policy.

34 (4) In meeting the requirements of this section, a policy may not
35 reduce the number of mental health outpatient visits or mental health
36 inpatient days below the level in effect on July 1, 2002.

37 (5) This section does not prohibit a requirement that mental health

1 services be medically necessary as determined by the medical director
2 or designee, if a comparable requirement is applicable to medical and
3 surgical services.

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

6 NEW SECTION. **Sec. 7.** The following acts or parts of acts are each
7 repealed:

8 (1) RCW 48.21.240 (Mental health treatment, optional supplemental
9 coverage--Waiver) and 2005 c 6 s 7, 1987 c 283 s 3, 1986 c 184 s 2, &
10 1983 c 35 s 1;

11 (2) RCW 48.44.340 (Mental health treatment, optional supplemental
12 coverage--Waiver) and 2005 c 6 s 8, 1987 c 283 s 4, 1986 c 184 s 3, &
13 1983 c 35 s 2; and

14 (3) RCW 48.46.290 (Mental health treatment, optional supplemental
15 coverage--Waiver) and 2005 c 6 s 9, 1987 c 283 s 5, 1986 c 184 s 4, &
16 1983 c 35 s 3.

17 NEW SECTION. **Sec. 8.** This act takes effect January 1, 2008.

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