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HOUSE BILL 1447

State of Washington 66th Legislature 2019 Regular Session

By Representatives Jinkins, DeBolt, Cody, Davis, Macri, Tharinger, Pellicciotti, Stonier, Riccelli, Thai, Robinson, Valdez, Eslick, Lekanoff, Lovick, Kloba, Frame, Bergquist, Leavitt, Fey, Ortiz-Self, Santos, and Ormsby

Read first time 01/22/19. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to mental health parity; and amending RCW
2 41.05.600, 48.20.580, 48.21.241, 48.41.220, 48.44.341, 48.46.291, and
3 70.47.200.

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

5 **Sec. 1.** RCW 41.05.600 and 2005 c 6 s 2 are each amended to read
6 as follows:
7 (1) For the purposes of this section, "mental health services"
8 means:
9 (a) For health benefit plans issued or renewed before January 1,
10 2020, medically necessary outpatient and inpatient services provided
11 to treat mental disorders covered by the diagnostic categories listed
12 in the most current version of the diagnostic and statistical manual
13 of mental disorders, published by the American psychiatric
14 association, on July 24, 2005, or such subsequent date as may be
15 provided by the administrator by rule, consistent with the purposes
16 of chapter 6, Laws of 2005, with the exception of the following
17 categories, codes, and services: ((~~(a)~~)) (i) Substance related
18 disorders; ((~~(b)~~)) (ii) life transition problems, currently referred
19 to as "V" codes, and diagnostic codes 302 through 302.9 as found in
20 the diagnostic and statistical manual of mental disorders, 4th
21 edition, published by the American psychiatric association; ((~~(c)~~))

1 (iii) skilled nursing facility services, home health care,
2 residential treatment, and custodial care; and ((~~(d)~~)) (iv) court
3 ordered treatment unless the authority's or contracted insuring
4 entity's medical director determines the treatment to be medically
5 necessary; and
6 (b) For health benefit plans issued or renewed on or after
7 January 1, 2020, medically necessary outpatient and inpatient
8 services provided to treat mental disorders covered by the diagnostic
9 categories listed in the most current version of the diagnostic and
10 statistical manual of mental disorders, published by the American
11 psychiatric association, on July 24, 2005, or such subsequent date as
12 may be provided by the administrator by rule, consistent with the
13 purposes of chapter 6, Laws of 2005.
14 (2) All health benefit plans offered to public employees and
15 their covered dependents under this chapter that provide coverage for
16 medical and surgical services shall provide:
17 (a) For all health benefit plans established or renewed on or
18 after January 1, 2006, coverage for:
19 (i) Mental health services. The copayment or coinsurance for
20 mental health services may be no more than the copayment or
21 coinsurance for medical and surgical services otherwise provided
22 under the health benefit plan. Wellness and preventive services that
23 are provided or reimbursed at a lesser copayment, coinsurance, or
24 other cost sharing than other medical and surgical services are
25 excluded from this comparison; and
26 (ii) Prescription drugs intended to treat any of the disorders
27 covered in subsection (1) of this section to the same extent, and
28 under the same terms and conditions, as other prescription drugs
29 covered by the health benefit plan.
30 (b) For all health benefit plans established or renewed on or
31 after January 1, 2008, coverage for:
32 (i) Mental health services. The copayment or coinsurance for
33 mental health services may be no more than the copayment or
34 coinsurance for medical and surgical services otherwise provided
35 under the health benefit plan. Wellness and preventive services that
36 are provided or reimbursed at a lesser copayment, coinsurance, or
37 other cost sharing than other medical and surgical services are
38 excluded from this comparison. If the health benefit plan imposes a
39 maximum out-of-pocket limit or stop loss, it shall be a single limit
40 or stop loss for medical, surgical, and mental health services; and

1 (ii) Prescription drugs intended to treat any of the disorders
2 covered in subsection (1) of this section to the same extent, and
3 under the same terms and conditions, as other prescription drugs
4 covered by the health benefit plan.
5 (c) For all health benefit plans established or renewed on or
6 after July 1, 2010, coverage for:
7 (i) Mental health services. The copayment or coinsurance for
8 mental health services may be no more than the copayment or
9 coinsurance for medical and surgical services otherwise provided
10 under the health benefit plan. Wellness and preventive services that
11 are provided or reimbursed at a lesser copayment, coinsurance, or
12 other cost sharing than other medical and surgical services are
13 excluded from this comparison. If the health benefit plan imposes a
14 maximum out-of-pocket limit or stop loss, it shall be a single limit
15 or stop loss for medical, surgical, and mental health services. If
16 the health benefit plan imposes any deductible, mental health
17 services shall be included with medical and surgical services for the
18 purpose of meeting the deductible requirement. Treatment limitations
19 or any other financial requirements on coverage for mental health
20 services are only allowed if the same limitations or requirements are
21 imposed on coverage for medical and surgical services; and
22 (ii) Prescription drugs intended to treat any of the disorders
23 covered in subsection (1) of this section to the same extent, and
24 under the same terms and conditions, as other prescription drugs
25 covered by the health benefit plan.
26 (3) In meeting the requirements of subsection (2)(a) and (b) of
27 this section, health benefit plans may not reduce the number of
28 mental health outpatient visits or mental health inpatient days below
29 the level in effect on July 1, 2002.
30 (4) This section does not prohibit a requirement that mental
31 health services be medically necessary as determined by the medical
32 director or designee, if a comparable requirement is applicable to
33 medical and surgical services.
34 (5) Nothing in this section shall be construed to prevent the
35 management of mental health services.
36 (6) The administrator will consider care management techniques
37 for mental health services, including but not limited to: (a)
38 Authorized treatment plans; (b) preauthorization requirements based
39 on the type of service; (c) concurrent and retrospective utilization
40 review; (d) utilization management practices; (e) discharge

1 coordination and planning; and (f) contracting with and using a
2 network of participating providers.

3 **Sec. 2.** RCW 48.20.580 and 2007 c 8 s 1 are each amended to read
4 as follows:

5 (1) For the purposes of this section, "mental health services"
6 means<u>:</u>

7 <u>(a) For health benefit plans issued or renewed before January 1,</u>
8 <u>2020,</u> medically necessary outpatient and inpatient services provided
9 to treat mental disorders covered by the diagnostic categories listed
10 in the most current version of the diagnostic and statistical manual
11 of mental disorders, published by the American psychiatric
12 association, on July 24, 2005, or such subsequent date as may be
13 provided by the insurance commissioner by rule, consistent with the
14 purposes of chapter 6, Laws of 2005, with the exception of the
15 following categories, codes, and services: ((~~(a)~~)) <u>(i)</u> Substance
16 related disorders; ((~~(b)~~)) <u>(ii)</u> life transition problems, currently
17 referred to as "V" codes, and diagnostic codes 302 through 302.9 as
18 found in the diagnostic and statistical manual of mental disorders,
19 4th edition, published by the American psychiatric association;
20 ((~~(c)~~)) <u>(iii)</u> skilled nursing facility services, home health care,
21 residential treatment, and custodial care; and ((~~(d)~~)) <u>(iv)</u> court-
22 ordered treatment unless the insurer's medical director or designee
23 determines the treatment to be medically necessary<u>; and</u>

24 <u>(b) For health benefit plans issued or renewed on or after</u>
25 <u>January 1, 2020, medically necessary outpatient and inpatient</u>
26 <u>services provided to treat mental disorders covered by the diagnostic</u>
27 <u>categories listed in the most current version of the diagnostic and</u>
28 <u>statistical manual of mental disorders, published by the American</u>
29 <u>psychiatric association, on July 24, 2005, or such subsequent date as</u>
30 <u>may be provided by the insurance commissioner by rule, consistent</u>
31 <u>with the purposes of chapter 6, Laws of 2005</u>.

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

35 (a) Mental health services. The copayment or coinsurance for
36 mental health services may be no more than the copayment or
37 coinsurance for medical and surgical services otherwise provided
38 under the disability insurance contract. Wellness and preventive
39 services that are provided or reimbursed at a lesser copayment,

1 coinsurance, or other cost sharing than other medical and surgical
2 services are excluded from this comparison. If the disability
3 insurance contract imposes a maximum out-of-pocket limit or stop
4 loss, it shall be a single limit or stop loss for medical, surgical,
5 and mental health services; and
6 (b) Prescription drugs intended to treat any of the disorders
7 covered in subsection (1) of this section to the same extent, and
8 under the same terms and conditions, as other prescription drugs
9 covered by the disability insurance contract.
10 (3) Each disability insurance contract delivered, issued for
11 delivery, or renewed on or after July 1, 2010, providing coverage for
12 medical and surgical services shall provide coverage for:
13 (a) Mental health services. The copayment or coinsurance for
14 mental health services may be no more than the copayment or
15 coinsurance for medical and surgical services otherwise provided
16 under the disability insurance contract. Wellness and preventive
17 services that are provided or reimbursed at a lesser copayment,
18 coinsurance, or other cost sharing than other medical and surgical
19 services are excluded from this comparison. If the disability
20 insurance contract imposes a maximum out-of-pocket limit or stop
21 loss, it shall be a single limit or stop loss for medical, surgical,
22 and mental health services. If the disability insurance contract
23 imposes any deductible, mental health services shall be included with
24 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
27 if the same limitations or requirements are imposed on coverage for
28 medical and surgical services; and
29 (b) Prescription drugs intended to treat any of the disorders
30 covered in subsection (1) of this section to the same extent, and
31 under the same terms and conditions, as other prescription drugs
32 covered by the disability insurance contract.
33 (4) In meeting the requirements of this section, disability
34 insurance contracts may not reduce the number of mental health
35 outpatient visits or mental health inpatient days below the level in
36 effect on July 1, 2002.
37 (5) This section does not prohibit a requirement that mental
38 health services be medically necessary as determined by the medical
39 director or designee, if a comparable requirement is applicable to
40 medical and surgical services.

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

Sec. 3. RCW 48.21.241 and 2007 c 8 s 2 are each amended to read as follows:

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

(a) For health benefit plans issued or renewed before January 1, 2020, 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 July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: ((~~(a)~~)) (i) Substance related disorders; ((~~(b)~~)) (ii) 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)~~)) (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and ((~~(d)~~)) (iv) court ordered treatment unless the insurer's medical director or designee determines the treatment to be medically necessary; and

(b) For health benefit plans issued or renewed on or after January 1, 2020, 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 July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.

(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 group health benefit plans for groups other than small groups, as defined in RCW 48.43.005 delivered, issued for delivery, or renewed on or after January 1, 2006, 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 group health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2008, 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 group health benefit plans delivered, issued for delivery, or renewed on or after July 1, 2010, 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.

Sec. 4. RCW 48.41.220 and 2007 c 8 s 6 are each amended to read as follows:

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

(a) For health benefit plans issued or renewed before January 1, 2020, 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 July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: ((~~(a)~~)) (i) Substance related disorders; ((~~(b)~~)) (ii) 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)~~)) (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and ((~~(d)~~)) (iv) court-ordered treatment unless the insurer's medical director or designee determines the treatment to be medically necessary; and

(b) For health benefit plans issued or renewed on or after January 1, 2020, 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 July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.

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

(a) 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 policy. 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 policy 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

(b) 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 policy.

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

(a) 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 policy. 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 policy 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 policy 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

(b) 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 policy.

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

(5) 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.

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

Sec. 5. RCW 48.44.341 and 2007 c 8 s 3 are each amended to read as follows:

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

(a) For health benefit plans issued or renewed before January 1, 2020, 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 July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: ((~~(a)~~)) (i) Substance related disorders; ((~~(b)~~)) (ii) 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)~~)) (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and ((~~(d)~~)) (iv) court ordered treatment unless the health care service contractor's medical director or designee determines the treatment to be medically necessary; and

(b) For health benefit plans issued or renewed on or after January 1, 2020, 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 July 24, 2005, or such subsequent date as

may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.

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

(a) For all group health benefit plans for groups other than small groups, as defined in RCW 48.43.005 delivered, issued for delivery, or renewed on or after January 1, 2006, 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 delivered, issued for delivery, or renewed on or after January 1, 2008, 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 delivered, issued for delivery, or renewed on or after July 1, 2010, 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.

Sec. 6. RCW 48.46.291 and 2007 c 8 s 4 are each amended to read as follows:

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

(a) For health benefit plans issued or renewed before January 1, 2020, 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 July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: ((~~(a)~~)) (i) Substance related disorders; ((~~(b)~~)) (ii) 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)~~)) (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and ((~~(d)~~)) (iv) court ordered treatment unless the health maintenance organization's medical director or designee determines the treatment to be medically necessary; and

(b) For health benefit plans issued or renewed on or after January 1, 2020, 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 July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.

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

(a) For all group health benefit plans for groups other than small groups, as defined in RCW 48.43.005 delivered, issued for delivery, or renewed on or after January 1, 2006, 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 delivered, issued for delivery, or renewed on or after January 1, 2008, 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 delivered, issued for delivery, or renewed on or after July 1, 2010, 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.

1 **Sec. 7.** RCW 70.47.200 and 2005 c 6 s 6 are each amended to read
2 as follows:
3 (1) For the purposes of this section, "mental health services"
4 means:
5 (a) For health benefit plans issued or renewed before January 1,
6 2020, medically necessary outpatient and inpatient services provided
7 to treat mental disorders covered by the diagnostic categories listed
8 in the most current version of the diagnostic and statistical manual
9 of mental disorders, published by the American psychiatric
10 association, on July 24, 2005, or such subsequent date as may be
11 determined by the ((administrator,)) director by rule, consistent
12 with the purposes of chapter 6, Laws of 2005, with the exception of
13 the following categories, codes, and services: (((a))) (i) Substance
14 related disorders; (((b))) (ii) life transition problems, currently
15 referred to as "V" codes, and diagnostic codes 302 through 302.9 as
16 found in the diagnostic and statistical manual of mental disorders,
17 4th edition, published by the American psychiatric association;
18 (((c))) (iii) skilled nursing facility services, home health care,
19 residential treatment, and custodial care; and (((d))) (iv) court
20 ordered treatment, unless the Washington basic health plan's or
21 contracted managed health care system's medical director or designee
22 determines the treatment to be medically necessary; and
23 (b) For health benefit plans issued or renewed on or after
24 January 1, 2020, medically necessary outpatient and inpatient
25 services provided to treat mental disorders covered by the diagnostic
26 categories listed in the most current version of the diagnostic and
27 statistical manual of mental disorders, published by the American
28 psychiatric association, on July 24, 2005, or such subsequent date as
29 may be determined by the director by rule, consistent with the
30 purposes of chapter 6, Laws of 2005.
31 (2)(a) Any schedule of benefits established or renewed by the
32 Washington basic health plan on or after January 1, 2006, shall
33 provide coverage for:
34 (i) Mental health services. The copayment or coinsurance for
35 mental health services may be no more than the copayment or
36 coinsurance for medical and surgical services otherwise provided
37 under the schedule of benefits. Wellness and preventive services that
38 are provided or reimbursed at a lesser copayment, coinsurance, or
39 other cost sharing than other medical and surgical services are
40 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, 2008, 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, 2010, 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

1 under the same terms and conditions, as other prescription drugs
2 covered under the schedule of benefits.
3 (3) In meeting the requirements of subsection (2)(a) and (b) of
4 this section, the Washington basic health plan may not reduce the
5 number of mental health outpatient visits or mental health inpatient
6 days below the level in effect on July 1, 2002.
7 (4) This section does not prohibit a requirement that mental
8 health services be medically necessary as determined by the medical
9 director or designee, if a comparable requirement is applicable to
10 medical and surgical services.
11 (5) Nothing in this section shall be construed to prevent the
12 management of mental health services.

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