S-2217.1

SUBSTITUTE SENATE BILL 5446

State of Washington 60th Legislature 2007 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored by Senators Keiser, Prentice, Brown, Kohl-Welles, Kline, Fairley, Tom, Murray, Rockefeller, Regala and Spanel)

READ FIRST TIME 02/23/07.

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

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

NEW SECTION. **Sec. 1.** A new section is added to chapter 48.20 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 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) 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) Each disability insurance contract delivered, issued for delivery, or renewed on or after January 1, 2008, providing coverage for medical and surgical services 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 disability insurance contract. 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 disability insurance contract 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 disability insurance contract.

(3) Each disability insurance contract delivered, issued for delivery, or renewed on or after July 1, 2010, providing coverage for medical and surgical services 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 disability insurance contract. 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 disability insurance contract 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 disability insurance contract 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 disability insurance contract.

(4) In meeting the requirements of this section, disability insurance contracts 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. 2. RCW 48.21.241 and 2006 c 74 s 1 are each amended 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 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) 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 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 ((~~for groups other than small groups, as defined in RCW 48.43.005~~)) 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 ((~~for groups other than small groups, as defined in RCW 48.43.005~~)) 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. 3. RCW 48.44.341 and 2006 c 74 s 2 are each amended 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 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) 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 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 ((~~for groups other than small groups, as defined in RCW 48.43.005~~)) 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 ((~~for groups other than small groups, as defined in RCW 48.43.005~~)) 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 48.46.291 and 2006 c 74 s 3 are each amended 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 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) 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 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 ((~~for groups other than small groups, as defined in RCW 48.43.005~~)) 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 ((~~for groups other than small groups, as defined in RCW 48.43.005~~)) 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. 5. RCW 48.41.110 and 2001 c 196 s 4 are each amended to read as follows:

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

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

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

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

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

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

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

(d) Drugs and contraceptive devices requiring a prescription;

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

(f) Services of a home health agency;

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

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

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

(l) Diagnostic x-rays and laboratory tests;

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

(n) Maternity care services;

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

(p) Hospice services;

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

(r) Mental health services pursuant to section 6 of this act; and

(s) Other medical equipment, services, or supplies required by physician's orders and medically necessary and consistent with the diagnosis, treatment, and condition.

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

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

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

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

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

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

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

NEW SECTION. **Sec. 6.** A new section is added to chapter 48.41 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 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) 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) 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.

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

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

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

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

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

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