
SENATE BILL 5211

State of Washington

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By Senators Thibaudeau, Long, Spanel, Winsley, B. Sheldon, Swecker, Fraser, Kohl-Welles, Kline, Carlson, Eide, Rasmussen, Fairley, McCaslin, Franklin, Haugen, Oke, Costa, McAuliffe, Prentice, Jacobsen, Constantine and Regala

Read first time 01/16/2001. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to comparable mental health benefits; amending RCW
2 48.21.240, 48.44.340, and 48.46.290; adding a new section to chapter
3 41.05 RCW; adding a new section to chapter 48.21 RCW; adding a new
4 section to chapter 48.44 RCW; adding a new section to chapter 48.46
5 RCW; adding a new section to chapter 70.47 RCW; creating a new section;
6 and repealing RCW 48.21.240, 48.44.340, and 48.46.290.

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

8 NEW SECTION. **Sec. 1.** Children are our future. We spend millions
9 of dollars educating Washington state children to ensure that their
10 future is as bright as possible. But, in order for our children to
11 learn, they must be healthy. They need strong minds as well as strong
12 bodies. According to Washington state data, one or two children in
13 every Washington classroom is suffering from serious emotional and
14 behavioral problems. Suicide is the second leading cause of death
15 among adolescents.

16 The legislature finds that without comparable mental health
17 benefits for children, families are often unable to pay for needed
18 services. As a result, many children do without the treatment they

1 need, which significantly impacts their ability to learn, and their
2 opportunities for a productive future.

3 For adults national data suggest that in any given year one in ten
4 Americans experiences a mental disorder, and one in five Americans will
5 have a mental disorder during his or her lifetime that requires
6 treatment.

7 The current disparity between coverage of mental health services
8 and coverage for medical/surgical services places Washington state
9 citizens at unreasonable financial risk. Most insurance policies have
10 no stop loss for mental health costs. Not only does this create a
11 significant barrier to appropriate treatment, it can also lead to
12 severe financial loss.

13 The legislature finds that the costs for leaving mental disorders
14 untreated or undertreated are enormous, and often include: Decreased
15 job productivity, increased job turnover, loss of employment, increased
16 disability costs, deteriorating school performance, increased use of
17 other health care services, treatment delays leading to more costly
18 treatments, suicide, family breakdown and impoverishment, and
19 institutionalization, whether in hospitals, juvenile detention, jails,
20 or prisons.

21 Therefore, the legislature intends to require comparable mental
22 health coverage for children and catastrophic mental health coverage
23 for adults under the terms of this act.

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

26 (1) For the purpose of this section, "mental health services"
27 means: (a) Outpatient and inpatient services provided to treat any of
28 the mental disorders covered by the diagnostic categories listed in the
29 most current version of the diagnostic and statistical manual of mental
30 disorders on the effective date of this section, or such subsequent
31 date as may be provided by the authority by rule, consistent with the
32 purposes of chapter . . . , Laws of 2001 (this act), except V codes and
33 those codes defining substance abuse disorders, 291.0 through 292.9 and
34 303.0 through 305.9 as of the effective date of this section; and (b)
35 prescription drugs, if the plan contract otherwise includes coverage
36 for prescription drugs.

37 (2) Each health plan offered to public employees and their covered
38 dependents under this chapter that is not subject to the provisions of

1 Title 48 RCW and is established or renewed after July 1, 2002, and that
2 provides coverage for hospital or medical care, shall provide coverage
3 for mental health services as follows:

4 (a) For children, as that term is defined in the policy, the health
5 plan shall only impose treatment limitations or financial requirements
6 on coverage for mental health services, if the same limitations or
7 requirements are imposed on coverage for medical and surgical services.
8 This includes but is not limited to copays, cost sharing, annual or
9 lifetime dollar limits, outpatient visit limits, outpatient day limits,
10 and inpatient limits. Wellness and preventive services that are
11 reimbursed at one hundred percent without deductible, coinsurance, or
12 other cost sharing are excluded from this comparison.

13 (i) If a plan requires annual deductibles, a separate deductible
14 for mental health services is allowed. The annual deductible for
15 mental health services may not be greater than the annual deductible
16 for medical and surgical services. This does not preclude a plan with
17 pharmacy benefits from establishing a separate deductible for those
18 benefits if it applies to all prescription drugs.

19 (ii) If a plan has maximum out-of-pocket limits, one single annual
20 maximum out-of-pocket limit for medical and surgical and mental health
21 services is required. This subsection (2)(a)(ii) does not preclude a
22 plan with pharmacy benefits from excluding prescription drugs from the
23 out-of-pocket limit as long as all prescription drugs are treated
24 equivalently.

25 (b) For adults, the provisions of subsection (1)(a)(i) and (ii) of
26 this section apply, except that plans are allowed to have differential
27 copays or coinsurance requirements, which means that plans may have a
28 greater copay or coinsurance for mental health services than for
29 medical and surgical services. However, the copay or coinsurance for
30 mental health services may be no greater than as of January 1, 2001.

31 (3) Each health plan is required to use those managed care tools
32 necessary for the cost-effective management of this act to include but
33 not be limited to the use of preauthorization screening prior to
34 authorizing the delivery of mental health services or the requirement
35 that mental health services must be medically necessary as determined
36 by its medical director or his or her designee. Managed care
37 requirements for mental health services may be different from those for
38 medical and surgical services.

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

3 (1) For the purpose of this section, "mental health services"
4 means: (a) Outpatient and inpatient services provided to treat any of
5 the mental disorders covered by the diagnostic categories listed in the
6 most current version of the diagnostic and statistical manual of mental
7 disorders on the effective date of this section or such subsequent date
8 as may be provided by the insurance commissioner by rule, consistent
9 with the purposes of chapter . . . , Laws of 2001 (this act), except V
10 codes and those codes defining substance abuse disorders, 291.0 through
11 292.9 and 303.0 through 305.9 as of the effective date of this section;
12 and (b) prescription drugs, if the insurance contract otherwise
13 includes coverage for prescription drugs.

14 (2) All group disability insurance contracts and blanket disability
15 insurance contracts providing health care services to groups with fifty
16 or more persons, issued or renewed after July 1, 2002, and for groups
17 with at least twenty-five persons but fewer than fifty persons, issued
18 or renewed after July 1, 2003, that provide coverage for hospital or
19 medical care shall provide coverage for mental health services as
20 follows:

21 (a) For children as that term is defined in the policy, the
22 contracts shall only impose treatment limitations or financial
23 requirements on coverage for mental health services, if the same
24 limitations or requirements are imposed on coverage for medical and
25 surgical services. This includes but is not limited to copays, cost
26 sharing, annual or lifetime dollar limits, outpatient visit limits,
27 outpatient day limits, and inpatient limits. Wellness and preventive
28 services that are reimbursed at one hundred percent without deductible,
29 coinsurance, or other cost sharing are excluded from this comparison.

30 (i) If a contract requires annual deductibles, a separate annual
31 deductible for mental health services is allowed. The annual
32 deductible for mental health services may not be greater than the
33 annual deductible for medical and surgical services. This does not
34 preclude a plan with pharmacy benefits from establishing a separate
35 deductible for those benefits if it applies to all prescription drugs.

36 (ii) If a plan has maximum out-of-pocket limits, one single annual
37 maximum out-of-pocket limit for medical and surgical and mental health
38 services is required. This subsection (2)(a)(ii) does not preclude a
39 plan with pharmacy benefits from excluding prescription drugs from the

1 out-of-pocket limit as long as all prescription drugs are treated
2 equivalently.

3 (b) For adults, subsection (1)(a)(i) and (ii) of this section
4 apply, except that insurance contracts are allowed to have differential
5 copays or coinsurance requirements, which means that contracts may have
6 a greater copay or coinsurance for mental health services than for
7 medical and surgical services. However, the copay or coinsurance for
8 mental health services may be no greater than as of January 1, 2001.

9 (3) This section does not prohibit an insurer from requiring the
10 use of preauthorization screening prior to authorizing the delivery of
11 mental health services or the requirement that mental health services
12 must be medically necessary as determined by its medical director or
13 his or her designee or other managed care tools. Managed care
14 requirements for mental health services may be different from those for
15 medical and surgical services.

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

18 (1) For the purpose of this section, "mental health services"
19 means: (a) Outpatient and inpatient services provided to treat any of
20 the mental disorders covered by the diagnostic categories listed in the
21 most current version of the diagnostic and statistical manual of mental
22 disorders on the effective date of this section, or such subsequent
23 date as may be provided by the insurance commissioner by rule,
24 consistent with the purposes of chapter . . . , Laws of 2001 (this act),
25 except V codes and those codes defining substance abuse disorders,
26 291.0 through 292.9 and 303.0 through 305.9 as of the effective date of
27 this section; and (b) prescription drugs, if the contract otherwise
28 includes coverage for prescription drugs.

29 (2) All health care service contracts for groups with fifty or more
30 persons, issued or renewed after July 1, 2002, and for groups with at
31 least twenty-five persons but fewer than fifty persons, issued or
32 renewed after July 1, 2003, that provide coverage for hospital or
33 medical care shall provide coverage for mental health services as
34 follows:

35 (a) For children as that term is defined in the contract, the
36 contract shall only impose treatment limitations or financial
37 requirements on coverage for mental health services, if the same
38 limitations or requirements are imposed on coverage for medical and

1 surgical services. This includes but is not limited to copays, cost
2 sharing, annual or lifetime dollar limits, outpatient visit limits,
3 outpatient day limits, and inpatient limits. Wellness and preventive
4 services that are reimbursed at one hundred percent without deductible,
5 coinsurance, or other cost sharing are excluded from this comparison.

6 (i) If a contract requires annual deductibles, a separate
7 deductible for mental health services is allowed. The annual
8 deductible for mental health services may not be greater than the
9 annual deductible for medical and surgical services. This does not
10 preclude a plan with pharmacy benefits from establishing a separate
11 deductible for those benefits if it applies to all prescription drugs.

12 (ii) If a plan has maximum out-of-pocket limits, one single annual
13 maximum out-of-pocket limit for medical and surgical and mental health
14 services is required. This subsection (2)(a)(ii) does not preclude a
15 plan with pharmacy benefits from excluding prescription drugs from the
16 out-of-pocket limit as long as all prescription drugs are treated
17 equivalently.

18 (b) For adults, the provisions of subsection (1)(a)(i) and (ii) of
19 this section apply, except that contracts are allowed to have
20 differential copays or coinsurance requirements, which means that
21 contracts may have a greater copay or coinsurance for mental health
22 services than for medical and surgical services. However, the copay or
23 coinsurance for mental health services may be no greater than as of
24 January 1, 2001.

25 (3) This section does not prohibit a health care service contractor
26 from requiring the use of preauthorization screening prior to
27 authorizing the delivery of mental health services or the requirement
28 that mental health services must be medically necessary as determined
29 by its medical director or his or her designee or other managed care
30 tools. Managed care requirements for mental health services may be
31 different from those for medical and surgical services.

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

34 (1) For the purpose of this section, "mental health services"
35 means: (a) Outpatient and inpatient services provided to treat any of
36 the mental disorders covered by the diagnostic categories listed in the
37 most current version of the diagnostic and statistical manual of mental
38 disorders on the effective date of this section, or such subsequent

1 date as may be provided by the insurance commissioner by rule,
2 consistent with the purposes of chapter . . . , Laws of 2001 (this act),
3 except V codes and those codes defining substance abuse disorders,
4 291.0 through 292.9 and 303.0 through 305.9 as of the effective date of
5 this section; and (b) prescription drugs, if the plan contract
6 otherwise includes coverage for prescription drugs.

7 (2) All health benefit plans offered by health maintenance
8 organizations to groups with fifty or more persons, issued or renewed
9 after July 1, 2002, and for groups with at least twenty-five persons
10 but fewer than fifty persons, issued or renewed after July 1, 2003,
11 that provide coverage for hospital or medical care shall provide
12 coverage for mental health services as follows:

13 (a) For children as that term is defined in the plan, the plan
14 shall only impose treatment limitations or financial requirements on
15 coverage for mental health services, if the same limitations or
16 requirements are imposed on coverage for medical and surgical services.
17 This includes but is not limited to copays, cost sharing, annual or
18 lifetime dollar limits, outpatient visit limits, outpatient day limits,
19 and inpatient limits. Wellness and preventive services that are
20 reimbursed at one hundred percent without deductible, coinsurance, or
21 other cost sharing are excluded from this comparison.

22 (i) If a contract requires annual deductibles, a separate
23 deductible for mental health services is allowed. The annual
24 deductible for mental health services may not be greater than the
25 annual deductible for medical and surgical services. This does not
26 preclude a plan with pharmacy benefits from establishing a separate
27 deductible for those benefits if it applies to all prescription drugs.

28 (ii) If a plan has maximum out-of-pocket limits, one single annual
29 maximum out-of-pocket limit for medical and surgical and mental health
30 services is required. This subsection (2)(a)(ii) does not preclude a
31 plan with pharmacy benefits from excluding prescription drugs from the
32 out-of-pocket limit as long as all prescription drugs are treated
33 equivalently.

34 (b) For adults, subsection (1)(a)(i) and (ii) of this section
35 apply, except that health maintenance organizations are allowed to have
36 differential copays or coinsurance requirements, which means that they
37 may have a greater copay or coinsurance for mental health services than
38 for medical/surgical services. However, the copay or coinsurance for

1 mental health services may be no greater than what was in existence on
2 January 1, 2001.

3 (3) This section does not prohibit a health maintenance
4 organization from requiring the use of preauthorization screening prior
5 to authorizing the delivery of mental health services or the
6 requirement that mental health services must be medically necessary as
7 determined by its medical director or his or her designee or other
8 managed care tools. Managed care requirements for mental health
9 services may be different from those for medical/surgical services.

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

12 Notwithstanding the provisions of RCW 70.47.060, this section
13 governs the provision of mental health services to subsidized enrollees
14 in the basic health plan.

15 (1) For the purpose of this section, "mental health services"
16 means: (a) Outpatient and inpatient services provided to treat any of
17 the mental disorders covered by the diagnostic categories listed in the
18 most current version of the diagnostic and statistical manual of mental
19 disorders on the effective date of this section, or such subsequent
20 date as may be provided by the Washington state health care authority
21 by rule, consistent with the purposes of chapter . . . , Laws of 2001
22 (this act), except V codes and those codes defining substance abuse
23 disorders, 291.0 through 292.9 and 303.0 through 305.9 as of the
24 effective date of this section; and (b) prescription drugs, if the plan
25 contract otherwise includes coverage for prescription drugs.

26 (2) After July 1, 2003, the basic health plan shall provide
27 coverage for mental health services to subsidized children and adults
28 as follows:

29 (a) For children as that term is defined by the basic health plan,
30 the plan shall only impose treatment limitations or financial
31 requirements on coverage for mental health services, if the same
32 limitations or requirements are imposed on coverage for medical and
33 surgical services. This includes but is not limited to copays, cost
34 sharing, annual or lifetime dollar limits, outpatient visit limits,
35 outpatient day limits, and inpatient limits. Wellness and preventive
36 services that are reimbursed at one hundred percent without deductible,
37 coinsurance, or other cost sharing are excluded from this comparison.

1 (i) If a contract requires annual deductibles, a separate
2 deductible for mental health services is allowed. The annual
3 deductible for mental health services may not be greater than the
4 annual deductible for medical and surgical services. This does not
5 preclude a plan with pharmacy benefits from establishing a separate
6 deductible for those benefits if it applies to all prescription drugs.

7 (ii) If a plan has maximum out-of-pocket limits, one single annual
8 maximum out-of-pocket limit for medical and surgical and mental health
9 services is required. This subsection (2)(a)(ii) does not preclude a
10 plan with pharmacy benefits from excluding prescription drugs from the
11 out-of-pocket limit as long as all prescription drugs are treated
12 equivalently.

13 (b) For adults, subsection (1)(a)(i) and (ii) of this section
14 apply, except the plan is allowed to have differential copays or
15 coinsurance requirements, which means that contracts may have a greater
16 copay or coinsurance for mental health services than for medical and
17 surgical services. However, the copay or coinsurance for mental health
18 services may be no greater than as of January 1, 2001.

19 (3) The plan is required to use those managed care tools necessary
20 for the cost-effective management of this act to include but not be
21 limited to the use of preauthorization screening prior to authorizing
22 the delivery of mental health services and the requirement that mental
23 health services must be medically necessary as determined by its
24 medical director or his or her designee. Managed care requirements for
25 mental health services may be different from those for medical and
26 surgical services.

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

29 (1) Each group insurer providing disability insurance coverage in
30 this state for hospital or medical care under contracts which are
31 issued, delivered, or renewed in this state on or after July 1, 1986,
32 shall offer optional supplemental coverage for mental health treatment
33 for the insured and the insured's covered dependents.

34 (2) Benefits shall be provided under the optional supplemental
35 coverage for mental health treatment whether treatment is rendered by:
36 (a) A physician licensed under chapter 18.71 or 18.57 RCW; (b) a
37 psychologist licensed under chapter 18.83 RCW; (c) a community mental
38 health agency licensed by the department of social and health services

1 pursuant to chapter 71.24 RCW; or (d) a state hospital as defined in
2 RCW 72.23.010. The treatment shall be covered at the usual and
3 customary rates for such treatment. The insurer, health care service
4 contractor, or health maintenance organization providing optional
5 coverage under the provisions of this section for mental health
6 services may establish separate usual and customary rates for services
7 rendered by physicians licensed under chapter 18.71 or 18.57 RCW,
8 psychologists licensed under chapter 18.83 RCW, and community mental
9 health centers licensed under chapter 71.24 RCW and state hospitals as
10 defined in RCW 72.23.010. However, the treatment may be subject to
11 contract provisions with respect to reasonable deductible amounts or
12 copayments. In order to qualify for coverage under this section, a
13 licensed community mental health agency shall have in effect a plan for
14 quality assurance and peer review, and the treatment shall be
15 supervised by a physician licensed under chapter 18.71 or 18.57 RCW or
16 by a psychologist licensed under chapter 18.83 RCW.

17 (3) The group disability insurance contract may provide that all
18 the coverage for mental health treatment is waived for all covered
19 members if the contract holder so states in advance in writing to the
20 insurer.

21 (4) This section shall not apply to a group disability insurance
22 contract that has been entered into in accordance with a collective
23 bargaining agreement between management and labor representatives prior
24 to March 1, 1987.

25 (5) This section does not apply to groups with fifty or more
26 persons beginning July 1, 2002.

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

29 (1) Each health care service contractor providing hospital or
30 medical services or benefits in this state under group contracts for
31 health care services under this chapter which are issued, delivered, or
32 renewed in this state on or after July 1, 1986, shall offer optional
33 supplemental coverage for mental health treatment for the insured and
34 the insured's covered dependents.

35 (2) Benefits shall be provided under the optional supplemental
36 coverage for mental health treatment whether treatment is rendered by:
37 (a) A physician licensed under chapter 18.71 or 18.57 RCW; (b) a
38 psychologist licensed under chapter 18.83 RCW; (c) a community mental

1 health agency licensed by the department of social and health services
2 pursuant to chapter 71.24 RCW; or (d) a state hospital as defined in
3 RCW 72.23.010. The treatment shall be covered at the usual and
4 customary rates for such treatment. The insurer, health care service
5 contractor, or health maintenance organization providing optional
6 coverage under the provisions of this section for mental health
7 services may establish separate usual and customary rates for services
8 rendered by physicians licensed under chapter 18.71 or 18.57 RCW,
9 psychologists licensed under chapter 18.83 RCW, and community mental
10 health centers licensed under chapter 71.24 RCW and state hospitals as
11 defined in RCW 72.23.010. However, the treatment may be subject to
12 contract provisions with respect to reasonable deductible amounts or
13 copayments. In order to qualify for coverage under this section, a
14 licensed community mental health agency shall have in effect a plan for
15 quality assurance and peer review, and the treatment shall be
16 supervised by a physician licensed under chapter 18.71 or 18.57 RCW or
17 by a psychologist licensed under chapter 18.83 RCW.

18 (3) The group contract for health care services may provide that
19 all the coverage for mental health treatment is waived for all covered
20 members if the contract holder so states in advance in writing to the
21 health care service contractor.

22 (4) This section shall not apply to a group health care service
23 contract that has been entered into in accordance with a collective
24 bargaining agreement between management and labor representatives prior
25 to March 1, 1987.

26 (5) This section does not apply to groups with fifty or more
27 persons beginning July 1, 2002.

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

30 (1) Each health maintenance organization providing services or
31 benefits for hospital or medical care coverage in this state under
32 group health maintenance agreements which are issued, delivered, or
33 renewed in this state on or after July 1, 1986, shall offer optional
34 supplemental coverage for mental health treatment to the enrolled
35 participant and the enrolled participant's covered dependents.

36 (2) Benefits shall be provided under the optional supplemental
37 coverage for mental health treatment whether treatment is rendered by
38 the health maintenance organization or the health maintenance

1 organization refers the enrolled participant or the enrolled
2 participant's covered dependents for treatment to: (a) A physician
3 licensed under chapter 18.71 or 18.57 RCW; (b) a psychologist licensed
4 under chapter 18.83 RCW; (c) a community mental health agency licensed
5 by the department of social and health services pursuant to chapter
6 71.24 RCW; or (d) a state hospital as defined in RCW 72.23.010. The
7 treatment shall be covered at the usual and customary rates for such
8 treatment. The insurer, health care service contractor, or health
9 maintenance organization providing optional coverage under the
10 provisions of this section for mental health services may establish
11 separate usual and customary rates for services rendered by physicians
12 licensed under chapter 18.71 or 18.57 RCW, psychologists licensed under
13 chapter 18.83 RCW, and community mental health centers licensed under
14 chapter 71.24 RCW and state hospitals as defined in RCW 72.23.010.
15 However, the treatment may be subject to contract provisions with
16 respect to reasonable deductible amounts or copayments. In order to
17 qualify for coverage under this section, a licensed community mental
18 health agency shall have in effect a plan for quality assurance and
19 peer review, and the treatment shall be supervised by a physician
20 licensed under chapter 18.71 or 18.57 RCW or by a psychologist licensed
21 under chapter 18.83 RCW.

22 (3) The group health maintenance agreement may provide that all the
23 coverage for mental health treatment is waived for all covered members
24 if the contract holder so states in advance in writing to the health
25 maintenance organization.

26 (4) This section shall not apply to a group health maintenance
27 agreement that has been entered into in accordance with a collective
28 bargaining agreement between management and labor representatives prior
29 to March 1, 1987.

30 (5) This section does not apply to groups with fifty or more
31 persons beginning July 1, 2002.

32 NEW SECTION. Sec. 10. The following acts or parts of acts are
33 each repealed, effective July 1, 2003:

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

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

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

3 NEW SECTION. **Sec. 11.** If any provision of this act or its
4 application to any person or circumstance is held invalid, the
5 remainder of the act or the application of the provision to other
6 persons or circumstances is not affected.

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