
SENATE BILL 5450

State of Washington

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2005 Regular Session

By Senators Thibaudeau, Oke, Brown, Mulliken, Keiser, Doumit, Prentice, Poulsen, Regala, Kline, Franklin, Parlette, Rockefeller, Spanel, McAuliffe, Kohl-Welles and Pflug

Read first time 01/25/2005. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to mental health parity; amending RCW 48.21.240,
2 48.44.340, and 48.46.290; adding new sections to chapter 41.05 RCW;
3 adding a new section to chapter 48.21 RCW; adding a new section to
4 chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; adding
5 new sections to chapter 70.47 RCW; adding a new section to chapter
6 48.02 RCW; creating a new section; and declaring an emergency.

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

8 NEW SECTION. **Sec. 1.** The legislature finds that the costs of
9 leaving mental disorders untreated or undertreated are significant, and
10 often include: Decreased job productivity, loss of employment,
11 increased disability costs, deteriorating school performance, increased
12 use of other health services, treatment delays leading to more costly
13 treatments, suicide, family breakdown and impoverishment, and
14 institutionalization, whether in hospitals, juvenile detention, jails,
15 or prisons.

16 Treatable mental disorders are prevalent and often have a high
17 impact on health and productive life. The legislature finds that the
18 potential benefits of improved access to mental health services are

1 significant. Additionally, the legislature declares that it is not
2 cost-effective to treat persons with mental disorders differently than
3 persons with medical and surgical disorders.

4 Therefore, the legislature intends to require that insurance
5 coverage be at parity for mental health services, which means this
6 coverage be delivered under the same terms and conditions as medical
7 and surgical services.

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

10 (1) For the purposes of this section, "mental health services"
11 means medically necessary outpatient and inpatient services provided to
12 treat mental disorders covered by the diagnostic categories listed in
13 the most current version of the diagnostic and statistical manual of
14 mental disorders, published by the American psychiatric association, on
15 the effective date of this section, or such subsequent date as may be
16 provided by the administrator by rule, consistent with the purposes of
17 this act, with the exception of the following categories, codes, and
18 services: (a) Substance related disorders; (b) life transition
19 problems, currently referred to as "V" codes, and diagnostic codes 302
20 through 302.9 as found in the diagnostic and statistical manual of
21 mental disorders, 4th edition, published by the American psychiatric
22 association; (c) skilled nursing facility services, home health care,
23 residential treatment, and custodial care; and (d) court ordered
24 treatment unless the authority's or contracted insuring entity's
25 medical director determines the treatment to be medically necessary.

26 (2) All health benefit plans offered to public employees and their
27 covered dependents under this chapter that provide coverage for medical
28 and surgical services shall provide:

29 (a) For all health benefit plans established or renewed on or after
30 July 1, 2005, coverage for:

31 (i) Mental health services. The copayment or coinsurance for
32 mental health services may be no more than the copayment or coinsurance
33 for medical and surgical services otherwise provided under the health
34 benefit plan. Wellness and preventive services that are provided or
35 reimbursed at a lesser copayment, coinsurance, or other cost sharing
36 than other medical and surgical services are excluded from this
37 comparison; and

1 (ii) Prescription drugs intended to treat any of the disorders
2 identified 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 (b) For all health benefit plans established or renewed on or after
6 January 1, 2008, coverage for:

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

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

20 (c) For all health benefit plans established or renewed on or after
21 July 1, 2010, coverage for:

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

37 (ii) Prescription drugs intended to treat any of the disorders

1 identified in subsection (1) of this section to the same extent, and
2 under the same terms and conditions, as other prescription drugs
3 covered by the health benefit plan.

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

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

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

14 (6) The administrator will consider care management techniques for
15 mental health services, including but not limited to: (a) Authorized
16 treatment plans; (b) preauthorization requirements based on the type of
17 service; (c) concurrent and retrospective utilization review; (d)
18 utilization management practices; (e) discharge coordination and
19 planning; and (f) contracting with and using a network of participating
20 providers.

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

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

1 ordered treatment unless the insurer's medical director or designee
2 determines the treatment to be medically necessary.

3 (2) All group disability insurance contracts and blanket disability
4 insurance contracts providing health benefit plans that provide
5 coverage for medical and surgical services shall provide:

6 (a) For all health benefit plans established or renewed on or after
7 July 1, 2005, for groups of more than fifty employees coverage for:

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

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

19 (b) For all health benefit plans established or renewed on or after
20 January 1, 2008, for groups of more than fifty employees coverage for:

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

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

34 (c) For all health benefit plans established or renewed on or after
35 July 1, 2010, for groups of more than fifty employees coverage for:

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

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

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

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

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

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

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

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

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

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

11 (a) For all health benefit plans established or renewed on or after
12 July 1, 2005, for groups of more than fifty employees coverage for:

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

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

24 (b) For all health benefit plans established or renewed on or after
25 January 1, 2008, for groups of more than fifty employees coverage for:

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

35 (ii) Prescription drugs intended to treat any of the disorders
36 identified in subsection (1) of this section to the same extent, and
37 under the same terms and conditions, as other prescription drugs
38 covered by the health benefit plan.

1 (c) For all health benefit plans established or renewed on or after
2 July 1, 2010, for groups of more than fifty employees coverage for:

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

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

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

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

30 (5) Nothing in this section shall be construed to prevent the
31 management of mental health 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 purposes of this section, "mental health services"
35 means medically necessary outpatient and inpatient services provided to
36 treat mental disorders covered by the diagnostic categories listed in
37 the most current version of the diagnostic and statistical manual of

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

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

17 (a) For all health benefit plans established or renewed on or after
18 July 1, 2005, for groups of more than fifty employees coverage for:

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

26 (ii) Prescription drugs intended to treat any of the disorders
27 identified 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 after
31 January 1, 2008, for groups of more than fifty employees coverage for:

32 (i) Mental health services. The copayment or coinsurance for
33 mental health services may be no more than the copayment or coinsurance
34 for medical and surgical services otherwise provided under the health
35 benefit plan. Wellness and preventive services that are provided or
36 reimbursed at a lesser copayment, coinsurance, or other cost sharing
37 than other medical and surgical services are excluded from this

1 comparison. If the health benefit plan imposes a maximum out-of-pocket
2 limit or stop loss, it shall be a single limit or stop loss for
3 medical, surgical, and mental health services; and

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

8 (c) For all health benefit plans established or renewed on or after
9 July 1, 2010, for groups of more than fifty employees coverage for:

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

25 (ii) Prescription drugs intended to treat any of the disorders
26 identified in subsection (1) of this section to the same extent, and
27 under the same terms and conditions, as other prescription drugs
28 covered by the health benefit plan.

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

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

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

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

3 (1) For the purposes of this section, "mental health services"
4 means medically necessary outpatient and inpatient services provided to
5 treat mental disorders covered by the diagnostic categories listed in
6 the most current version of the diagnostic and statistical manual of
7 mental disorders, published by the American psychiatric association, on
8 the effective date of this section, or such subsequent date as may be
9 determined by the administrator, by rule, consistent with the purposes
10 of this act, with the exception of the following categories, codes, and
11 services: (a) Substance related disorders; (b) life transition
12 problems, currently referred to as "V" codes, and diagnostic codes 302
13 through 302.9 as found in the diagnostic and statistical manual of
14 mental disorders, 4th edition, published by the American psychiatric
15 association; (c) skilled nursing facility services, home health care,
16 residential treatment, and custodial care; and (d) court ordered
17 treatment, unless the Washington basic health plan's or contracted
18 managed health care system's medical director or designee determines
19 the treatment to be medically necessary.

20 (2)(a) Any schedule of benefits established or renewed by the
21 Washington basic health plan on or after July 1, 2005, shall provide
22 coverage for:

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

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

34 (b) Any schedule of benefits established or renewed by the
35 Washington basic health plan on or after January 1, 2008, shall provide
36 coverage for:

37 (i) Mental health services. The copayment or coinsurance for
38 mental health services may be no more than the copayment or coinsurance

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

8 (ii) Prescription drugs intended to treat any of the disorders
9 identified in subsection (1) of this section to the same extent, and
10 under the same terms and conditions, as other prescription drugs
11 covered under the schedule of benefits.

12 (c) Any schedule of benefits established or renewed by the
13 Washington basic health plan on or after July 1, 2010, shall include
14 coverage for:

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

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

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

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

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

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

9 (1) For groups not covered by section 3 of this act, each group
10 insurer providing disability insurance coverage in this state for
11 hospital or medical care under contracts which are issued, delivered,
12 or renewed in this state ((on or after July 1, 1986,)) shall offer
13 optional supplemental coverage for mental health treatment for the
14 insured and the insured's covered dependents.

15 (2) Benefits shall be provided under the optional supplemental
16 coverage for mental health treatment whether treatment is rendered by:

17 (a) A ~~((physician licensed under chapter 18.71 or 18.57 RCW; (b) a~~
18 ~~psychologist licensed under chapter 18.83))~~ licensed mental health
19 provider regulated under chapter 18.57, 18.71, 18.79, 18.83, or 18.225
20 RCW; ((+e)) (b) a community mental health agency licensed by the
21 department of social and health services pursuant to chapter 71.24 RCW;
22 or ~~((+d))~~ (c) a state hospital as defined in RCW 72.23.010. The
23 treatment shall be covered at the usual and customary rates for such
24 treatment. The insurer~~((, health care service contractor, or health~~
25 ~~maintenance organization))~~ providing optional coverage under the
26 provisions of this section for mental health services may establish
27 separate usual and customary rates for services rendered by
28 ~~((physicians licensed under chapter 18.71 or 18.57 RCW, psychologists~~
29 ~~licensed under chapter 18.83 RCW, and community mental health centers~~
30 ~~licensed under chapter 71.24 RCW and state hospitals as defined in RCW~~
31 ~~72.23.010))~~ the different categories of providers listed in (a) through
32 (c) of this subsection. However, the treatment may be subject to
33 contract provisions with respect to reasonable deductible amounts or
34 copayments. In order to qualify for coverage under this section, a
35 licensed community mental health agency shall have in effect a plan for
36 quality assurance and peer review, and the treatment shall be

1 supervised by (~~a physician licensed under chapter 18.71 or 18.57 RCW~~
2 ~~or by a psychologist licensed under chapter 18.83 RCW~~) one of the
3 categories of providers listed in (a) of this subsection.

4 (3) For groups not covered by section 3 of this act, the group
5 disability insurance contract may provide that all the coverage for
6 mental health treatment is waived for all covered members if the
7 contract holder so states in advance in writing to the insurer.

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

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

14 (1) For groups not covered by section 4 of this act, each health
15 care service contractor providing hospital or medical services or
16 benefits in this state under group contracts for health care services
17 under this chapter which are issued, delivered, or renewed in this
18 state (~~on or after July 1, 1986,~~) shall offer optional supplemental
19 coverage for mental health treatment for the insured and the insured's
20 covered dependents.

21 (2) Benefits shall be provided under the optional supplemental
22 coverage for mental health treatment whether treatment is rendered by:

23 (a) A (~~physician licensed under chapter 18.71 or 18.57 RCW; (b) a~~
24 ~~psychologist licensed under chapter 18.83~~) licensed mental health
25 provider regulated under chapter 18.57, 18.71, 18.79, 18.83, or 18.225
26 RCW; ((+e)) (b) a community mental health agency licensed by the
27 department of social and health services pursuant to chapter 71.24 RCW;
28 or ((+d)) (c) a state hospital as defined in RCW 72.23.010. The
29 treatment shall be covered at the usual and customary rates for such
30 treatment. The (~~insurer,~~) health care service contractor(~~, or~~
31 ~~health maintenance organization~~) providing optional coverage under the
32 provisions of this section for mental health services may establish
33 separate usual and customary rates for services rendered by
34 (~~physicians licensed under chapter 18.71 or 18.57 RCW, psychologists~~
35 ~~licensed under chapter 18.83 RCW, and community mental health centers~~
36 ~~licensed under chapter 71.24 RCW and state hospitals as defined in RCW~~
37 ~~72.23.010~~) the different categories of providers listed in (a) through

1 (c) of this subsection. However, the treatment may be subject to
2 contract provisions with respect to reasonable deductible amounts or
3 copayments. In order to qualify for coverage under this section, a
4 licensed community mental health agency shall have in effect a plan for
5 quality assurance and peer review, and the treatment shall be
6 supervised by ~~((a physician licensed under chapter 18.71 or 18.57 RCW~~
7 ~~or by a psychologist licensed under chapter 18.83 RCW))~~ one of the
8 categories of providers listed in (a) of this subsection.

9 (3) For groups not covered by section 4 of this act, the group
10 contract for health care services may provide that all the coverage for
11 mental health treatment is waived for all covered members if the
12 contract holder so states in advance in writing to the health care
13 service contractor.

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

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

20 (1) For groups not covered by section 5 of this act, each health
21 maintenance organization providing services or benefits for hospital or
22 medical care coverage in this state under group health maintenance
23 agreements which are issued, delivered, or renewed in this state ~~((on~~
24 ~~or after July 1, 1986,))~~ shall offer optional supplemental coverage for
25 mental health treatment to the enrolled participant and the enrolled
26 participant's covered dependents.

27 (2) Benefits shall be provided under the optional supplemental
28 coverage for mental health treatment whether treatment is rendered by
29 the health maintenance organization or the health maintenance
30 organization refers the enrolled participant or the enrolled
31 participant's covered dependents for treatment ~~((to))~~ by: (a) A
32 ~~((physician licensed under chapter 18.71 or 18.57 RCW; (b) a~~
33 ~~psychologist licensed under chapter 18.83))~~ licensed mental health
34 provider regulated under chapter 18.57, 18.71, 18.79, 18.83, or 18.225
35 RCW; ((+e)) (b) a community mental health agency licensed by the
36 department of social and health services pursuant to chapter 71.24 RCW;
37 or ((+d)) (c) a state hospital as defined in RCW 72.23.010. The

1 treatment shall be covered at the usual and customary rates for such
2 treatment. The (~~insurer, health care service contractor, or~~) health
3 maintenance organization providing optional coverage under the
4 provisions of this section for mental health services may establish
5 separate usual and customary rates for services rendered by
6 (~~physicians licensed under chapter 18.71 or 18.57 RCW, psychologists~~
7 ~~licensed under chapter 18.83 RCW, and community mental health centers~~
8 ~~licensed under chapter 71.24 RCW and state hospitals as defined in RCW~~
9 ~~72.23.010~~) the different categories of providers listed in (a) through
10 (c) of this subsection. 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~~
16 ~~or by a psychologist licensed under chapter 18.83 RCW~~) one of the
17 categories of providers listed in (a) of this subsection.

18 (3) For groups not covered by section 5 of this act, the group
19 health maintenance agreement may provide that all the coverage for
20 mental health treatment is waived for all covered members if the
21 contract holder so states in advance in writing to the health
22 maintenance organization.

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

27 NEW SECTION. Sec. 10. A new section is added to chapter 48.02 RCW
28 to read as follows:

29 The insurance commissioner may adopt rules to implement sections 3
30 through 5 of this act, except that the rules do not apply to health
31 benefit plans administered or operated under chapter 41.05 or 70.47
32 RCW.

33 NEW SECTION. Sec. 11. A new section is added to chapter 70.47 RCW
34 to read as follows:

35 The administrator may adopt rules to implement section 6 of this
36 act.

1 NEW SECTION. **Sec. 12.** A new section is added to chapter 41.05 RCW
2 to read as follows:

3 The administrator may adopt rules to implement section 2 of this
4 act.

5 NEW SECTION. **Sec. 13.** If any provision of this act or its
6 application to any person or circumstance is held invalid, the
7 remainder of the act or the application of the provision to other
8 persons or circumstances is not affected.

9 NEW SECTION. **Sec. 14.** This act is necessary for the immediate
10 preservation of the public peace, health, or safety, or support of the
11 state government and its existing public institutions, and takes effect
12 immediately.

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