CERTIFICATION OF ENROLLMENT

HOUSE BILL 2501

Chapter 74, Laws of 2006

59th Legislature
2006 Regular Session

MENTAL HEALTH SERVICES--GROUP COVERAGE

EFFECTIVE DATE: 3/15/06

Passed by the House February 9, 2006
Yeas 98 Nays 0

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate March 3, 2006
Yeas 46 Nays 0

BRAD OWEN

President of the Senate

Approved March 15, 2006.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Richard Nafziger, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **HOUSE BILL 2501** as passed by the House of Representatives and the Senate on the dates hereon set forth.

RICHARD NAFZIGER

Chief Clerk

FILED

March 15, 2006 - 3:27 p.m.

Secretary of State
State of Washington

HOUSE BILL 2501

Passed Legislature - 2006 Regular Session

State of Washington 59th Legislature 2006 Regular Session

By Representatives Schual-Berke, Cody and Morrell; by request of Insurance Commissioner

Prefiled 1/6/2006. Read first time 01/09/2006. Referred to Committee on Health Care.

AN ACT Relating to clarifying that coverage for mental health services as defined in RCW 48.21.241, 48.44.341, and 48.46.291 applies to all group health plans for groups other than small groups as defined in RCW 48.43.005; amending RCW 48.21.241, 48.44.341, and 48.46.291; and declaring an emergency.

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

Sec. 1. RCW 48.21.241 and 2005 c 6 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 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 ((~~established or renewed on or after~~)) 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, ((~~for groups of more than fifty employees~~)) 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 ((~~established or renewed on or after~~)) 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, ((~~for groups of more than fifty employees~~)) 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 ((~~established or renewed on or after~~)) 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, ((~~for groups of more than fifty employees~~)) 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. 2. RCW 48.44.341 and 2005 c 6 s 4 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 ((~~established or renewed on or after~~)) 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, ((~~for groups of more than fifty employees~~)) 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 ((~~established or renewed on or after~~)) 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, ((~~for groups of more than fifty employees~~)) 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 ((~~established or renewed on or after~~)) 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, ((~~for groups of more than fifty employees~~)) 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 48.46.291 and 2005 c 6 s 5 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 <u>group</u> health benefit plans ((~~established or renewed on or after~~)) <u>for groups other than small groups, as defined in RCW 48.43.005 delivered, issued for delivery, or renewed on or after</u>

January 1, 2006, ((~~for groups of more than fifty employees~~)) 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 ((~~established or renewed on or after~~)) 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, ((~~for groups of more than fifty employees~~)) 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 ((~~established or renewed on or after~~)) 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, ((~~for groups of more than fifty employees~~)) 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.

NEW SECTION. **Sec. 4.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately.

Passed by the House February 9, 2006.
Passed by the Senate March 3, 2006.
Approved by the Governor March 15, 2006.
Filed in Office of Secretary of State March 15, 2006.