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**SUBSTITUTE HOUSE BILL 2338**

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**State of Washington 66th Legislature 2020 Regular Session**

**By** House Health Care & Wellness (originally sponsored by Representatives Macri, Thai, Wylie, Doglio, Cody, and Pollet)

AN ACT Relating to prohibiting discrimination in health care coverage; and amending RCW 41.05.600, 48.20.580, 48.21.241, 48.41.220, 48.44.341, 48.46.291, 70.47.200, 48.30.300, and 48.43.0128.

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

**Sec.**  RCW 41.05.600 and 2005 c 6 s 2 are each amended to read as follows:

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

(a) For health benefit plans issued or renewed before January 1, 2021, 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~~)) the effective date of this section, or such subsequent date as may be provided by the ((~~administrator~~)) director by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: ((~~(a)~~)) (i) Substance related disorders; ((~~(b)~~)) (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; ((~~(c)~~)) (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and ((~~(d)~~)) (iv) court ordered treatment unless the authority's or contracted insuring entity's medical director determines the treatment to be medically necessary; and

(b) For health benefit plans issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use 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 the effective date of this section, or such subsequent date as may be provided by the director by rule, consistent with the purposes of chapter 6, Laws of 2005.

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

~~(a) For all health benefit plans established or renewed on or after January 1, 2006, coverage for:~~

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

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

~~(b) For all health benefit plans established or renewed on or after January 1, 2008, coverage for:~~

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

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

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

((~~(i)~~)) (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 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)~~)) (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 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)~~)) (4) Nothing in this section shall be construed to prevent the management of mental health ((~~services~~)).

((~~(6)~~)) (5) The ((~~administrator~~)) director will consider care management techniques for mental health services if a comparable benefit management requirement is applicable to medical and surgical services, including but not limited to: (a) Authorized treatment plans; (b) preauthorization requirements based on the type of service; (c) concurrent and retrospective utilization review; (d) utilization management practices; (e) discharge coordination and planning; and (f) contracting with and using a network of participating providers.

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

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

(a) For health benefit plans issued or renewed before January 1, 2021, 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~~)) the effective date of this section, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: ((~~(a)~~)) (i) Substance related disorders; ((~~(b)~~)) (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; ((~~(c)~~)) (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and ((~~(d)~~)) (iv) court-ordered treatment unless the insurer's medical director or designee determines the treatment to be medically necessary; and

(b) For a health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, or to be a student-only health plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution, issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use 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 the effective date of this section, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.

(2) Each 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)~~)) (3) 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)~~)) (4) Nothing in this section shall be construed to prevent the management of mental health services if a comparable benefit management requirement is applicable to medical and surgical services.

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

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

(a) For health benefit plans that provide coverage for medical and surgical services issued or renewed before January 1, 2021, 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~~)) the effective date of this section, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: ((~~(a)~~)) (i) Substance related disorders; ((~~(b)~~)) (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; ((~~(c)~~)) (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and ((~~(d)~~)) (iv) court ordered treatment unless the insurer's medical director or designee determines the treatment to be medically necessary; and

(b) For health benefit plans that provide coverage for medical and surgical services issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use 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 the effective date of this section, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.

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

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

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

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

~~(b) For all group health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2008, coverage for:~~

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

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

~~(c) For all group health benefit plans delivered, issued for delivery, or renewed on or after July 1, 2010,~~)) coverage for:

((~~(i)~~)) (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 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)~~)) (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 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)~~)) (4) Nothing in this section shall be construed to prevent the management of mental health services if a comparable requirement is applicable to medical and surgical services.

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

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

(a) For each health insurance policy issued or renewed by the pool before January 1, 2021, 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~~)) the effective date of this section, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: ((~~(a)~~)) (i) Substance related disorders; ((~~(b)~~)) (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; ((~~(c)~~)) (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and ((~~(d)~~)) (iv) court‑ordered treatment unless the insurer's medical director or designee determines the treatment to be medically necessary; and

(b) For each health insurance policy issued or renewed by the pool on or after January 1, 2021, 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 health and substance use disorders, published by the American psychiatric association, on the effective date of this section, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.

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

(a) ((~~Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the policy. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the policy imposes a maximum out~~‑~~of~~‑~~pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services; and~~

~~(b) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the policy.~~

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

~~(a)~~)) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the policy. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the policy imposes a maximum out‑of‑pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the policy imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and

(b) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the policy.

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

~~(5)~~)) (3) 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)~~)) (4) Nothing in this section shall be construed to prevent the management of mental health services if a comparable requirement is applicable to medical and surgical services.

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

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

(a) For health benefit plans issued or renewed before January 1, 2021, 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~~)) the effective date of this section, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: ((~~(a)~~)) (i) Substance related disorders; ((~~(b)~~)) (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; ((~~(c)~~)) (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and ((~~(d)~~)) (iv) court ordered treatment unless the health care service contractor's medical director or designee determines the treatment to be medically necessary; and

(b) For a health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use 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 the effective date of this section, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.

(2) ((~~All~~)) A health service contract((~~s~~)) or a plan deemed by the commissioner to have a short-term limited purpose or duration, providing health benefit plans that provide coverage for medical and surgical services shall provide((~~:~~

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

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

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

~~(b) For all health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2008, coverage for:~~

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

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

~~(c) For all health benefit plans delivered, issued for delivery, or renewed on or after July 1, 2010,~~)) coverage for:

((~~(i)~~)) (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 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)~~)) (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 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)~~)) (4) Nothing in this section shall be construed to prevent the management of mental health services if a comparable requirement is applicable to medical and surgical services.

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

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

(a) For health benefit plans issued or renewed before January 1, 2021, 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~~)) the effective date of this section, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: ((~~(a)~~)) (i) Substance related disorders; ((~~(b)~~)) (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; ((~~(c)~~)) (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and ((~~(d)~~)) (iv) court ordered treatment unless the health maintenance organization's medical director or designee determines the treatment to be medically necessary; and

(b) For a health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use 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 the effective date of this section, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.

(2) ((~~All~~)) A health benefit plan((~~s~~)) or a plan deemed by the commissioner to have a short-term limited purpose or duration, offered by health maintenance organizations that provide coverage for medical and surgical services shall provide((~~:~~

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

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

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

~~(b) For all health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2008, coverage for:~~

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

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

~~(c) For all health benefit plans delivered, issued for delivery, or renewed on or after July 1, 2010,~~)) coverage for:

((~~(i)~~)) (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 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)~~)) (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 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)~~)) (4) Nothing in this section shall be construed to prevent the management of mental health services if a comparable requirement is applicable to medical and surgical services.

**Sec.**  RCW 70.47.200 and 2005 c 6 s 6 are each amended to read as follows:

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

(a) For any schedule of benefits established or renewed by the Washington basic health plan before January 1, 2021, 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~~)) the effective date of this section, or such subsequent date as may be determined by the ((~~administrator~~)) director, by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: ((~~(a)~~)) (i) Substance related disorders; ((~~(b)~~)) (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; ((~~(c)~~)) (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and ((~~(d)~~)) (iv) court ordered treatment, unless the Washington basic health plan's or contracted managed health care system's medical director or designee determines the treatment to be medically necessary; and

(b) For any schedule of benefits established or renewed by the Washington basic health plan on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental health or substance use disorders, published by the American psychiatric association, on the effective date of this section, or such subsequent date as may be determined by the director by rule, consistent with the purposes of chapter 6, Laws of 2005.

(2)((~~(a)~~)) Any schedule of benefits established or renewed by the Washington basic health plan ((~~on or after January 1, 2006,~~)) shall provide coverage for:

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

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

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

~~(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the schedule of benefits. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the schedule of benefits imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services; and~~

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

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

~~(i)~~)) (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 schedule of benefits. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the schedule of benefits imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the schedule of benefits imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and

((~~(ii)~~)) (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 under the schedule of benefits.

(3) ((~~In meeting the requirements of subsection (2)(a) and (b) of this section, the Washington basic health plan 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)~~)) (4) Nothing in this section shall be construed to prevent the management of mental health services if a comparable requirement is applicable to medical and surgical services.

**Sec.**  RCW 48.30.300 and 2006 c 4 s 18 are each amended to read as follows:

Notwithstanding any provision contained in Title 48 RCW to the contrary:

(1) A person or entity engaged in the business of insurance in this state may not refuse to issue any contract of insurance or cancel or decline to renew such contract because of the sex, marital status, or sexual orientation as defined in RCW 49.60.040, or the presence of any sensory, mental, or physical handicap of the insured or prospective insured. The amount of benefits payable, or any term, rate, condition, or type of coverage may not be restricted, modified, excluded, increased, or reduced on the basis of the sex, marital status, or sexual orientation, or be restricted, modified, excluded, or reduced on the basis of the presence of any sensory, mental, or physical handicap of the insured or prospective insured.

((~~This~~)) (2) Except as provided in RCW 48.43.0128, 48.44.220, or 48.46.370, this subsection does not prohibit fair discrimination on the basis of sex, or marital status, or the presence of any sensory, mental, or physical handicap when bona fide statistical differences in risk or exposure have been substantiated.

**Sec.**  RCW 48.43.0128 and 2019 c 33 s 15 are each amended to read as follows:

(1) A health carrier offering a nongrandfathered health plan ((~~in the individual or small group market~~)) or a plan deemed by the commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution may not:

(a) In its benefit design or implementation of its benefit design, discriminate against individuals because of their age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions; and

(b) With respect to the health plan or plan deemed by the commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

(2) Nothing in this section may be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques.

(3) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act.

**--- END ---**